

SYMPOSIUM

ALBANY LAW REVIEW SPRING 2018 SYMPOSIUM:

RECONSIDERING THE RIGHT TO DIE: THE DEBATE OVER
ASSISTED SUICIDE

ALBANY LAW SCHOOL
Dean Alexander Moot Courtroom
Thursday, November 9, 2017, 5:30pm

Keynote Address: Honorable Eugene M. Fahey, *Court of Appeals,
N.Y.*

Introduction: Dean Alicia Ouellette, *President and Dean of Albany
Law School*

Moderator: Professor Vincent M. Bonventre, *Justice Robert H.
Jackson Distinguished Professor of Law*

Panelists:

Edward Mechmann, *Director, Public Policy at Archdiocese of New
York*

Peter Strauss, *Of Counsel, Drinker, Biddle & Reath LLP; Board of
Directors member, End of Life Choices of New York*

David Levin, *Executive Director Emeritus and Senior Consultant for
End of Life Choices New York*

Stephanie Woodward, *Director of Advocacy, Center for Disability
Rights*

I. WELCOME & OPENING REMARKS

Charlotte Rehfuss: Good evening everyone. Thank you for coming out. My name is Charlotte Rehfuss and I'm the Executive Editor for State Constitutional Commentary on the Albany Law Review. On behalf of the Albany Law Review, I would like to welcome

all of you to the 12th Annual Chief Judge Lawrence H. Cooke State Constitutional Commentary Symposium. Over the years, the Cooke symposium has provided a forum to discuss the history and background of state courts and judges. We are honored to add to this tradition by having Judge Fahey and our four panelists here with us tonight.

I would like to introduce our moderator, Albany Law School's own Professor Bonventre, the Justice, Robert H. Jackson, Distinguished Professor of Law. This symposium would not be possible over the years without Professor Bonventre, who has worked tirelessly to support the Albany Law Review, and we are so lucky to have him as our faculty advisor. I would next like to introduce Dean Ouellette. Dean Ouellette is the 18th President and Dean of Albany Law School. She is a graduate of Albany Law and was the Editor-in-Chief of the Albany Law Review. We are grateful for her continued contributions to the Albany Law Review and I am pleased to introduce her to start off tonight's discussion.

Dean Alicia Ouellette: Thank you, Charlotte, and welcome to all of you. Tonight should be a very special evening where we have some really good conversation about a very important topic. For those of you who have never been here before, you're sitting in a building built in 1928. This room used to be, for sixty years, a two-story library, so it's been transformed over time. The law school has been teaching law students continuously since 1851, so we've been at this a long time. I want to thank all of our panelists for being here tonight, and I also want to congratulate Charlotte Rehfuss, who is the Executive Editor for the State Constitutional Commentary.

You've done an extraordinary job putting together a great panel. Can you all join me in congratulating Charlotte? The topic of tonight's symposium is one that I care deeply about, both professionally and personally. I've spent much of my scholarly career exploring how choices in medicine affect our ability to have a good life, what it means to have a good death, and how laws that affect choice and dying affect persons with disabilities. All of those issues are relevant to tonight's discussion. The issues have also affected me on a personal level. Two years ago, my beloved father-in-law, Pete, ended a rousing and painful battle with terminal cancer on his own terms.

Pete was a great man, a Harvard-educated physician, and he had the help of another physician in obtaining lethal cocktail. At that time, he was in California, and physician aid in dying was not legal.

It was actually legalized by the legislature in California two weeks after he died. Pete's experience brought home, in a very personal way for family, the issues that we're going to talk about tonight—and they are complex both legally, ethically, morally, and they're not easy answers, so we're going to talk about them, and I congratulate the Law Review for picking this as a topic.

To start our discussion, we have with us a wonderful keynote speaker, the Honorable Eugene M. Fahey. Judge Fahey is an Associate Judge on New York's Court of Appeals, New York's highest court. Judge Fahey was appointed in 2006 to the Appellate Division, Fourth Department by Governor George Pataki, and then he was appointed in 2015. He was nominated in 2015 to the Court of Appeals by Governor Andrew Cuomo. He was confirmed unanimously by the New York State Senate. When Judge Fahey was appointed to the Court of Appeals, Governor Cuomo predicted that he would be a formidable judge.

The Governor's prediction was spot-on. Judge Fahey is a strong, principled writer, and a tough, if sometimes funny presence on a bench. Appearing before Judge Fahey can be quite a challenge. As a jurist, Judge Fahey is not afraid to stand his ground. Professor Bonventre has written that Judge Fahey, "Apparently feels no overriding need to just go along with his colleagues when he thinks they are mistaken." In fact, Bonventre notes that Judge Fahey has issued over fifty dissents. He often sides with the rights of the accused, except when the accused are officials or people doing harm to children, so an interesting observation by Professor Bonventre.

In *Myers v. Schneiderman*,¹ the case that gave rise to tonight's symposium, Judge Fahey concurred with the court's per curiam opinion, which rejected the plaintiff's arguments for right to physician aid in dying, or in the court's words, "physician-assisted suicide." I'm going to urge all of you, especially the students, to take note of the use of language tonight. People refer to the practice that we're talking about now in different ways. Some people will talk about death with dignity. Some people will talk about physician aid in dying, and some people will talk about physician-assisted suicide.

Think about what the words mean and how they're being used, and what it means to our arguments. In his concurrence, Judge Fahey expressed concern that permitting the practice, whatever we call it, would place New York on a slippery slope toward legalizing non-voluntary euthanasia, because a right to assisted suicide by the

¹ *Myers v. Schneiderman*, 73 N.E.3d 847 (N.Y. 2017).

terminally ill in circumscribed last resort situations would inevitably lead to expand, to include, persons who are not terminally ill. I'm sure that we're about to hear more of the thinking behind these words and Judge Fahey, we are incredibly honored to have you here tonight at Albany Law School. You all join me in welcoming Judge Eugene Fahey.

II. KEYNOTE ADDRESS

Hon. Eugene Fahey: I have to give judge . . . not judge, who wants to be a judge, Professor Bonventre, credit. He does pay attention and I think sometimes he even gets it right, which I have to give him credit for. First, I want to say that I'm honored to be here this evening. I think I have been asked to give the opening remarks. In the case of *Myers v. Schneiderman*, which was a 2017 Court of Appeals decision concerning physician-assisted suicide and the statutes under New York penal law, whether or not those statutes outlying their practice are constitutional. I felt that the legal questions in that case were relatively straightforward, but that the moral questions underlying the decisions were both difficult and profound.

That's of course why it makes it such a compelling case. Immanuel Kant, I don't get to quote Immanuel Kant very often, but Immanuel Kant said, "The difficult decisions are not choosing between what's right and wrong, but choosing between two different rights, what's right on one hand, and then what's right on the other hand." This case, in many ways, embodies a difficult choice between two very arguable rights, and I don't take an absolutist position, and my personal concurrence is really a reflection of my thinking of the historical realities of this decision in the world that we live in. Anyway, let me just talk a little bit about the procedural posture. How did this suit end up in front of the Court of Appeals?

A lot of law students I'm assuming are here, so this is a minor test for you. This originated in the plaintiff's request for a declaratory judgment that physicians who apply aid in dying are not violating the state's assisted suicide statutes which are penal law 120.30 and 125.15(3). The Attorney General moved to dismiss under CPLR 3211(a)(7), which means failure to state a cause of action, and the Supreme Court granted that motion to dismiss. The appellate division modified, but still dismissed. The appellate division modified in the analysis saying that the statutes do not violate the state constitution.

Now, as you may know, those of you who, and particularly the students here, the appeal itself generated four opinions, a per curiam opinion which we all agreed with, and then three concurrences. Now, a per curiam opinion, and per curiam simply means by the court, is an opinion that an appellate court decision makes it. It does not identify the individual judges who authored the opinion. It need not be unanimous to what was unanimous in this case. Now, why an opinion is done per curiam in any particular case is one of those secrets of appellate practice that the judges are bound never to speak of and really keeps people like Bonventre in business, and really any law professors throughout the auditorium in business really because they can really dig.

They can speculate on why we did what we did. Here, Judges Rivera, Stein Garcia, Wilson and myself, joined the unanimous per curiam willing, and then Judges Rivera, Garcia and myself wrote separate concurring opinions expanding on, or parting from the per curiam in certain respects. Two of the judges on the court, Judge DiFiore and Judge Feinman, took no part in the decision. Judge DiFiore had been Westchester County DA and been involved in a lower court ruling on the case, and Judge Feinman was from the first department where the case from, so that's why they were recused in those cases.

Now, the per curiam opinion held that the state constitution does not encompass a broad fundamental right to physician's assistance in suicide, and that the state's prohibition is rationally related to a number of legitimate government interests. The opinion concluded by noting, for the legislature might at some point specify conditions under which it will commit assisted suicide, but the present absolute has survived constitutional scrutiny. More interestingly, I thought, was Judge Rivera's concurrence, which noted that the assisted suicide prohibition might not survive the rational basis test to the extent it would criminalize the assisted suicide of a person, quoting from the judge, "Approaching the final stage of a dying process that is agonizingly painful and debilitating."

As an example, individuals who are so close to death that they would qualify for a terminal or a palliative sedation. Judge Rivera suggested that there's no rational distinction in the final stage of a terminal illness between assisted suicide and terminal sedation. Now, Judge Garcia's concurrence, and Judge Stein joined there, responded to Judge Rivera's ruling. Judge Stein, as you may know, is a graduate of Albany Law School, and so is Judge Garcia. Judge Garcia, of course, they were both very bright, very capable, and I

think you should be proud of them as an Albany graduate, but Judge Garcia observed that both facial and as applied challenges to the assisted suicide statute both fail.

The contrary to judge was there, the state's interest when a patient is in the final stage of life. In other words, that the constitutional challenge isn't changed by what stage in life a person is at, and the state's interests remain the same all the way through. That's what they said. Judge Rivera said, "It does change," and that was the core of her argument, that the closer you get to death, the state's interest in keeping you alive become diminished. This is just to give you a sense of what the dynamic was in the philosophical argument between us.

My own concurrence addressed a broader view, the consequences of assisted suicide. I tend to be elaborate on the point that the per curiam decision mentioned in passing and I know I talked a little bit about that, but I want to talk about the complexities of the *Myer* case. It really begins with terminology, which is something that the Dean talked about. In our fetid world of 24-hour news, blogs, and caught in a Twitter universe, terminology becomes all important and I noticed, among litigants, that on that fact that we all agree and that it is called by different things and related in different ways, and that many times, in the court, it was personal.

I'm always speaking for myself, no, not for the court, or as a whole. I look for labeling particular acts in neutral ways because I don't want the latest that we put on them to be reflective of agreeing with any particular political or policy point of view beyond the decision that we're making. The terminology does become important in the *Myers* case and the terminology is a reflection of the litigants' points of view. The plaintiffs here prefer the term aid in dying rather than assisted suicide, and I personally think that to some degree this is because they believe the word suicide suggests the state of mind of a clinically depressed person who commits suicide as a result of impaired judgment.

Plaintiffs argued that this state of mind is the reasoning of a mentally competent, a terminally ill patient who may wish to bring about his or her death, if the patient finds the dying process unbearable, is entirely different from that of a person who ends his or her life irrationally. New York law professors, led by Professor Bonventre, took that same position in a very well-written brief, I want to say. Now, this may be more the connotations of the word suicide rather than its dictionary meaning, and speaking for myself, I use the word physician-assisted suicide. The standard dictionary

definition of suicide is, “The act or instance of taking one’s own life voluntarily and intentionally.”

That’s from Merriam Webster’s dictionary and it makes no reference to how long the person has to live or whether the self-killing will be regarded as irrational. In other words, I’m trying to restrict myself in writings to a dictionary definition as much as possible rather than the cultural connotations of particular words. A second point is more significant. Although the *Myers* case concerned physician-assisted suicide and not euthanasia, the topic of euthanasia is never far away from the subject of assisted suicide. Of course, there are two legally, very different and conceptually distinct, concepts we’re talking about here.

In this country, physician-assisted suicide has been legalized by statute in five states: Oregon, Washington, Vermont, California, Colorado, and the District of Columbia, of course, which isn’t a state, and by a non-constitutional high court decision in the State of Montana. Now, albeit, these decisions were limited to mentally competent adult patients who have been diagnosed with a terminal illness that would lead to death within six months, euthanasia, by contrast, is illegal in every United States jurisdiction. In euthanasia, a physician brings about the death of a patient, motivated by the physician’s concern for the patient’s suffering or loss of dignity.

In physician-assisted suicide on the other hand, it is the patient who kills himself or herself with the aid of a physician. The common thread, more significant in my view, and the conceptual difference is the use of the lethal dosage of medication intended to end a person’s life. Now, in *Myers*, the issue of euthanasia was pertinent to the question of whether the penal law prohibition of assisted suicide is constitutionally permissible because it’s rationally related to a legitimate legislative state interest.

The per curiam stated that one such government concern, one of the reasons that the state has the right to enact this, is the government has started to avoid a possible slide towards euthanasia. This was the subject of my concurrence. It’s worth noting though some other distinctions, and that’s a distinction between what’s called voluntary euthanasia and non-voluntary euthanasia. Voluntary euthanasia is euthanasia in accordance with the request of a mentally competent patient. Non-voluntary euthanasia is euthanasia performed on someone else because of a factor such as infancy, mental incompetence, coma, et cetera, while the patient is not able to choose euthanasia and has never recorded a directive, and, especially, this is her will in regard to euthanasia.

Now, I want to make clear that in our opinion of it, and in my concurrence, involuntary euthanasia, as opposed to voluntary and non-voluntary euthanasia, was not implicated here and that would be euthanasia performed on a person who is able to give consent but has not done so either because the person was not asked to, because he or she withheld consent, was the third category of euthanasia performed against a person's will, of course because we trust that [it's] carried out against a disabled and physically and mentally impaired . . . by theories of eugenics.

We're not talking about that here and we're not talking about that in our decision. One of the principal points of my concurrence was to develop a point that the legislature may reasonably criminalize assisted suicide because to permit the practice would be to open the door to both voluntary and non-voluntary euthanasia. It is a familiar metaphor and the Dean referred to it, it would place New York on a slippery slope towards legalizing non-voluntary euthanasia. I did not suggest, and I don't suggest today, it would lead us towards involuntary euthanasia. In other words, towards euthanasia that would be against the expressed wishes of a patient.

Now, as you probably all know since you have probably read up on this a little bit before, actually it's throughout the world. The Netherlands has the longest history of socially accepted euthanasia, and I focused in my concurrence on that jurisdiction. Of course, the court can take notice, the judicial notice of properly cited research and factual findings outside the immediate record of a case, and I hesitate to do that normally about a concurrence where you're just writing from yourself, I didn't feel constrained in the liberty to talk about those issues in a broader basis as long as they're factually based.

In 2002, a termination of life on request in an assisted suicide act was enacted in the Netherlands to legalize the longstanding informal practices of physician-assisted suicide, involuntary euthanasia in that country. Under that statute, the physician may end the life of a patient who is experiencing unbearable suffering without hope of relief that the patient's explicit request, either by directly administering lethal doses of medication made by the doctor which would be euthanasia, or by prescribing a pharmaceutical means of suicide which would be physician-assisted suicide.

By 2015, both euthanasia and physician-assisted suicide accounted for 5,516 reported deaths in the Netherlands, almost four percent of the deaths in their country. The proportion of deaths attributed to euthanasia and physician-assisted suicide had doubled over the ten-

year period. In my view, the striking aspect of the end of the life decision-making in Netherlands is that there is no legal distinction drawn between physician-assisted suicide, which was the issue before us, and euthanasia. Similarly, physician-assisted suicide and euthanasia were made legal at the same time as one another in both Belgium in 2002, Luxembourg in 2009.

Recently in Canada, in 2015, a Supreme Court decision striking down a prohibition on assisted suicide led to a June 2016 law legalizing both physician-assisted suicide and euthanasia in Canada. As I pointed out in my concurrence including now, the movement from allowing physician-assisted suicide to permitting euthanasia is facile. By that, I mean effortless. It apparently has not even been perceived as a transition in some societies outside the United States, but now they legalized the former practice. One reason for this, I believe, is that the ethical boundary between physician-assisted suicide and euthanasia was very difficult to defend.

If a person has a statutory or honorary right to a doctor helping him commit suicide, does that person waive that right if he or she suddenly becomes too physically weak to self-administer lethal prescribed drugs? Excuse me, legally prescribed drugs? If not, the line between suicide and euthanasia has been crossed. Indeed, this concern about the transition from physician-assisted suicide to euthanasia was recognized by the United States Supreme Court about twenty years ago in *Washington v. Glucksberg*,² a decision where the court ruled,

in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them; and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to 'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain.³

That's all from *Glucksberg*. For these reasons and in light of the practices of the Netherlands, it is certainly reasonable to fear in all that inevitable expansion from the physician-assisted suicide by a patient taking a prescription of lethal drugs to euthanasia by a nurse or physician administering a prescription of lethal drugs. Now that

² *Washington v. Glucksberg*, 521 U.S. 702 (1997).

³ *Id.* at 733 (citations omitted).

benevolence has also displayed another trend that I find disturbing, and that's the countenancing of non-voluntary euthanasia.

In my concurrence, I said at the 2005 study showing that 560 people died in the Netherlands as a result of use of legal drugs not at the explicit request of the patient. The study [stated] that for every five people who died in the Netherlands as a result of euthanasia or a physician-assisted suicide in the immediate wake of the legalization and regulation of [such] practices, one died without explicitly requesting death. It was an argument in the study that this was a violation of Dutch law, but I'm not an expert on Dutch law, so I can't speak on it, but there was the argument. Such cases involved, for example, patients who are unconscious or mentally incompetent, and it was more common for euthanasia to be justified by a discussion with the patient's relatives or caregivers, and by past discussion with the patient him or herself.

Now, in studying this Dutch modern experience, we're of course not facing government-sanctioned forced or involuntary euthanasia. The decision-makers in non-voluntary euthanasia may be very well-meaning. Yet, neither the sympathetic motive nor consultation with family members renders the euthanasia voluntary, and whispers to my mind a necessity of ensuring the decision-making about prematurely ending the lives of vulnerable, terminally ill people not be entrusted entirely to those who have the financial and emotional burden of caring for them. There's also a reason of concern that the slippery descent from physician-assisted suicide to non-voluntary euthanasia would be [a] special risk in vulnerable and disadvantaged parts of society.

This is an issue that we've confronted many times before. In 1994, this issue was being discussed broadly in society and in New York. The New York State Task Force on Life and the Law had been established by Governor Mario Cuomo in commission with a broad mandate to recommend public policy at the intersection of medicine, technology and law. That commission unanimously recommended that New York laws prohibiting assisted suicide and euthanasia should not be changed. The Task Force reasoned that, and I'm quoting from them, "Legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. The risk of harm is greatest for many individuals in our society whose autonomy and well-being are already compromised by poverty, the lack of access to good medical care, advanced age, or membership in the stigmatized social group."

As the Task Force went on and observed, "No matter how carefully

any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society including healthcare. The practices will pose the greatest risk to those who are poor, elderly, members of a minority group, or without access to good medical care.” As I see it, those who not have healthcare advocates would be most at risk. This is indeed been a concern of medical emphasis for decades.

Now, Judge Rivera in her concurrence questioned this prediction, noting that research from Oregon shows no heightened risk for the poor, elderly, or the uninsured. My view isn’t the same of the experiment with physician-assisted suicide on the West Coast. It’s still relatively young, and the Dutch experience supports the rationality of the fears as to where these decisions can lead us. These concerns are especially compelling given the . . . proportion of our healthcare resources spent on people that are terminally ill. We spend a lot of money on the terminal ill, to the extent that the forming of medical care for the terminally ill becomes limited by economic constraints in the United States.

It is not hard to imagine a society in which non-voluntary euthanasia or those whose lives have been adversely affected by such a reduction in care is tacitly accepted. Another community that would be significant in long term risk is people who are disabled. The court had the benefit of amicus proof by a number of disability rights associations and contended that while plaintiffs used the term “dignified death” to justify assisted suicide, the indignities non-disabled and some newly disabled people described, are the need for assistance in daily activities like bathing, dressing, and the other realities of having a disability.

Legalizing assisted suicide enshrines in the law the prejudice that death is preferable to receiving the assistance that many disabled people rely on. In other words, for many members of disabled community who are not terminally ill, the indignities that plaintiffs tried to avoid are suffered on a daily basis. In my concurrence, I made the point that legalizing position of assisted suicide will convey a societal value judgment that such “indignities” as they’re called, [such] as physical vulnerability and dependence deprive human life of intrinsic value. By contrast, quoting now, “A disability does not deprive life of integrity or value. There’s no lack of nobility or true dignity in being dependent on others. The natural developments of old age and final illness are dependence and waning consciousness. Many disabilities come with similar challenges. It would be a

profound mistake to equate when it's imposed on a person's life with the conclusion that such a life has no value." On the other hand, Judge Rivera and her concurrence suggested that the concept of dignity was a subject to debate and controversy, and perhaps I think we [will] have more of this from the panelists tonight. I also developed a point of concurrence [that] the legislature may reasonably criminalize physician-assisted suicide because a way to assisted suicide by the terminally ill in circumscribed last resort situations would inevitably expand to include persons who are not in fact terminally ill.

Once again, I look to the experience of euthanasia in the Netherlands to justify this assertion. Let me give an example. A [person] whose illness is psychiatric, for example severe depression, may legally receive euthanasia or commit assisted suicide in the Netherlands so long as his or her suffering is considered be unbearable and without prospect of improvement. Even more disturbingly, the Dutch practice have legalized euthanasia and physician-assisted suicide has been extended to young children. In the Netherlands, children may themselves request euthanasia from the age of twelve and do not require parental consent after they reach the age of sixteen.

Recently, the Dutch Pediatric Association called for the age minimum of twelve years to be eliminated, so that each child's ability to ask to die would be evaluated on a case-by-case basis. This would put the Netherlands in line with Belgium, where, in 2014, euthanasia [and] physician-assisted suicide were legalized for children if they met the same conditions as adults, and they possess, quoting now, "The capacity of discernment and have parental consent." This expansion of euthanasia is in my view an especially disturbing consequence of legalizing physician-assisted suicide. Before I wrap up, it's necessary to, I think, to mention a point [of] disagreement between Judge Rivera's concurrence on one hand and another opinion in this case . . . in speaking about euthanasia in the Netherlands.

I've been referring to the act of intervention to bring about a patient's death. There's a quote in a new medical practice which emphasis called passive euthanasia, which now said and described as, "Euthanasia at all, in which a physician lets a patient die." This essentially passive physician practice occurs when medical personnel remove a patient from the machine that would prolong the life of a patient or to have nutrition and hydration from a patient undergoing palliative sedation. It's a common practice. It's ubiquitous. It's now generally considered to be unobjectionable and it is clearly legal in

the proper circumstances.

The Supreme Court decision verified that in *Cruzan v. Director of the Department of the Montana Department of Health*,⁴ which is a 1990 decision. The per curiam decision in *Myers* in my concurring opinion, in the opinions of judges like I see in Stein all made the point that there's a rational distinction widely recognized and endorsed in the medical profession, in the law between the withdrawal of life sustaining treatment, on the one hand, and assisted suicide of the other. Readopted the reasoning of *Vacco v. Quill*⁵ case, which made it in New York in 1997, the Supreme Court decision upheld the New York prohibition on assisted suicide on a federal constitutional challenge.

Our challenge was a state constitutional challenge. Although New York courts can refer to the United States Supreme Court when it's opening potentially broader state constitutional protections under the due process clause as opposed to the equal protection clause—as the amici law professors in New York Civil Liberties Union who reminded us that we could do that. We found . . . the *Vacco* analysis persuasive. In *Vacco*, the Supreme Court reasoned that a physician who withdraws life-sustaining medical treatment may intend and I'm quoting now from the decision,

to cease doing useless and futile things to a patient when the patient no longer stands to benefit from them.

The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead. . . . The law has long used an actor's intent or purpose to distinguish between two acts that may have the same result."⁶

Put differently, the law distinguishes [between] actions taken because of a given [outcome], from actions taken in spite of their unintended but foreseen consequences.

This is a philosophical, ethical principle called the principle of double effect. Basically, that means that there is a legally and more significant difference between performing an action with the intention of bringing about a bad effect and performing the same

⁴ *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

⁵ *Vacco v. Quill*, 521 U.S. 793.

⁶ *Id.* at 801 (citation omitted).

action without the intention even though the bad consequence is foreseen. The most common example that occurs is the application of pain killing drugs, [such as] morphine, in the end stages of life. Although the Court of Appeals [agreed] as a whole about this reason, Judge Rivera's concurrence made a point and I want to bring it to you because it was well-argued skepticism.

She wrote that, "When a physician removes a patient from a life-sustaining apparatus or declines to administer life-saving procedures, the physician's intent, in accordance with the wishes of the patient, is to precipitate the death of the patient. A physician who complies with the patient's choice to forego life-sustaining treatment knows when a ventilator is withdrawn for example, the patient will soon die. The drugs involved in terminal sedation are known to cause the patient's death in certain cases. A physician providing this medical option knows very well about the potential immediate consequence and must forewarn the patient.

Furthermore, while sedation maybe necessary to alleviate a patient's pain, the withdrawal of nourishment which forms part of the treatment, can only serve to bring about death." I was quoting from Judge Rivera's concurrence there. The analytical difficulties in this area are considerable and perhaps the panelists tonight were touched on those topics but suffice to say that a clear majority of the court is not ready to depart from further pressing into this area. I end by saying that *Myers* was among the most interesting and emotionally challenging cases I've heard so far in the court. He had the benefit of excellent briefing and so many amicus proofs [that] my staff had to prepare a chart outlining their interrelated positions. The advocacy in both sides in this case was of the highest quality.

We decided here only [whether] legislature may permissibly ban assisted suicide, not whether it may allow assisted suicide and I'm not sure with the . . . excuse me. I'm sure with the merits to reclaim his claims and those of others facing [terminal diseases] will be debated particularly in the legislative circles for many years to come. I just want to close by saying I've been reading lately the essays of an author, Marilynne Robinson. She won the Pulitzer Prize a few years ago for a book called *Gilead*. Anyway, . . . she was talking about decision-making in an essay about society and she said, "The acquisition of wisdom is found through the exercise of humility."

Now, when conforming issues like physician-assisted suicide, I recognize that there are no perfect solutions. In other words, everyone isn't going to agree with you. Usually everyone will disagree with you. It's an issue that judges will be always wise to

consider the consequences of any decision at great length and most importantly when making those decisions, to exercise careful restraint. Now, whether you agree or disagree with that decision, I can assure you that in this instance it was made after long and careful consideration. I want to thank you all for the invitation and for your attention this evening. Take care.

III. PANEL DISCUSSION

Professor Vincent Bonventre: Thank you so much, Judge Fahey. Judge Fahey is definitely one of the reasons why the Court of Appeals is either one of the finest or the finest courts in the country. I want to take my students to the court. They are always impressed with Judge Fahey. They're always impressed with his questions because they never . . . those nitpicky, fact-based questions as though the court doesn't realize that they're setting precedents and not just deciding a dispute between parties? Those questions are overly legalistic as opposed to understanding that the judges on that court are making policy choices but they're always thoughtful.

They always get to the essential nature of the case, and so my students and I have always been very impressed, and as I talked to lawyers around, especially those who are geeks like me and follow the Court of Appeals like a fanatic, they all just love Judge Fahey. They love Judge Fahey and actually ask Judge Fahey, recently I said, "Were you educated by the Jesuits?" which I said was a complement. He said, "No, but by the Christian Brothers," which I think is even better. I've also told Judge Fahey that I disagreed with his concurring opinion with the result in this concurring opinion, but I was educated by the much inferior holy cross brother so I'm probably well-judged.

In any event, again, thank you, Charlotte, for putting this together, our State Con Editor, and Emma Tiner, our Editor-in-Chief, and everybody on the Albany Law Review. I get to be standing here because I'm a faculty advisor. It's really a privilege to be the advisor to these students. In fact, I was the faculty advisor when Alicia Ouellette was the Editor-in-Chief, and now she's my Dean, and let me tell you, she is by far the best Dean this school has had in the 100 years I've been here; truly magnificent. This is the 12th Annual Chief Judge Lawrence Cooke Symposium. He's a 1938 graduate of this school.

When Chief Judge Cooke was a member of the court, without any question that was the leading progressive court in the country,

meaning that with regard to the rights of the accused, free press and free speech. There is nothing in the country like the United States Supreme Court and we we're terribly proud of him. In fact, he was a Founding Chair of State Constitutional Commentary which hosts this symposium. I also want to thank the Sobota family who have been very, very generous with helping to subsidize the Cooke Symposiums throughout the year. Now, I'm not going to recite the bios that are in the programs but I would like to say a few things about each of our panelists and we're thrilled to have them.

Edward Mechmann is the Director of Public Policy for the Archdiocese of New York. Before that, he had spent six years as an Assistant District Attorney in Manhattan, three years as an Assistant U.S. Attorney in the Eastern District. He specializes in religious liberty, child protection programs, and Catholic theology. We're really honored to have him here. Then, there's Peter Strauss. Peter Strauss, among other things, he's a Member of the Board of Directors of End of Life Choices in New York. He's a Co-Director and Founder of Guardianship, the Guardianship Clinic which he founded in New York Law School, and he's a graduate of NYU Law School.

He did his undergraduate work at Bowdoin College, and I understand he was in the ski club and the glee club, and he's promised me he's going to sing part of his presentation. Actually, he never said such a thing but.

Peter Strauss: I said, I would.

Professor Bonventre: He could, yeah. He could. Apparently he's famous in Maine. Stephanie Woodward who's a Disability Rights Lawyer and Advocate, and she promotes brightly colored wheelchairs, and on her . . . it's either you're LinkedIn, or your Facebook or Twitter, it says she's all an all-around mess. Well, I don't know about that, but she earned her law degree and a master's in disability studies at Syracuse University. Several months ago she participated in a die-in outside Senator Mitch McConnell's office at the United States capital. She was protesting the proposed cuts to Medicaid and she was actually forcibly removed from the capital, and there are pictures online of you being forcibly removed from the capital.

Stephanie Woodward: In my wheelchair.

Professor Bonventre: In your wheelchair, yeah. I think it should be said that a lot of American heroes have been forcibly removed from protest movements, so we're really proud to have you here. David Levin was Executive Director of the End of Life Choices New York for 14 years. Before that, Executive Director of Prisoner Legal Services

for 20 years. He's a graduate of University of Rochester and Syracuse Law School. He's an active speaker and writer, and as one commentator I read noted, David has a masterful understanding of the horse trading, that is needed when working with the lawmakers at Albany.

Horse trading? You mean they don't do everything based on substantive merit, David? I can't even imagine that, but those are our four panelists, and we're really thrilled to have them here, so what we're going to do is we're going to allow each of them to speak for 10 minutes, and Charlotte's going to be very, very strict about the 10 minutes so we can get the discussions back and forth among the panelists, and then questions and answers. First up is Stephanie Woodward. Again, we're thrilled to have you here, Stephanie. Stephanie?

Stephanie Woodward: Thanks for having me, so hopefully I'll get this in five minutes time. It's been a long time since I've been in the court, so I'm hoping for the best here. Before I start getting into the disability community's argument, again . . . is it on? Argument on assisted suicide and opposition, I want you all to just think for a second. If you hadn't already thought this or said it out loud, you probably know someone who does. I'm a person in a wheelchair and at least twice a month someone will come up to me and say, "You're so brave." If you're not already thinking it, someone you know, and I say, "Brave? For what?" "For living with your disability." What was my other choice?

They think it's a compliment when they say, "Well, I could never live like that." What disabled people hear is, "You think that death is a better alternative to living the life that I live?" I think that Judge Fahey really hit them on the fact that our societal values and stereotypes and stigmas about others can impact our views and we impose our values of life on other people, and I think that's a really important part of our perspective with the disability community. The disability community, and I say with the disability community because every disability rights group that has spoken out on assisted suicide has spoken against assisted suicide, and we've done that because we recognize that the reasons that people are choosing assisted suicide are disability-related.

A lot of the discussion is about terminal illness and pain, but what we recognize is that when the studies have been done in Oregon on why people are choosing assisted suicide, the top five reasons do not touch upon pain. The top five reasons touch up on things that are all disability-related, such as perceived loss of autonomy, loss of

independence, feeling like a burden on other people, loss of bodily functions such as incontinence, and these are all experiences that disabled people experience every single day.

For example, feeling like a burden on others. I used to tell my boyfriend all the time, “I can’t hang this please. Please hang it for me. I’m sorry I can’t do it.” One day he finally stopped me and said, “Stephanie, if you could hang that picture, you wouldn’t. Don’t act like it’s your disability that’s stopping you. You wouldn’t hang the picture and it’s okay to ask for help. We live in an interdependent world. We can depend on each other.” Disabled people are used to that. We are used to asking for help on others and our society has valued, has determined that that is undignified, to depend on others, and that it’s okay to want to die based on feeling like a burden on another human being.

My great grandmother turned 101 in January and her mother lived to be 110, so I’m the one who greeted her first birthday, I said, “Are you going to make it to 110?” She said, “I really hope not.” I said, “Why?” She said, “It’s too much work for other people.” Feeling like a burden on other people should not be a reason that you choose to die and it shouldn’t be a reason why we choose to legalize death, for certain vulnerable populations. With the disability community, we recognize that our lives have been devalued in society. There is a great political cartoon that shows a person in a wheelchair and they have . . . they’re in front of a building. The stairs lead to suicide prevention services and the ramp leads to assisted suicide.

That is the feeling that you get as a person with a terminal diagnosis. You’re starting to experience disability. When you say, “I want to die,” suddenly people say, “I understand why.” If any of you in this room said, “I want to die,” you will receive suicide prevention services. Why are we choosing a select population, a vulnerable population that would receive suicide assistance when the rest of our world would receive suicide prevention? Our perspective goes to people with disabilities, terminally ill and elderly, because we recognize that we all experience the same disabling conditions and that those disabling conditions cause us to devalue those particular lives.

We also recognize that in a profit-driven healthcare system, assisted suicide will lead to more deaths of vulnerable people, so when looking at other states that have legalized assisted suicide, there had been circumstances where people have been denied insurance coverage for life prolonging treatment and offered instead an option for assisted suicide. Recently I wrote an email to the

Oregon Health Plan on posing a circumstance that if there was a treatment available that will either prolong a terminally ill person's life or turn their terminal condition into a chronic condition instead, but in turn would not cover those treatments, would they be eligible for assisted suicide?

The Health Plan wrote back that, "Yes. Those individuals in those circumstances would be eligible for assisted suicide." What we're seeing is that as a disabled person I know how expensive it is to keep disabled people alive. I know how expensive it is just to keep me in a society in a wheelchair. I'm sitting in about \$8,000 guys. I'm not cheap. To keep someone alive on a ventilator or chemotherapy is expensive. To prescribe one pill that can cause death is cheap so it lead the insurance companies to choose the cheaper option, and disabled people already know how hard it is just to get the care that we need to live, instead would be offered the choice to die.

I think what we need to question then is if insurance is denying life prolonging treatment or truly they can take a terminal illness and turn it non-terminal, and instead offering you death, is it a choice? Is physician-assisted suicide a choice to die if you're not given a chance to live? When we're looking at this, we haven't seen any safeguard that has everyone proposed that can prevent people from dying as a result of mistake, coercion, and abuse as well, so we live in a society where elder abuse is on the rise. One in ten elders is experiencing abuse and this is happening behind closed doors. Of the laws that we have seen, there is nothing that stops a family member that can benefit from the death of their loved one or let's use the word loved one.

We can take them to the doctor, encouraging them to ask for the prescription, picking up the prescription for them, and even being the person to administer that lethal dose, and whether or not that is voluntary, it's up in the air because it does not require a witness at that time of ingestion, so whether that person wanted to take that lethal dose, we won't know. By the time when elder abuse is on the rise, that's a serious concern to have. There's also a lot of mistake when we look at diagnosis. As a disabled person I can't tell you how many times I was supposed to die by now.

My mother is probably very disappointed that she had to pay for college because I was supposed to die at 10. She wasn't planning for that, so we have people who will die as a result of misdiagnosis as well and it's important to recognize that there's nothing to stop doctor shopping as well. If your doctor that you have been seeing your entire life says, "I don't think this is the right choice for you." You can easily

go online, find a website which will connect you with a doctor who will, or on the average time that a person knows their doctor, then he's prescribed that lethal dose, it's about 13 weeks.

I've dated people for 13 weeks and I wouldn't trust knowing my quality of life on whether I should die. Should your doctor that you've known for . . . I went to law school, not med school, but I think that's like what, three months, be able to determine if you should die? These are the things that as a part of the disability community we're seeing every day and it is important to recognize that we would be codifying into law the fact that our societal value devalues the lives of disabled people and people experiencing disabled conditions, and people who are experiencing terminal illnesses do experience disabling conditions.

If we codify into law that it is undignified to live this way, what we're saying in our lives, if it's undignified, to be a person with the disability and there is already enough abuse happening of disabled and elderly individuals that we don't need to make another legal pathway forward to allow us to die without any prosecution moving forward. In thinking about this, I want you to think beyond just this idea of excruciating pain because the top five reasons people are choosing this have absolutely nothing to do with pain and everything to do with the lives of the disabled people, people like me, with every single day. Thank you.

Professor Bonventre: Peter?

Peter Strauss: Am I next? Okay.

Professor Bonventre: You're going to sing for us or?

Peter Strauss: There has been a little uncertainty about the order so I thought my colleagues to the right were going to finish up, but this is fine. I'm delighted to be here. This is an exciting series and difficult topic, and I respect the views of all of my friends who don't agree with me. There was a time when I was on their side. I had been Trustee and Vice-President of an organization that's long since gone called Choice in Dying. It was the merged organization of the Society for the Right to Die and Concern for Dying, and I had opposed physician aid in dying because I felt we weren't ready for it in this country.

I've changed my position and I want to say at the outset I think many of the things that you've heard tonight, some of Judge Fahey's comments, are changing views and the fact that the Court of Appeals I believe has taken the more traditional position is to be respected, but I think when we look at the fact that we now have seven jurisdictions that have made physician aid in dying legal, and we

have about 32 or 35 legislatures that are discussing legislation, including our own here in New York, I think that there are whims of change, and I think people are going to reevaluate these years. I'm a law practitioner. I deal with the law of trusts and estates.

I deal with clients in my office or in their homes who are wrestling with these problems and I can tell you they don't want to talk very long about the complexities of the state tax law if anybody including the lawyers this month, the next can understand the new laws. They want to talk about their end of life choices and I tried to make them avoid this issue by clear expression of their issues in advanced directives particularly healthcare proxy and the living will which I prefer to call healthcare declaration, but I don't want to divert from tonight's subject. I just wanted to offer some debrief in *Myers* of the National Academy of Elder Law Attorneys.

We are represented that in the vicinity of New York chapter of that organization, and *Myers* did not take a position on the fundamental issue. *Myers* took the position that the court needed to send the case back for full exploration over all of the issues that you're hearing about tonight. We felt that the factual issues basically should drive the decision in the courts and not have a motion to dismiss which was granted by lying on old assumptions and old facts, and again, I really have found Judge Fahey's presentation tonight fascinating.

I think his concurring opinion was way important. I believe more stronger than the views of Judge Rivera as you can imagine, and I think that you really need to read both, but in particular Judge Fahey and Judge Rivera's concurring opinions. I often say to myself that Judge Rivera's opinion, I don't know why it's just called a concurrence. I think it might had better been called a partial dissent, but that's a matter of language, and I do not understand the complexities of the Court of Appeals, nor the state legislature by the way, but that's for another day. Let me just touch first on why I feel why Judge Fahey's language is critical.

Having said that Judge Fahey used to add his remarks to face physician-assisted suicide and you've heard me already say physician aid in dying, so we've made a choice, and I think we really should find some more mutual decision, but I think that's something we need to think about, and I think it does call the discussion because suicide is a word packed with powerful emotions and raises a lot of anger in all of us, and I just don't think that sets the right tone. Maybe medical aid in dying or a physician aid in dying doesn't work well either in your view, but I think we at least have to acknowledge that these are important words.

One thing I want to say about euthanasia. Medical aid in dying is not euthanasia because it's a voluntary wish on the part of the person. To mean euthanasia, whether we can pose it to voluntary or partially involuntary euthanasia, or not, euthanasia is when somebody does something to you. It's your life without your knowledge and consent. It is a vile, disgusting, awful, scary policy. I abhor what happens in the Netherlands and in Belgium. I think we only have to look 30 or 40 miles east of the Netherlands to see the Nazi holocaust and that's going on in other places in the world, and I stand 100% behind this word about this. There's nothing that she said, except perhaps some interpretation of the facts, that we disagree with in the physician aid in dying movement.

Of course there's discrimination against persons with disabilities, but we think it would be disgusting and hard, and tragic, if a physician aid in dying statute, such as those which exist in Oregon, Washington, and now California, would be allowed to influence the lives to the point of making people want to die because they have a disability, and we want to reach out to the organizations that represent persons with disabilities to find a bridge to resolve those issues, and make sure that these concerns are not brought into the implementation of the aid in dying statutes. We continue to make that offer, but I, with all due respect, we've really not gotten cooperation. Now, I ran a conference in New York Law School a few years ago on end of life choices and the changing political environment, and Ms. Woodward's colleagues from . . . not dead yet, came to the second floor. There was a wonderful group of them.

Process it, I have their signs. I invited them into here to debate and participate, have some coffee and muffins. I was graciously declined and at the outset, they decided not to come in and listen to the debate, and I want to stop that. We do need to work together. What we are asking for here is an understanding that the act of a physician providing terminal medication is not helping someone commit suicide. I heard from David once, the story about asking people whether they thought that people in the towers of 9/11 who jumped out of the towers were committing suicide. I've never had a person tell me they thought that was suicide. I think that we all agree that that act was choosing better method of their death which was inevitable and not being crushed to death with rock piles and steel piles.

These are dying people. They have to be certified as having their death likely to occur within six months. They'll go through rigorous evaluation by a psychiatrist and another physician depending on the

state statute. They have to be determined to be free of depression which is driving the decision to take terminal medication. Obviously, we can't say they're not a little bit depressed. I think we'd all be depressed if we knew we were dying within six months. There can be counseling. One way, whether it works or not, that they control the influence in family is that there's no requirement that family will notify. There's a variety of factors here in these statutes to protect against these things.

I don't agree with Judge Fahey's fears about the slippery slope. We can't even pass legislation to allow aid in dying in New York and the current legislation which is similar to those from the last couple of years. If you sat in at the debates of the executive committee of the New York State Bar Association and Law Section, the executive committee won't pass a recommendation to endorse the bill because we've been fighting for two years over the details of the credentials of the translators of the people who might be subject to receiving medical aid in dying. We have tough legislatures in this country. I don't agree with many of the state's decisions on issues of concern to Ms. Woodward and myself, about benefits and services to the poor, the minorities, the disabled groups, but I can't conceive that this is really on our doorstep within the next 20 or 50, or 100 years, that we're going to adopt actual real euthanasia.

It is not within our Constitution. You violate our rights under the Declaration of Independence and the right to rightful living and the pursuit of happiness. I do agree with Judge Rivera when she wrote in her concurring opinion that the state's interest in protecting and promoting rights diminish when a mentally incompetent, terminally ill person, approaches the final stages of dying, that the state's interest basically disappears. Now, look at what we do allow. It's legal to withhold treatment for a person. It's legal in all states to allow withdrawal of treatment knowing that the patient will die because of the removal of the respirator or dialysis. I'm getting the one minute signal. Is that one or is that 20?

You know what? Time in sedation. Just think of this. A patient who is suffering and in this case, probably including pain and suffering, is much broader than pain. We allow a person to be given so much medication, allowed by the Supreme Court and with double effect, that they're unconscious and we watch the family sit around and watch them die a week, two weeks, three weeks, a month perhaps. Now, it's not the family's interest I'm concerned about. It's the right to the patient. Maybe they participated in that decision. Maybe they said, "No. It was okay." Maybe they didn't. Look at all

the things we allow. From a moral and ethical point of view, the difference between that and a comparable person, as soon when we provide the proper safeguards of asking for relief from suffering, so they don't have to be terminally sedated until they die. Thank you.

Professor Bonventre: Edward Mechmann.

Edward Mechmann: Thanks very much. It is an honor to be here. I'm going to start out on a legalistic point, I suppose, by saying that if this were a trial, I would object to the title of the symposium, and the reason I would object is that it assumes a fact not in evidence, mainly that there is a right to die that we're reconsidering. There is no such way. The Supreme Court of the United States rejected it in the *Glucksberg*, in the *Vacco* cases. It rejected it in the *Cruzan* case. Our Court of Appeals has rejected it here in the *Myers* case. Our new state high court has adopted any generalized right to die as implicit in a patient's right to decline treatment, and even if any court were to do so, it still does not in any way imply that there's a right to assistance from anyone else.

We have to remember, there are two people in the room. There are two separate moral actors in the room. There's the patient and his doctor. We have to make a very careful distinction in the way that we look at those two people, their intention, their role in the causality of death. We do it all the time in the law. All of you studied tort law, criminal law. We do this all the time and we have to do that here. I agree 1000% with Judge Fahey. We have to be very careful about language and what language we use here because the terms, they imply things. They shade meanings. They give the impression that we don't want them to mean. Let's use the real term, it is suicide.

When one takes an action to cause one's own death. It has always been understood to be that all the way back to the ancient world. Think of Socrates. The reason we read that dialog about Socrates' suicide is because everyone understands, that's a suicide. Our penal law definition is about as clear as it can get, intentionally aid a person to commit suicide. We didn't have to define the term because everyone knows what it means. The Court of Appeals unanimously understood that the normal meaning of the word suicide is what we're talking about here. The Appellant Division First Department, four judges unanimously agreed that what we are talking about here was suicide. The Supreme Court judge who initially heard the case agreed that what we are talking about here is suicide.

When the legislature wrote the penal law, whether you accept whatever meaning, means of statutory construction you adopt, whether it's original understanding or original public meaning, or

legislative intent, it's very clear that the legislature intended that what we're talking about here to be suicide, and also that they meant the statutes to reach anyone who assists in doing that even in hard cases. Each one of the courts that heard this case sided with the drafters' commentary to the New York State Court penal law and in that commentary, they stated that the statute, these are the drafters of the statute, stated that the statute would encompass anyone who gave assistance, "In the more sympathetic cases." For example, suicide packs or assistance rendered at the request of a person tortured by painful disease and the like.

What we're talking about here is assisting another person in suicide and there are two, again, two moral actors in the room, and this has made a distinction between palliative sedation and withholding care, versus assisted suicide because it's so important to understand that, because in each of those cases, the two actors have different intentions. They're involved in different elements of the causation of the death, and they have to be treated differently, and even if the individual, the patient has a right to decline treatment, which they do, that doesn't mean that they have the right to the assistance of anyone else or that we can basically require doctors or hospitals to give them assistance, or refer them to people who will give them assistance, because that's a feature of every statute that's been passed here in the United States, in every statute that is under consideration here in the United States, a mandatory referral.

Think about it, with the decline of treatment, two people in the room, the patient is exercising their right not to have any more treatment, to accept death as inevitable. The doctor, the doctor's not causing death. The doctor's not intending that person's death. The doctor is acquiescing in a decision by the patient, and in fact the doctor's legally prohibited from giving treatment that the patient declines. We have two different moral actors, two completely different situations, between that and assisted suicide. The same thing with palliative sedation. This is where the person is sedated to a state of unconsciousness so that they don't experience the symptoms and the other clinical symptoms of the terminal disease.

They die of the terminal disease. They do not die from the action of the doctor. The doctor's intention is to ease pain, not to kill. The cause of death is the underlying disease, not the sedation. So, we cannot attempt to analogize between declining treatment and palliative sedation, and assisted suicide falls apart once we've realized the significance of the language we use and the significance of there being two actors in the room that we have to account for their

separate intentions and their separate involvement in the line of causation, okay? Now, Judge Fahey gave an outstanding overview of the slide to euthanasia and the other policy reasons behind the legislators' decision to ban assisted suicide. I want to highlight one of the reasons that the legislator talked about and I also want to follow up on something that both the Judge and Stephanie spoke about.

The first thing I want to talk about is the very powerful state interest in preventing suicide. Suicide is a major public health problem in the United States. It's one of the top 10 causes of death of people in the United States. More people die of suicide than die of homicides or motor vehicle accidents combined. It's gone up 26% in the last decade. We all read about the suicides. We all also know what happens in a school or someplace if there is a suicide. Everybody rushes in to make sure that what happens is not what we know might happen, which is something called suicide contagion. It's a term that's been accepted by the World Health Organization.

What it means is that every time there's a suicide within that person's social group, there's an increased risk of suicide. Every school, because as you all know, this from being students. We spend massive efforts. Everybody's driven over a bridge, knows the signs that we see. Life is worth living. Here's the phone call to make. The state spends a ton of money advertising, paying for counselors, sending people out for a crisis prevention. We have suicide hotlines. There's a gigantic social agenda, a legal agenda, and a public policy agenda to prevent suicide. Legalizing suicide for some people would completely undermine that because what it would say is that some lives are worth living, but for some, it's okay.

If we allow some, what's to prevent the contagion then from spreading? It will. It inevitably will. We also have a legal issue here in New York State under the mental hygiene law. It's article nine. If any of us were to walk over to Albany Medical Center, which I think is right across the street, walk into the emergency room and say, "I'm thinking about killing myself." You know what happens was? You'll be involuntary committed for 72 hours for an evaluation by doctors, psychiatrists, social workers; judges and lawyers might get involved to that point. In fact, if they feel that I'm going to continue the risk to myself, I can be involuntarily committed for, I think, it's like six weeks to save my life. I have a loved one who attempted suicide at least once and threatened suicide another time, and whose life was saved by an article nine, involuntary commitment.

If anybody's life does not count, then nobody's life counts. If we

allow suicides for some, we're telling others that it's okay to do it. The other point I want to make is about the inevitable spread to euthanasia. It's very nice for people to say that we want to incorporate or they want to incorporate safeguards into statutes, but the reality is, and I respect Peter and David an awful lot. I actually respect very much Kathryn Tucker who's going to be here except for her plane flight being canceled. Kathryn wrote an article. She used the principle, one of the principle authors of the main plaintiff's brief in the *Myers* case. She wrote an online article two years ago in a journal called *The Jurist*, which is published out of the University of Pittsburgh Law School, and she spoke about the legislative protections that we're talking about here.

She called them burdens and restrictions, and she specifically opposed any of that. She alleged that the medical profession should be allowed to self-regulate with no legislative regulations on the practice, and she specifically objected to things like requiring a patient to make multiple requests, including that one of them be in writing. Requiring that the request be witnessed. We're going to say if we witness plaintiff get proxies and powers of attorney, we wouldn't witness or request for suicide. Obtaining a second opinion for the diagnosis, referring the patient for a mental health specialist, which under the bills that are being proposed, is just to determine confidence. It's not to treat for depression by the way.

There's no mandatory referral for treatment for depression. Then, during the waiting period, just last month, a law professor from Minnesota, Thaddeus Mason Pope, wrote an article for oncologists entitled *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, and he proposed expanding assisted suicide from adults to mature minors, from people with contemporaneous capacity to people who say it in advanced directives. There's your voluntary euthanasia by the way. From people with terminal illnesses to people whose death is reasonably predictable, which is actually what Stephanie was talking about, people who may have a long standing disease or decline treatment, and from self-ingestion to physician administration, and there we are with the third party.

Again, that second person in the room having to do this. Europe has gone there. Canada's going near. There's no reason that New York won't, just because they're having a hard time getting this bill before the legislature. There's no reason that we're not going to go there. Again, we have to remember, the words are important. The two people in the room are important, and we also have to watch out for not the slippery slope, current events, what's happening in Europe

and Canada, and elsewhere. Thank you.

Professor Benventre: David?

David Levin: You got me. How many of you think you're going to die? Anybody? Okay, the only question is, how are we going to die? Who's going to make a decision, and is it going to be a decision that you've made or is it going to be a decision that the government might make for you? For my whole career, I've fought for justice. Professor Bonventre mentioned that I was the Executive Director of Prisoner Legal Services for some 20 years representing prisoners. For 10 years, I worked in legal services for the poor in Rochester, New York, and for the last 16 years, I've been working on behalf of dying persons, and the justice issues for all of those groups of people. For dying patients, medical aid in dying or physician aid in dying is a justice issue.

It's extremely important other than many other issues which are also important. Life is precious, but it's going to end for all of us, so the only question really is, how is it going to end and who's going to decide, and are we going to be able to make our own decisions at the end of our lives which comport with our own values and wishes? Aid in dying should be an available option for those who have impending deaths, who've been determined that they are going to die within six months. That's the group that we are talking about. I'm not talking about people with preexisting disabilities or anything else like that. We are talking only about people who are going to soon die and the only question is whether or not those people, and it's a very small number of people who've exercised such rights in states where it's legal, about one in 300.

Those people have the right to get medications if they are determined to be terminally ill and mentally competent. This is a deeply personal right of liberty and autonomy. It is a deeply personal and intimate decision, and there's no credible argument, in my view, for preventing this right when patients make a very thoughtful and considered decision to take medications to end their suffering, if they can do it in their homes, in the time and place of their choosing. Final goodbyes can be said and the patient can have a peaceful death. It is really documented that aid in dying now takes place across the country but it is illegal. It is underground and it's unregulated, so the question really is, should we bring legal aid in dying and should we make it legal?

Should we dig it above ground until we make it appropriately regulated? The practice should be legal and physicians and family members should not be at risk of arresting punishment as they are

now. Now, aid in dying really is not suicide. Differences exist between those patients who hasten their deaths by aid in dying and those who commit suicide. Suicides are committed by people with a mental illness, who could continue to live, but chose not to. It's done in isolation, usually out of desperation, often impulsively and violently, and those deaths are tragic. We should do everything that we possibly can to prevent those deaths. To the contrary, aid in dying is available only to terminally ill persons who will soon die.

The process usually takes at least several weeks and of course, always after consultation with physicians, and almost always with family members, and it is empowering. The term assisted suicide is rejected by the American Public Health Association, the American Academy of Hospitals and Palliative Medicine, the American Medical Women's Association, among others, and in the laws which promote medical aid in dying throughout this country, although there are only six of them right now. Just recently, and this points me to the point that the Court of Appeals was really mistaken when they decided to hear some amends rather than give the plaintiff's the opportunity to develop a factual record and evidence.

Just recently, the American Association of Suicidology came out with a position statement that suicide is not the same as physician aid in dying. The American Association of Suicidology recognizes that the practice of physician aid in dying, also called some other things, has been traditionally described as suicide although they may be overlapped. Legal physician assistance suicide should not be considered to be cases of suicide and now therefore, a matter outside the central focus of the American Association of Suicidology. The American Association of Suicidology recognizes that suicides are a tragic event which our organization works so hard to prevent.

This recognition does not assume that there cannot be overlapped cases, but only if the two practices can in principle, be conceptually distinguished and the professional obligation of those with all have been suicide prevention may differ, and then it gives 15 reasons why these two processes are completely different from each other, and at the end of this paper which just came out at the end of last year, it says, "The American Association of Suicidology is dedicated to preventing suicide that this has no bearing on the reflective anticipated death a physician may legally help the dying patient facilitate, whether called physician-assisted suicide, et cetera.

It constitutes a critical reason why these distinct death categories are so often conflated and should be deleted from use. Such deaths should not be considered to be cases of suicide and are therefore a

matter outside the central focus of the AAS.” There is no definition of suicide in our penal law. There is a prevention of assisted suicide, that even though when the person passed, there is concern about people helping other people who are maybe in great pain that did not contemplate doctors because they also passed before medical aid in dying was legalized in Oregon, Washington, and other states. Now, consider. We’ve had an experience in those states for 20 years in Oregon, almost 10 years in Washington, and now several years in other states.

There’s absolutely no evidence of disproportioned impact on volatile populations, none. Nor is there any evidence of coercion or abuse. In fact, the Executive Director of Disability Rights in Oregon, the Advocacy and Protection Agency in Oregon said that he’s not received one complaint of abuse or coercion in Oregon in that state in 20 years. There is evidence that, according to one site, family members and relatives who requested aid in dying feel better prepared with accepting of death, and there are no negative effects.

About 90% of those who end their lives by aid in dying are actually receiving hospice care. The gold standard of end of life care, but still their suffering is just so great that they feel that they can no longer go on living. These are not people who want to die. They want to live, but in fact they are dying and the only question is, how are they going to die? There is no evidence in this country of any slippery slope. In fact, as Peter mentioned, it is very difficult to get aid in dying laws enacted and this is why we only have six states and the District of Columbia.

I think that the slippery slope argument really is not a very valid one because there simply isn’t evidence. Our culture and our experience in this country is so much different than the Netherlands and other countries. There is no reason to think that in the near future or in the distant future that we are going to allow anybody, the people who are terminally ill to pursue self-consumed medications to achieve a peaceful death for themselves. In Washington, there’s a Comprehensive Regional Cancer Center in Seattle. It implemented a program for patients who might want aid in dying. Why?

Because they realize that this was an appropriate choice, an appropriate option for some people, it has been long accepted by patients and coalitions. In New York, 77% of the public, according to a 2015 poll, supports aid in dying. Physicians support aid in dying in accordance to a med scale poll of 2016 by a 57% to 29% margin, almost two to one, and there is a groundswell of medical associations now

taking neutral positions that had once opposed medical aid in dying. Why? In about 10, just in the past couple of years, why? Because medical aid in dying has worked as intended in the states where it's been legalized.

It is clear that hospice isn't enough for everybody. The Executive Director of Oregon Hospice Association, for 15 years, was opposed to aid in dying when it was first implemented in Oregon, but like you said, because I was arrogant, and I realized that there are people who are suffering so much that aid in dying is an appropriate option for those people, and then she said, "Well, some healthcare professionals express fierce opposition to medical aid in dying prior to law change in Oregon." Since then, those voices have softened in the face of indisputable evidence and no representative medical organization has called for the law to be appealed.

There is simply no evidence of any problems in this, except on rare occasions that Stephanie pointed out, there are mistakes that are going to be made, because no one works perfectly, but the aid in dying laws that have been enacted in the United States have worked about as well as any law could. Thank you very much.

Professor Bonventre: Thank you, David. Now, maybe we can engage in some immediate give and take, and Judge, can I move your chair up here?

Hon. Eugene Fahey: Yeah. I'll be fine here.

Professor Bonventre: Let me start off. Yeah, terms are important and it should be stated that depending upon which side they're on, their objections to whether we're talking about aid in dying, right to die, and their objections to assisted suicide, some pretty strong objections to both terms depending upon what side of the argument you're on, but let me ask you a question that's a little more basic, a little more simple and that is, it seems like there is an assumption that everyone is making, that there is something wrong with suicide, with taking one's life. Is that mutual enough?

Taking one's life? There's something wrong with that. Is that simply a . . . no, is it a cultural and religious construct, or is there something inherently wrong with a mentally competent adult choosing to take that adult's own life? Is there something inherently wrong with that? Because whether we're talking about, no, it should be barred, or whether we're talking about, well, it should be very limited. We all seem to be assuming that there's something wrong with it. Am I mistaken that everybody is assuming? Who wants a shot of that one?

Stephanie W: This is dangerous. I'd like to point out that it's

wrong in that it's a choice that can't be taken back, so Michael Phelps we all know likes to swim a lot. He went through a significant depression recently and had suicide attempts, and got counseling, and when he got out of that, he said, "I'm so glad I got help. I'm so glad I'm still alive. If it wasn't for that, that's not a choice that he can take back." In its permanence, it is wrong because given that help that you could need, you could change your mind and you don't have the opportunity to do that if you're in a casket.

Professor Bonventre: Anyone?

Peter Strauss: I'm not so sure that that question is really relevant here. It is a philosophical, theological issue. This is the side of normal. I just assume suicide is not a good thing. You need to help people to prevent it whether it's because they have a disability and they feel isolated and wronged. These are terrible causes of suicide. This is not a subject of theology and I'm not a theologian but some of our leaders group say, "Only God can take your life," and I think that's the fundamental part of the societal view about suicide.

There's a story in Judaism. I cannot speak for Catholicism but I know in Judaism, you're not supposed to, in theory, this has changed in the reform movement, but not necessarily in the orthodox Jewish movement, that withdrawal of treatment, withholding of treatment is wrong because only God can take a life, and it is only at the vague few moments before death that you could assist someone in dying, and that's the orthodox view. There's an older big story about this great Rabbi who was dying for years and there were 30 Rabbis on the street below his mud hut, and they were praying for him to live, and his servant person felt he should be let go.

She went up to the roof and she pushed this earth and vase off of the roof. It fell to the ground that caused a loud noise. The Rabbis were startled and stopped praying and the great Rabbi died, and that story is viewed with great reverence even in orthodox tradition, so there's no right or wrong on this, but it is an issue. Again, it comes back to the starting point here. If this is not suicide, then the suicide law should not be applied and cannot be applied. Fundamentally, how we view this is critical and that's why our brief from the National Academy of Elder Attorneys asked the court to look at this while they're being aligned on old dictionary definition of what suicide is.

That we need philosophers and theologians, and lawyers, and doctors, and family members, and persons with disabilities to come before a judge at a trial, and parse out all of these views based on old laws and old definitions we fit in terms of society's attitude towards life and death. Thank you.

Professor Bonventre: Judge, did you want to weigh in?

Hon. Eugene Fahey: I'm not speaking as a judge, and so I'm not giving you my legal opinion, but the short answer to the questions is yes. I think it's wrong. I think suicide is wrong. I think it's a denial of life and it's an act of despair, and so I would always think it's wrong. That is not the same as making a decision as to whether or not someone should have assistance in terminating their life as a legal question, and I think it's more subtle and more complicated than that, but I think that as . . . I do start from a moral place where I believe suicide is wrong and I wouldn't want you to think anything different.

That doesn't determine my decision, but I think the philosophical position is also reflected in our law and pretty much through old Anglo-American jurisprudence, and frankly throughout the Judaeo-Christian ethic, it's standing almost 2,500 years, so it has a sound foundation in the fundamentals of our jurisprudence, but I just think it's wrong because there's a . . . I'm talking about books a lot tonight here. There's a book written by a guy named Walker Percy. It's called *The Thanatos Syndrome*. I don't know if you ever had a chance to read it but it talks about . . . it is a speculation about a near future where a culture of death has taken over versus a culture of life.

These are very emotional and highly toxic topics to talk about, so I want to say I really respect the way you've all acted tonight about these very, very difficult topics we talk about because almost all of us have someone we know who's gone through a difficult experience and it's almost difficult to tolerate and even talk about it sometimes, but anyway, if you get a chance, read the book. I think it's worthwhile to get a perspective, but a short answer to your question is yes, I do think it's wrong, and no, I don't think it's a choice you should be able to make.

Professor Bonventre: Thank you, Judge. David?

David Levin: I'm a little bit on a tangent I think, but still, doctors help their patients die all the time, and patients are ready to die. They're on a life-sustaining treatment, a ventilator, a feeding tube. The doctor acts to remove that at the request of the patient who is now prepared to die. The patient may not even be terminally ill and they have that absolute right to have this happen which will cause their deaths. Maybe the result is going to be, we'll know what the intent of the patient is going to be, and the doctor assists them to make that happen. We of course don't call that assisted suicide.

The patient is no different than the patient who wants to die by some other option mainly by medical aid in dying. In fact, when the

doctor participates in withdrawing life sustaining treatment such as a ventilator or a feeding tube, that doctor is much more actively involved in the resulting death than when the doctor simply prescribes life ending medications for the patient which the patient may or may not take. About one third of patients in fact never take these medications to end their lives, and we don't know what the intent of the doctor really is in any situation.

The doctor may not want his patient to die. He wants to have the ventilator withdrawn but he's doing that or she's doing that because that's what the patient wants, and the doctor is simply carrying out the lawful wishes of the patient. The same is true with medical aid in dying. The patient, the doctor may or may not intend that the patient actually take the medications. We don't know what the intent of the doctor is, so I think these are all important points when we consider this in the context of what is going on when people are at the end of their lives, and again remember, people can end their lives very prematurely by having life-sustaining treatment withdrawn even though they're not terminally ill.

Professor Bonventre: Thank you.

Edward Mechmann: I'll just add that I think it's very facet to use the Judge's word to dismiss the entirety of the immemorial tradition of again, the Anglo-American legal system in the Judaeo-Christian ethic against suicide. It is very clear that there has been just this one standing traditional understanding of that and I think there's . . . I think it's Chesterton that said that the democracy of the dead, and I think we have to respect these traditions, long-standing moral judgments. I think even though if we transcend from that and even though we didn't talk about theology, if we look at what the biologist will say, they say that self-preservation is one of the fundamental motivations of any living being.

If you look even at the, I guess the anthropologist is saying, is the hierarchy of needs. At the bottom of that pyramid is life, preserving life, so I think that it's a very deeply ingrained notion in human nature. I think also in our legal and social tradition that suicide is wrong, that we have a duty to preserve our lives and we have a duty to preserve the lives of others.

Professor Bonventre: Let me bring it back to from philosophy, just law in a free society, a law in a free society, and I'm trying not to take sides over. You know what my side is, and remember, I should not take credit for that brief. The Judge keeps giving me credit.

Hon. Eugene Fahey: I thought you wrote it.

Professor Bonventre: There you go. It was not that good.

Hon. Eugene Fahey: It's okay, but-

Professor Bonventre: No, just that the names were in alphabetical order, so my name happened to come first, yeah. In a free society, we repeatedly reject notions that have been held dear for a long, long time and even just in the past few decades we have seen that, that there are notions of Judeo-Christian morality, or other cultural beliefs that we've had, and we've now rejected them, so I think there are some people who will say, "Well, the fact that this has been a belief for a long time," isn't necessarily a particularly strong argument. Again, instead of philosophically in free society, again, is suicide something against which the government does have a legitimate interest in and of itself in preventing, or is it the risks?

Is it the possible slippery slope? Is it that we're not going to be able to limit it to people who actually are competent at the time they make the choice? Is that what's wrong with suicide in a free society, that there are all these risks and possibilities, or there's something in a free society where we could say, "Government actually does have some interest in telling an individual or doubt you can't do it?" I am just opening that up as somebody who is not educated by Christian Brothers.

Peter Strauss: My response would be to look at Judge Rivera's concurrence. She does not say that it's wrong to enforce the state interest in preserving life up to a point, which she says at some point where death is inevitable. It's going to happen soon. We can't stop it. People are suffering, that the state interest is not the same. What is the interest of a state to prolong suffering if it's factually happening? I think that's the answer to your question. We're not saying that the state has no interest in preserving life. Of course we do, just as the state has an interest in protecting the rights of persons with disabilities and the poor, and the uneducated, and providing healthcare which we don't do of quality throughout the country.

Those are state interests, notwithstanding what some sections of government may be saying these days, but I don't want to get political, but I think that's the answer to the problem. There is a right but it diminishes under appropriate circumstances.

Professor Bonventre: Anyone want to add to that? David? Okay.

Edward Mechmann: I'll just say, I think that we all understand that the law has an enormous teaching value, and I don't think that it's any one of those factors. I think it's all of those factors. I think there is a general social interest in preserving life, but I think that a free society doesn't transcend from morality or tradition. I think

those are important factors since every law is a moral judgment, but I think that we have to really look at what is the law saying if we say that it's all right for some people to take their own lives, and I think this, it goes back to the very important point that I think that Stephanie made before, that since the primary reasons that people give for making this decision of assisted suicide have to do with living as a disabled person, they're getting the message, and that's not a good message for us to be sending.

Peter Strauss: The use of the term protecting tradition is very scary to me. We no longer protect the tradition in barring interracial marriage. We no longer protect the tradition of hanging blacks in the south. We no longer protect the tradition of prohibiting gay marriage. We've come a long way under the Supreme Court cases and remember, in the two cases in 1997, seven or three, '97, that Kathryn Tucker argued before the Supreme Court. The Court was very kind to the plaintiffs in those cases. The court said, "This is an important debate which should be repeatedly discussed throughout the nation and under different circumstances and different times, we might reach a different conclusion."

Professor Bonventre: David.

David Levin: The Court of Appeals, there was only debate about same-sex marriage. Our Court of Appeals made their own ruling. On the other hand, it's made correct rulings in looking forward instead of in *Myers*, where I think it looked backwards with a person's rights. They both were forward looking at the Court of Appeals. Unfortunately, in this case, they looked backward and what they should've done in my opinion, the judges of the court, respectfully, should've looked at this Second Circuit decision which ruled against *Vacco*.

The writing of a prescription to hasten death involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation, or dehydration. Withdrawal of life support requires physicians, or those acting at their direction, physically to remove equipment, and often to administrate palliative drugs which may themselves contribute to death. It simply cannot be said that those mentally competent, terminally ill persons, who seek to hasten death, but just truly does not include life support, are treated equally. Then, the court asked what I think is probably the most important question, which really we need to think about, and that is what interest can the state possibly have in requiring the preservation of a life that is all but ended?

The state's interest clearly diminishes, and diminishes a great

deal, to the extent that they don't have a valid interest in preserving a life which is virtually over with in any event when the patient decides for him or herself that it is time for him or her to go even though they would like to keep on living, but they are in fact dying.

Professor Bonventre: Stephanie, did you want to speak?

Stephanie Woodward: A lot has happened since I was going to talk. I think that we need to recognize that we're not just talking about lives that have all but ended. When we're talking about terminal, we're talking about people who have six months left to live and that is with or without treatment, so when we're thinking about terminal illness, I was thinking about a diabetic who can choose to forgo their diabetes treatment, who would then be considered eligible for assisted suicide. Are you thinking about me? I'm an average, healthy 20 year old girl. I own a house, four cats, living it up over here.

I get kidney infections regularly. Should I choose to forgo kidney infection treatment? I will undoubtedly be terminal within six months. We're not talking about people who have all but ended their life. We're talking about people who could just choose to end their life based on their circumstance. If my boyfriend hadn't accepted me, I could become depressed and say, "I don't want to live anymore," and all I have to do is stop taking kidney medication to become eligible for assisted suicide. You have to think beyond your stereotype that's in your mind of what has been shown to you in social media of the sad person who is just on the edge of death.

There are more people at risk here, and I think our country's interest in this is not in upholding tradition, although I am so happy that our courts haven't upheld traditions of continuing harm against vulnerable populations. This will perpetuate harm of vulnerable populations, allowing suicide to all would eventually only impact the most vulnerable because people who have access to services wouldn't have reason to want to die. People who are living in the worst circumstances would.

Professor Bonventre: With regard to what Stephanie was speaking about, let me just relay this story briefly. When I was at New York College, we had a geneticist who was teaching one of our biology courses, and he was advocating that parents who knew that the child yet to be born was going to have a physical impairment had a moral obligation to abort that unborn child for any physical impairment, and I have to say that Tony Carpinello, former appellate division judge, was one of the few, one of the few students in that class who protested mightily what that geneticist was saying.

There are people with some very, very different views that I think that any of them we've been hearing here, but we have a question in the audience. Go ahead, sir.

IV. QUESTION AND ANSWER

Audience Member: If New York enacts the medical aid in dying law from California, and that might be taken away. In other words, can the statute legally be challenged on some constitutional ground?

Hon. Eugene Fahey: There's a case up here in front of me but could there be a challenge? Yes. Sure, you could challenge anything. Any law that's passed, you could challenge. I have no idea what would happen. I honestly don't and I couldn't give you an opinion even if I had one.

Audience Member: Do you have anything from California or Oregon challenging the existing statutes?

David Levin: Challenges that have been made in the past have failed because the Supreme Court of the United States held that while there is no constitutional right to aid in dying under either the equal protection or due process clauses, or the federal constitution, if this was an issue, it's to be left to the law between the states and that's why some states have legalized medical aid in dying and in each law that has been made, there had been a few that had been unsuccessful.

Audience Member: Does an equal protection claim between voluntary euthanasia and physician assisted suicide/aid in dying apply if you have an individual who otherwise meets all criteria including a terminal diagnosis of six months, but they are not able to self-administer? Wouldn't there be an immediate equal protection requirement that those people also had to have access to a right in dying if it were enshrined in state constitutional protection, and how does that affect your attestation that we would never reach voluntary euthanasia being legalized in this country?

Peter Strauss: I'm not a constitutional expert but it would seem to me that the requirement that you have to be able to self-administer would not violate the equal protection rules based on the way the courts have looked at this, but again, this is not my area, but there are lots of discrimination in the existing statutes that might trouble a lot of people. This hasn't come up to me but I point to my students because I also teach a course called Aging in America in elder law, as well as running the Guardianship Clinic, and we talk about the fact that the six month rule means that people who are not dying can avail

themselves of aid in dying, if you have Alzheimer's disease but still have some capacity to make rational judgments.

You're on a level, four out of seven perhaps, and you don't want to suffer the final stages in five, six and seven, where you live in a terrible state. You can avail yourself of aid in dying because you don't need the six month's test, and more people who feel that's wrong, and they have been clamorous to expand the rules, and I think Judge Fahey referred to this role, but I wouldn't call it a slippery slope, but that would be an expansion, which at the moment we're not prepared to accept because I think it could lead to potential abuse. I think so far these rules have worked. I don't think 20 years is enough to start eliminating some of those restrictions.

I do want to say that the clemency about Kathryn Tucker's clause for elimination of some of the requirements is somewhat taken out of context because Kathryn is making those arguments in the context of saying, "Aid in dying should be a medical decision, not a legal one." It should be discussed and decided in the context of the patient-physician relationship and as you read based on issues of standard of care and whether aid in dying would meet appropriately adopted medical determinations of what's an appropriate standard of care, rather than having this risk of statutory restrictions.

I don't give an opinion in that but I feel that when you quote Kathryn's statement that we should eliminate all these rules and reporting requirements, she believes that it should be brought into the same way we deal with withdrawal of treatment, withholding of treatment, and voluntarily stopping eating and drinking, which is illegal. You can end your life by stopping eating and drinking and that's a common practice now and a growing one in this country, so I think we have to look at these restrictions in the context of how we want to view these decisions, and I agree that it really should be confined to the medical decision making between patient and physician.

Professor Bonventre: Edward?

Edward Meckmann: I also think that's exactly how these, the medical aid in dying act before enacted as proposed, would be expanded in all the legislative barriers or protections, would be eliminated. We're lawyers. What we learn to do is we learn to define things and then we stretch the definition, and then try to fit other things into the definition, and then come up with a new definition. The rules will be evaluated by courts based on if it's a legal protection challenge, based on a rational basis standard.

If we judge things that there's no rational basis to distinguish

between a 19-year old and a mature 17-year old, the law goes, that then it goes. If a judge thinks that it's irrational to say six months as opposed to 12 months, that goes. If a judge thinks that it's irrational to distinguish between a terminal diagnosis and unbearable suffering and some other kind, that goes also, so that's the way of the equal protection argument, and we've seen this in other areas as well, throughout the law. The equal protection, the argument is used as a wedge to expand legal rights and protections and that's exactly, I'm absolutely convinced, that's exactly what would happen here.

Peter Strauss: The whole slippery slope argument is, I think, from people who have such a narrow view of the trustworthiness of Americans. Now, I'm not saying we're all perfect, but we don't allow physicians to be unfettered in their decision making and this is truly in the issues of mentally ill in article nine. We do have laws about the time when it's for involuntary commitment, for psychiatric reasons, and we don't leave it up to total standard of care. We have to get someone to approve a decision to go beyond commitment for certain time periods, even the doctor feels that it might be appropriate.

Stephanie W.: On a separate note, to answer gentleman your question, just this week in Canada, a man with a terminal illness is suing the Canadian government for offering assisted suicide without guaranteeing Canadians would receive proper care if they want to live, because he was denied coverage for his treatment to prolong his life, but was offered assisted suicide. While not in U.S. courts, sometimes we listen to our neighbors occasionally depending on who we are in the country, so it could impact the U.S. as well. Though it's just a claim right now but hopefully we'll see how that goes.

Professor Bonventre: The gentleman up here.

Audience Member: Yes, thank you. First off, fantastic discussion. I appreciate the opportunity to hear both sides of the argument, very, very, very good. Thank you. Mrs. Woodward, at the beginning of the conversation, you started off by saying that the elimination of suffering was not one of the top five reasons for assisted suicide or medical aid in dying. Mr. Strauss and Mr. Levin both said there's no evidence of abuse and further stated that our culture is so much different than that of the Netherlands that we ought to dismiss the observations and the findings of that practice. Perhaps you can elaborate on the cultural differences between the Netherlands and U.S. to allow us to dismiss those rules or other's observations.

Also, maybe you can just help us understand what seems to be a

disconnect? Would you say one thing about or absence of pain and suffering, whereas Mr. Strauss, Mr. Levin, your argument has been completely on the elimination of pain and suffering.

Professor Bonventre: Go ahead, David.

David Levin: Stephanie is right that pain is not one of the top four or five reasons why people at least initially opt for seeking medical aid in dying, but suffering is always an issue for people, in tied to suffering from whatever their circumstances are which they define. Stephanie may just define suffering one way and another person who's dying and terminally ill may define suffering in another way for him or herself, so it's about the quality of life of that particular person who's dying who wants to decide for him or herself, as to how much suffering he or she can endure.

Audience Member: Being a burden could be defined as a means of suffering?

David Levin: It could potentially be for time and the person is likely to die within generally speaking, weeks or so, if the time that they do have a terminal illness. They can decide for themselves what constitutes good quality of life, what constitutes suffering for them, and that's what we're talking about. As long as they're mentally competent, and in the states which had legalized medical aid in dying, there has to be two different doctors who make a determination that the person is not only trying to rule, but is also mentally competent, and if either one of them thinks that a person is suffering from a psychiatric or psychological illness, then that person has to be for counseling before they would be giving a prescription for the drugs.

Peter Strauss: I think it's important to note, I'm doing this very quickly, that in the statutes where they exist in the six states, pain is not a factor for eligibility. It is just not in the statute.

Audience Member: It's just the suffering is what's in the statute?

Peter Strauss: I don't even think it says . . . it mentions suffering. It's the death that set over the capacity, the counseling, things like that. Yeah.

David Levin: One thing I can tell you is the process usually takes about an average of seven weeks so this is not something which people are doing on spur-of-the-moment or thinking, "Well, it's time for me to die because I now have a terminal illness. I've been given six months or less to live." These are people who think about this a lot. In fact, about one out of the other six people thinks about the possibility of medical aid in dying. About one in five . . . 450, talks with their doctor about it, but only one in 300, five less than 1%

actually end up taking their medications.

Peter Strauss: Restrictions. I think you should-

David Levin: Yeah, about 1,500 prescriptions in Oregon, so we know it's expanding the use, and that's a good thing, and that shows that the law has worked the way it's intended for. It only applies to people who feel they are suffering to such a great extent that they can no longer go on living as much as they would like to do so.

Stephanie Woodward: I would like to point out that only in this using 4% of people who requested assisted suicide in Oregon were referred for a psychological evaluation, so to say that a doctor would know if you're depressed, but to just throw out there that you all, a lot of you are law students. If you go to a doctor, your doctor might not see that you're depressed, but I know that you are. In fact, studies do show that after graduating law school, people come out with depression from graduating law school. Your community medical physician is not going to see your depression, and I would like to point out that it is horrible for me as a disabled person to hear that living in the way that I live is considered more suffering to others in that instead of giving those other who view more life as suffering and living my life is suffering, help in getting a suicide prevention services that any other person would receive, would accept that their view of my life is suffering is a good reason to want to die.

I'm going to be honest, that's incredibly offensive to me and it's not lost on me but I feel that where people who may not understand that perspective because you all walked up steps to get in here, but I hope that you'll consider that when you're considering what you think is suffering because disabled people aren't suffering. That transition can feel very scary but that doesn't mean it's suffering.

Professor Bonventre: Okay. Yes.

Audience Member: Isn't the issue of not how I perceive you or how you perceive you?

Stephanie Woodward: Right, and when the world tells me there's something wrong with you every single day, you start to believe it, so you could give a person suicide prevention services to help them see a different view of themselves just as you would've on a disabled person if they wanted to kill themselves.

Professor Bonventre: Sir?

Audience Member: How would you argue that somehow allowing someone to end their life has been a benefit to the society?

Professor Bonventre: Anyone?

Edward Mechmann: I'll start off a little bit on that. Being very sensitive to what Stephanie said about the notion of suffering, if

suffering was a reality in everyone's life, not all lives, and it is a very subjective thing, but what the challenge is I think in any case, but particularly a person who has an illness, is to deal with the multilayered suffering that they may be going through and to help them to live. We keep saying, "The person is dying. The person is dying. The person is dying." The person is alive. They're living, so we have to help them to live while they're alive, and to do that, maybe we have to alleviate their pain.

Maybe we have to alleviate their psychological suffering because they're depressed or anxious, or whatever. Maybe we have to help them alleviate their family suffering. Maybe there's been divisions in their family that we need to help them to reconcile or heal. Maybe there's spiritual suffering which many people have and they need spiritual help. That's why there are chaplains in every hospital, so I think that we get lost I think when we focus too much on suffering and then we focus too much on dying. The person who is terminally ill is living and I think the focus should be then by society as a whole is to help that person live better.

That's an answer to what Stephanie is saying about how demeaning it is to her to hear that people think she's suffering. No, she's alive. She's really alive and we need to help her to live better and to be happy with her life. Same thing with a person with a terminal illness, so I think that's the overall ideology I guess maybe of how we would be approaching this with, not focusing on the negative life positively.

Peter Strauss: We do have solutions for your question. Since the Supreme Court cases in 1997, the growth of palliative care has been remarkable. It's now in existence in every hospital in the country whereas formally it was pooh-poohed by the general medical profession, and hospice has grown dramatically, and that is an alternative to aid in dying. People go into hospice whereas David pointed out earlier a large percentage of people who do aid in dying, already in the hospice, but that isn't satisfying their need to be relieved of whatever you want to call it, suffering or pain, or whatever. We do have an expanding role of palliative care in hospice which should be supported and I think we are on the same side here.

We all support that, but also if people don't want to go into hospice, they want to go home, they need home care aids and poor people can't afford that, and only New York provides a home care program under the Medicaid system. Other states don't have that. Medicaid doesn't cover a long term custodial care. Hospice at home gives you a few hours of aids a week but we need more of that, and we can't just cut

budgets and cut back on Medicare and Medicaid programs which offer people options to some of these more perhaps closed radical solutions because they don't have alternatives.

Stephanie Woodward: If I may just quickly, that is an argument that we've before, the founder of Hemlock Society said that people in nursing facilities said that they would rather die than be there, so why don't we give them what they want and let them die? For me, the decision is not to let them die. It's to provide the resources to live at home, so when you say that people want to be at home when you need home care, but poor people can't afford that, to me, the solution is not, so let them die. The solution is to fix our system to help people live and we can't have the system that gives you the choice to die when you don't give them the choice to live.

Peter Strauss: We totally agree. We're on the same team here.

Professor Bonventre: David?

David Levin: I believe all three of you, an assessment should always be done to see what we can possibly do for the patient so that the patient might not want to die if there's a way of improving that patient's quality of life but that's also through the patient who says, "I want to have my ventilator withdrawn." We should treat all patients the same. Now, there isn't any difference. We're talking about patients who say they're ready to die. Maybe they really are. Maybe they're not. Maybe they can deal with some of the spiritual or psychosocial, or anxiety, or pain, or other issues that they're suffering from.

They would want to have that respirator, the ventilator withdrawn, their feeding tube withdrawn, or they may not want a medical aid in dying if it were legal, but we should treat our patients the same way. It doesn't matter whether you're certain to have life-sustaining treatment withdrawn or if they're seeking possible medical aid in dying.

Stephanie Woodward: If we should treat our patients the same way, does it matter if they're terminally ill then? Why wouldn't we allow them access to assisted suicide?

David Levin: We do allow people who are not terminally ill to have their life-sustaining treatment withdrawn, so anybody who's for example on dialysis, even if they're 30 years old could say at any point in time, "I do not want to continue to receive dialysis because I have to receive this every day, 24 hours a day, and I cannot, for me, my quality of life has been so diminished that I'm suffering to such an extent that I want to have to stop dialysis," and that patient has an absolute right to stop the dialysis and the result is going to be death.

Professor Bonventre: Ma'am?

Audience Member: Hi there. Thank you. This has been a good debate. I have two different things to say. One is that we talk a lot about the six month prognosis. If you ask me, 10% to 15% of patients, Medicare patients that may lead to hospice or discharge to life, no longer have over six month prognosis, so that's a fairly large margin of error. The science and the art behind prognostication of six months is very, very difficult, so that's one of my comments, not actually a question. The second is, I feel obligated to talk about the state of palliative care at hospice in the State of New York as I represent hospice and palliative care providers across the state and it is a little disturbing to me that we have less than half of the hospitals in the State of New York having palliative care providers.

In New York, we have 48 out of all of the other states in hospice utilization on a Medicare, with Medicare statistics. We have a flush hospice and palliative care program, so as we're talking about legalizing aid in dying in New York State, then we really have to look at what the other alternatives are and we need to spend much more attention in joining more hospice and palliative care services to light.

David Levin: I completely agree with all of your facts. Prognostication is often wrong, but doctors should inform their patients so that patients can make an informed decision for him or herself as to whether or not he or she still wants to obtain medication, just as the patient who might want to have life-sustaining treatment withdrawn can be told, "If you stay on this ventilator, you could live another 20 years." The patient has a right to make that decision and I also tell you that even though we are an organization of hospice in New York, there are lots of hospice medical directors who support medical aid in dying.

I have 80 of them across the state who in fact support medical aid in dying either current or a formal medical directors of hospices, so hospice is even though people should be in hospice and most who have been getting hospice, would not want aid in dying because hospice will provide excellent care and services in general. There would be a small number of people who suffer and can't be controlled and the medical directors of these hospices recognize that and that is why they support medical aid in dying.

Edward Mechmann: Just to add the one in hospice element, I fear for the ethos of the hospice movement if aid in dying is legalized because right now my understanding is that hospice would not promote assisted suicide, but I think if it is legalized, then there's going to be an element introduced into hospice that either encourages

it or offers it, or facilitates it, so I wonder for the . . . we all look to hospice as having a wonderful ethos of life-sustaining and life-affirming care, but I worry that if assisted suicide is legalized that hospice will become corrupted by it, and will become a facilitator.

V. CLOSING REMARKS

Professor Bonventre: Well, I know we could continue for another couple of hours. To wrap this up, I would like to ask the panelists if they would like to make one brief final comment before I let you all go. Edward?

Edward Mechmann: Well again, I think that the most important thing for us to understand is that we have to affirm everybody's life as it is. Life is an incredible gift to all of us. It is a beautiful thing even when it may have some difficulties, it is a beautiful thing. I think as a society, if we start to recognize and continue to recognize given what else is going on in our world, if we recognize that someone is not worth living, that it's a very dangerous place to be, especially if one becomes weak or vulnerable, or depressed. We should be more protective. We should be more affirming and not disaffirming of the way people live their lives.

Professor Bonventre: Thank you, Edward. Now, I'm going to back and forth. Peter, another brief comment, perhaps in song? We haven't heard a melody from you tonight.

Peter Strauss: The fear of a slippery slope should not deny people a fundamental right.

Professor Bonventre: Thank you. Stephanie?

Stephanie Woodward: We live in a world that doesn't afford everyone the opportunity to live, particularly vulnerable populations and we're now considering, allowing vulnerable populations to die and talking about it as if it's a choice. It's not a choice when we offer one option to the most vulnerable populations and this to get rid of us, and I say us because I'm part of that population that would very much like to stick around.

Professor Bonventre: Thank you. David?

David Levin: This issue is not about people with disabilities but for those who may have the disability. Consider Paul Spears. He was in a wheelchair. A New York psychologist told him and went to Boston University. What he said was this, "I'm better protected because we have laws which have all of these safeguards for medical aid in dying." What he said was, "If I should ever be in a situation where I'm terminally ill, I would want the right to make that decision

as someone who does have a disability.” Maybe the decision that other people would make but it would be my decision. I can protect myself.

I don’t want others to protect me. I can make my own decisions. That’s essentially what Paul Spears said, a wheelchair user, because again, this is about human rights and about the individual’s right to make a decision, whoever the law in determining when their quality of life is diminished to such an extent that they can no longer live as in fact they are dying.

Professor Bonventre: Thank you, David, and our honorable keynote speaker?

Hon. Eugene Fahey: This is a fascinating discussion. When I was listening to everyone tonight I thought, “I should’ve come here before I wrote the opinion.”

Professor Bonventre: Yeah.

Hon. Eugene Fahey: They’re all brilliant. They were all great and it was . . . you never stop learning in these things, and so I feel that as this gentleman asked the question here, I imagine this issue will be forced again and I’ll take this experience and incorporate that hopefully into whatever decision we have to make again on this issue, but I want to thank you for being invited. It’s great.

Professor Bonventre: Thank you to all of the panelists and the judge. Great. Thank you.

Charlotte Rehfuss: Thank you so much again to all of our panelists and Judge Fahey, and our wonderful moderator, Professor Bonventre, and thank you everyone for coming out.