TUESDAY, APRIL 29, 2025 11:04 A.M.

ACTING SPEAKER HUNTER: The House will come to order.

Good morning -- almost afternoon, colleagues.

Reverend Jahmel Robinson will offer a prayer.

REVEREND JAHMEL ROBINSON: Let us pray.

Eternal and Almighty God, we gather in this sacred Chamber not merely as legislators, but as stewards of justice, truth, and public good. We acknowledge Your sovereignty over this State, and seek Your wisdom as we carry out the duties entrusted to us by the people of the great State of New York.

Today, O God, we ask that You crown this Assembly with clarity of thought, compassion of heart, and courage and conviction. May every debate be seasoned with dignity, every decision be rooted in righteousness, and every law be shaped by love for the least, the last, and the lost.

We lift up the people of the State from the bustling boroughs of the City to the quiet corners of the countryside.

Let our policies protect the vulnerable, promote equity, and pave the way for opportunity and peace.

We also lift up the dedicated staff who serve behind the scenes. Those who research, write, coordinate, and communicate. Their unseen sacrifices and steadfast support are the scaffolding that holds this great work together. Bless them with endurance, insight, and encouragement as they labor for the common good.

Strengthen all who serve, elected and appointed, with a vision beyond politics, purpose beyond power, and passion for people. Remind us that our work here echos beyond the walls into the daily lives of families, communities, and generations to come. And when the record of this day is written in the archives of time, may it be said that in this Assembly, hearts were guided by heaven and hands were strengthened by hope. Order our steps, align our hearts, fortify our spirits, and let justice roll down like waters and righteousness like a mighty stream.

In Your holy and sovereign name we pray. Amen.

MEMBERS: Amen.

ACTING SPEAKER HUNTER: Visitors are invited to join members in the Pledge of Allegiance.

(Whereupon, Acting Speaker Hunter led visitors and members in the Pledge of Allegiance.)

A quorum being present, the Clerk will read the Journal of Monday, April 28th.

Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: Madam Speaker, I move to dispense with the further reading of the Journal of Monday, April the 28th and that the same stand approved.

ACTING SPEAKER HUNTER: Without objection, so ordered.

MRS. PEOPLES-STOKES: Thank you, Madam Speaker.

To the guests that are in our Chambers as well as our colleagues, I'd like to share a quote with you today. This one comes from James Baldwin, a very well-known African-American writer and civil rights activist.

His words for us today: "Not everything that is faced can be changed, but nothing can be changed until it is faced."

Again, James Baldwin.

Madam Speaker, members have on their desk a main Calendar, and before any housekeeping or introductions, we're gonna be calling for the following committees to meet: Ways and Means, followed by Rules. These committees are gonna produce an A-Calendar, which we will take up today. We're also gonna be calling for the following committees to meet as well: Children and Families, followed by Education, followed by Social Services, followed by

Mental Health, and Corporations.

We're going to begin our floor work by taking up resolutions on page 3. There may be a need for additional floor activity. If so, Madam Speaker, I will acknowledge it at that point.

Majority members should certainly be aware that there will be a need for a conference immediately following the conclusion of our work on the floor today. And, as always, we'll check with our colleagues on the other side of the aisle.

That's the general outline of where we're going today, Madam Speaker. If you could begin by calling the Ways and Means Committee to the Speaker's Conference Room.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

Ways and Means Committee to the Speaker's Conference Room. Immediate Ways and Means Committee to the Speaker's Conference Room.

We have no housekeeping this morning, but plenty of introductions.

Ms. Romero for the purposes of an introduction.

MS. ROMERO: Thank you.

I rise today with great pride to introduce one of my mentors and constituents of the 109th Assembly District, the Honorable Reverend Jahmel K. Robinson, and his family and colleagues, please.

The Reverend Robinson was born and raised in the

City of Albany, New York. Growing up, he worked to transform his community through service. Inspired by his mother and grandmother, and having grown up in a single-parent household, Jahmel consistently strove to create positive change for himself and others.

He pursed higher education and sought to support his community through his childhood church, Metropolitan New Testament Mission Baptist Church. Through the church he worked with the Home Mission Food Pantry, visited nursing homes, and aided local senior citizens. He wears many hats in his community work, including serving on the Albany Common Council and as the Pastor of Mt. Zion Baptist Church. And he works to address social determinants of health in the health space. He also served as the Director of Ministry Operations at the Metropolitan New -- New Testament Mission Baptist Church, and as the Vice President of Green Tech High Charter School Board of Trustees.

As a councilman, Reverend Robinson represents the residents of the 5th Ward, representing the people of Arbor Hill, West Hill, and West End neighborhoods. He's a strong advocate for reducing poverty, eliminating blight, and investing in his neighborhoods, and has been very proactive about supporting and writing legislation to address these concerns.

He's joined today by Denise Rhodes, Associate Minister at Mt. Zion Baptist Church; Pearl Drake, his grandmother; Tammy Alexander, Reverend Robinson's mother; Lynette Robinson, Reverend Robinson's wife, as well.

It's an honor to have Reverend Robinson in the Chamber and to have him provide the invocation for tonight -- today's proceedings. But it's especially important because the Reverend has been a real mentor for me through my life -- and I see my time is up.

But one really quick thing is that he's been such a calm and thoughtful leader, and we're both caucus chairs of the Albany Black and -- Black and Hispanic Caucus. And it means so much to be full circle here with Reverend Robinson in my time as a Zion member here, and to see him here and give the invocation. It means so much to me.

Please, Madam Speaker and my colleagues, may you grant him the cordialities of the House and the good graces of New York State.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

On behalf of Ms. Romero, the Speaker and all members, we welcome you, Reverend Robinson, to the People's House, the Assembly Chamber, extend the privileges of the floor to you. Thank you so very much for your gracious words this morning. We will need them through our -- the course of our work today. We hope you enjoy our proceedings. Thank you so very much for joining us.

(Applause)

Mr. Benedetto for the purposes of an announcement [sic].

MR. BENEDETTO: Thank you, Madam Chair [sic], for allowing me to speak here this morning.

I'm very proud to have with me today, coming up to Albany, is the Assistant Commissioner of the New York City Police Department Public Relations Unit, Mr. Alden Foster. Commissioner Foster is here with some very special guests that he brought with him from a high school in my district; a high school which our Speaker, Carl Heastie, graduated from, Truman High School. It is a high school that I have visited many times to see the fine performance of the students that attend that school. And some of the goods students have come up here today. Some are prelaw students, economic interested students, who have come up here to Albany to see how we do business up here in this wonderful Chamber.

So would you please, Madam Chair [sic], extend the cordialities of the House to these fine students from Truman High School. And, Mr. Speaker, if you would also give them some nice words to encourage these fine, new young people.

SPEAKER HEASTIE: So it's -- it's always a privilege for us to welcome any visitors here to the People's House. This is called the People's House. But, of course, this is a special moment for me because these amazing youngsters are from the same high school that I graduated from, Truman High School in the Bronx.

And, so, they're up here to observe how government works, and I tried to give them a little bit of a history lesson of how I got here. And even though my politic career started off with lots of losses, that you just never know where you're gonna go in this life.

But I really want to applaud all of you for coming up here, wanting to see how government works. I know there's a lot of things that you all could be doing, looking at other things, these devices that seem to have caught the eye. But it just -- it really warms my heart to see my high school up here.

So consider yourselves to have all of the privileges of the floor and the House, and you all can come back here any time, because, like I said, this is the People's House.

So thank you all for being here.

(Applause)

ACTING SPEAKER HUNTER: Ms. Hyndman for the purposes of an introduction.

MS. HYNDMAN: Thank you, Madam Speaker.

Today -- April is also known as Community College Month, which is a time to recognize and celebrate the vital role that these institutions play and strengthen local economies, expand and access to education, and fostering lifelong learning.

I would like to introduce -- because I don't want the buzzer to go on me -- so if -- if my guests today could stand -- to introduce the President of Adirondack Community College, Dr. Duffy; President of Corning Community College, Dr. Mullaney and Mr. Pindel, Professor of Biology; Hudson Valley Community College, Mr. Coplin; Onondaga [sic] Community College, Anastasia Urtz, who is the incoming President of Adirondack Community College effective

July 1st; Orange [sic] Community College President, Dr. Young, and Eric -- Erika Hackman, the Provost; Sullivan [sic] Community College President, Dr. David Potash; Tompkins Cortland Community College, Dr. Amy Kremenek; and Ulster Community College President, Dr. Alison Buckley.

I'd also like to introduce Ann Fleming Brown, Schenectady Community College Trustee; and the government relations for all of this, Andres Pazmino.

So on behalf of Assemblymember Jacobson and -- and myself, Madam Speaker, if you would give our guests cordialities of the House because of the work they do throughout New York State.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

On behalf of Ms. Hyndman, the Speaker and all members, we welcome you community college presidents and administrators here today. We extend the privileges of the floor to you. It's always wonderful to see our community colleges. To my OCC family back there, good to see you. My son went to CC-3. So this is a great day for community colleges. Extend the privileges of the floor to you. Hope you enjoy the proceedings today, as long as you can stay. Thank you so very much for joining us today.

(Applause)

Mr. Carroll for the purposes of an introduction.

MR. P. CARROLL: Good morning, Madam Speaker.

On behalf of Assemblyman Eachus, Assemblyman Wieder and Assemblyman Brabenec, it is my pleasure to welcome to the Chamber members of the Rockland County Business Association.

Since its founding in 1967, the Rockland County Business Association has been a cornerstone of supporting businesses in the community of Rockland County. As a nonprofit, the RBA is dedicated to educating, informing and providing valuable services to its members while actively advocating for the interests of the business community.

Over the years, the RBA has played a pivotal role in fostering growth and success of the countless businesses across the region, and specifically in Rockland County.

The RBA's commitment goes beyond just business. Although the organization is focused on supporting its members, it's -- it's also dedicated to the wellbeing of the greater Rockland community through partnerships of local charities, volunteer efforts by members, and collaboration with government agencies. The RBA drives -- help drives economic development and community service initiatives throughout the county.

So it's my pleasure, Madam Speaker, to welcome members of the RBA here today, and I'd wish you offer them the cordialities of the House. Thank you.

ACTING SPEAKER HUNTER: Yes.

On behalf of Mr. Carroll, the Speaker, the Rockland County delegation and all the members, we welcome you to the

Assembly Chamber, the Rockland County Business Association, extend the privileges of the floor to you. Hope you are able to enjoy our proceedings today. Thank you so very much for traveling to join us.

Thank you.

(Applause)

(Pause)

Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: Madam Speaker, would please call the Rules Committee to the Speaker's Conference Room?

ACTING SPEAKER HUNTER: Rules Committee to the Speaker's Conference Room. Rules, Speaker's Conference Room.

Resolutions, page 3, the Clerk will read.

THE CLERK: Assembly Resolution No. 379, Mr. Raga.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim April 23, 2025, as Book and Copyright Day in the State of New York.

ACTING SPEAKER HUNTER: On the resolution, all those in favor signify by saying aye; opposed, no.

The resolution is adopted.

THE CLERK: Assembly Resolution No. 380, Ms. Clark.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim April 20-26th, 2025, as Medical Laboratory

Professionals Week in the State of New York.

ACTING SPEAKER HUNTER: On the resolution, all those in favor signify by saying aye; opposed, no. The resolution is adopted.

THE CLERK: Assembly Resolution No. 381, Ms. Hunter.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim April 2025, as Community College Month in the State of New York.

ACTING SPEAKER HUNTER: On the resolution, all those in favor signify by saying aye; opposed, no. The resolution is adopted.

THE CLERK: Assembly Resolution No. 382, Mr. Vanel.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim April 2025, as Financial Literacy Month in the State of New York.

ACTING SPEAKER HUNTER: Mr. Vanel on the resolution.

MR. VANEL: Thank you, Madam Speaker.

April is Financial Literacy Month, and financial literacy is about making sure that we empower New Yorkers about economic stability and upward mobility. Financial insecurity impacts our workforce productivity, it impacts public health and social services.

New York State is the financial capital of the world, so we must make sure that we enable and help New Yorkers navigate student loans, mortgages and retirement. It's really important for -- to make sure that we put New Yorkers ahead on making sure that our everyday New Yorkers have the proper education, being -- to make sure that they navigate their financial and economic world properly.

Also, we, as lawmakers, one of our most important jobs and what we're doing now is working on the New York State budget. And we have to make sure that we are also financially literate. So that's why we're excited to make sure that we're promoting financial literacy here in New York.

Thank you, Madam Speaker.

ACTING SPEAKER HUNTER: Thank you.

On the resolution, all those in favor signify by saying aye; opposed, no. The resolution is adopted.

THE CLERK: Assembly Resolution No. 338, Ms. Cruz.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim April 2025, as Workplace Violence Prevention Month in the State of New York.

ACTING SPEAKER HUNTER: Ms. Cruz on the resolution.

MS. CRUZ: Thank you, Madam Speaker.

Colleagues, today I rise to introduce a resolution memorializing Governor Kathy Hochul to proclaim April 2025 as Workplace Violence Prevention Month in the State of New York.

Every individual deserves a workplace free from the threat of violence; a place where they can feel safe, respected, and secure. Yet workplace violence remains an urgent and growing issue across many industries.

According to the U.S. Bureau of Labor Statistics, nearly 2 million Americans report being victims of workplace violence. Healthcare workers are especially vulnerable. They are five times more likely to experience workplace violence than workers in any other field. In fact, nearly 75 percent of all work -- workplace assaults happen in healthcare settings, affecting nurses, emergency room staff, and countless others in the front lines.

April is Federally recognized as Workplace Violence Prevention Awareness Month, and by designating April 2025 as Workplace Violence Prevention Month in New York, we reinforce our commitment to protecting workers and recognizing the risks that they face daily.

Everyone from healthcare workers to teachers, from transit employees to service industry staff, deserve the basic dignity of workplace free from violence.

And before I conclude, I also want to take a moment to recognize several distinguished guests who are here with us today. Dr. Marilyn Dollinger, R.N. -- oh, I think she stepped out. Yes. So I -- I'm just gonna skip to Dr. Kurien Mathews. Dr. Mathews is an emergency medicine physician at the Staten Island University Hospital designated the Level I Trauma Center within the Northwell Health System. Day in and day out he provides lifesaving care to the Staten Island community, helping patients and families throughout some of the most critical moments of their lives.

Dr. Louis Calderon. Dr. Calderon is an Associate Director of Nursing for the emergency -- Mr. Calderone, I'm sorry, in the emergency department of Staten -- Mount Sinai, and brings more than 25 years of leadership in emergency room trauma. He began his public service career at the New York City EMS, where he served heroically during September 11 attacks. And he has since dedicated his career to improving the emergency services and advocating for frontline workers.

Diana Rodriguez, a BS and RN. And Ms. Rodriguez represents the future of our healthcare system. She begins her nursing career in -- in -- she began her nursing career in 2024 as the new graduate of the emergency department of Mount Sinai. Even at the start of her journey she exemplifies the spirit and resiliency and dedication we are proud to see in the next generation of nurses.

I urge my colleagues to join me in supporting this resolution and sending a clear message that New York stands firmly with workers, especially with our healthcare workers.

Thank you, and I respectfully request the support of this Body for this resolution. Thank you.

ACTING SPEAKER HUNTER: Thank you.

And welcome to our respected healthcare leaders.

On the resolution, all those in favor signify by saying aye; opposed, no. The resolution is adopted.

THE CLERK: Assembly Resolution No. 384, Mr. Brabenec.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim April 2025 as Pet Cruelty Awareness Month in the State of New York.

ACTING SPEAKER HUNTER: On the resolution, all those in favor signify by saying aye; opposed, no. The resolution is adopted.

THE CLERK: Assembly Resolution No. 385, Ms. Buttenschon.

Legislative Resolution memorializing Governor Kathy Hochul to proclaim May 4-10, 2025, as Small Business Week in the State of New York.

ACTING SPEAKER HUNTER: Ms. Buttenschon on the resolution.

MS. BUTTENSCHON: Thank you, Madam Speaker.

I rise today to present this resolution, and to acknowledge the importance of small business in the State of New York.

It is estimated that nearly 500,000 small businesses are within the State of New York, making up 98 percent of New York businesses that employ those individuals that are dedicated and committed to the mission of those businesses. This includes close to 3 million New Yorkers. Many of these businesses are family-owned that include veterans, minorities, women, and immigrants who believe in the American Dream and know how it comes to life in the State of New York.

This resolution reminds all of us of the hard work, dedication, and innovation that it takes to run a business and how it supports the communities in which they are in. Thank you to our small business owners, employees, and those that support them.

In closing, I challenge everyone to spend that week within our small businesses within your communities or communities across the State of New York.

Thank you, Madam Speaker.

ACTING SPEAKER HUNTER: Thank you.

On the resolution, all those in favor signify by saying aye; opposed, no. The resolution is adopted.

Mr. Palmesano for the purposes of an introduction.

MR. PALMESANO: Yes. Thank you, Madam Speaker, my colleagues.

It is a great privilege for me to recognize and introduce in the Chamber today Dr. William Mullaney. Dr. Mullaney is currently the president of Corning Community College. He came to Corning in the summer of 2019. He is the seventh president of Corning Community College. During his tenure he oversaw and brought major progress and revitalization to the Corning Community

College for the betterment of the students and for the business community.

He is leaving at the end of the month, in May, to -- he's going to be leaving. He's going to Rockland Community College. So Corning Community College has lost as Rockland Community College has gained. But I have said to him earlier, and his impact here at -- he made at Corning will be felt long beyond his years here.

So I'll -- also, just on behalf of myself, his -- district -- Corning Community College covers -- covers Chemung County and Steuben County. So -- also, in addition to myself, Assemblyman Chris Friend from Chemung County, Assemblyman Joe Sempolinski and Assemblywoman -- woman Andrea Bailey, on behalf of all of us, if you could recognize him.

But I also have someone here who's joining him; David Pindel. He's a professor of biology at Corning Community College. But definitely for Dr. Mullaney, and all of you, thank you for your service and what you did -- what you've contributed to Corning. Like I said, the impact you've made there will be felt long beyond your years here. So we salute you, we thank you.

And Madam -- Madam Speaker, will you please pass the cordialities and thanks from the House from all of us?

Thank you.

ACTING SPEAKER HUNTER: Yes.

On behalf of Mr. Palmesano, delegations from the Corning Community College area, the Speaker and all members, welcome, Dr. Mullaney and Professor Goodell [sic], to the Assembly Chamber. We extend the privileges of the floor to you. Thank you for all the work that you do for our young people, and older adults, in community college. Just truly an exceptional education provided. We hope you enjoy the proceedings today. Thank you so very much for joining us.

(Applause)

(Pause)

Mr. Schiavoni for the purposes of an introduction.

MR. SCHIAVONI: Madam Speaker, I rise today to introduce a resident of eastern Long Island, Suffolk County, Diane Costello. Diane is a sincere, engaging, committing -- committed, compassionate leader and individual. She is a career educator, teaching our nation's youth for the better part of three decades.

Hers a New York story. Born in Brooklyn, raised in Nassau County, and now living on the eastern end of Long Island. Diane is deeply committed to her community, and advocates for them on all levels of government.

She is here today with a group -- with the group Moms Demand Action for Gun Sense in America, a group which ensures legislative leaders -- that legislative leaders keep our kids safe in schools and across the State and nation. Diane volunteers and works across many districts.

So on behalf of Assemblymember Giglio and myself, Madam Speaker, I ask that you extend the cordialities of the House to

Diane as she sets a fine example for others as a leader in our community.

ACTING SPEAKER HUNTER: Thank you.

On behalf of Mr. Schiavoni, Ms. Giglio, the Speaker and all members, we welcome you, ma'am, Ms. Costello, to the People's House. We extend to you the privileges of the floor. Thank you so much for the advocacy work that you've been doing to reduce gun violence. Hope you enjoy our proceedings today. Thank you so very much for joining us.

(Applause)

Ms. Solages.

MS. SOLAGES: Members have on their desk an A-Calendar. Madam Speaker, I now move to advance the A-Calendar.

ACTING SPEAKER HUNTER: On a motion by Ms. Solages, the A-Calendar is advanced.

We just want to make sure we have quiet in the Chamber, please. Thank you.

MS. SOLAGES: I now direct members to bring their attention to Rules Report No. 155 by Mr. Pretlow.

ACTING SPEAKER HUNTER: Thank you.

Page 3, Rules Report No. 155, the Clerk will read.

THE CLERK: Assembly No. A08095, Rules Report 155, Pretlow. An act making appropriations for the support of government; to amend Chapter 113 of the Laws of 2025 making appropriations for the support of government, in relation thereto; to amend Chapter 118 of the Laws of 2025 making appropriations for the support of government, in relation thereto; to amend Chapter 119 of the Laws of 2025 making appropriations for the support of government, in relation thereto; and providing for the repeal of such provisions upon expiration thereof.

ACTING SPEAKER HUNTER: Governor's message is at the desk. The Clerk will read.

THE CLERK: I hereby certificate to an immediate vote. Kathy Hochul, Governor.

ACTING SPEAKER HUNTER: An explanation has been requested.

Mr. Pretlow.

MR. PRETLOW: Yes, Madam Speaker.

This extender, our ninth extender, would ensure funding for the State operations and other programs through May 1, 2025. The bill includes additional funding for institutional payroll, Children's Health Insurance programs, WIC, unemployment insurance, support for OPWDD services, veterans' homeless housing, and general State charges.

ACTING SPEAKER HUNTER: Mr. Ra.

MR. RA: Thank you, Madam Speaker. Would Chairman Pretlow yield?

MR. PRETLOW: Yes, I will.

ACTING SPEAKER HUNTER: The Chair yields.

MR. RA: Thank you.

So, this is extender number nine, to May 1st. Can you just give me the appropriation amount and the additional amount from the last extender?

MR. PRETLOW: The total appropriation to date is $11.9 billion, which is an additional $520.6 million.

MR. RA: Okay. And what is the total amount we have appropriated through these nine emergency extenders?

MR. PRETLOW: $14.7 billion.

MR. RA: Thank you.

And what would we be anticipating as we got into May 1st in terms of if a tenth extender is necessary? Payroll coming due or other charges --

MR. PRETLOW: Well, the tenth extender will be necessary no matter what we do today or tomorrow, and we will make arrangements for those payments.

MR. RA: Okay.

So as we're all aware at this point, the Governor made an announcement last evening. So do we have a deal? Is that $254 billion number accurate and set in stone?

MR. PRETLOW: Mr. Ra, could I answer that question in the form of a parable?

MR. RA: Sure.

MR. PRETLOW: In life we make certain decisions. And one of those decisions, for many of us, is to -- to marry. And we court our -- our future spouse for a length of time, and we decide to wed, and send out invitations, and everybody's planning for a wedding. And one of the two decides, *I really don't want to do this. I want to change my mind.* And you go to your prospective spouse and say, *Honey, I love you. But I don't think we should get married.* And your prospective spouse says, *But the invitations are out*. And with that statement, you decide to get married, live miserably for the rest of your life. But you did it because the invitations were out.

This is the Governor giving us invitations, trying to force us into something that we don't necessarily want to do right now.

(Laughter)

MR. RA: Okay. I -- I don't even know what to do with that, but well -- well done, Mr. Pretlow.

(Applause)

So, Madam Speaker, on -- on the bill.

ACTING SPEAKER HUNTER: On the bill, sir.

MR. RA: Thank you, Chair Pretlow. I -- I would say perhaps that's confirming what -- what many of us felt might be the situation.

I -- I just want to remind everybody, we have nine budget bills that we still need to do to put a budget in place for the upcoming fiscal year. We still have four Article -- or, I'm sorry, five Article VII bills, four appropriation bills. The only thing we have acted on is Debt Service.

We have now passed the point where our school districts have had to put out budgets. They're waiting. And, you know, you need to look no further than some of the communications we've gotten from them, quotes they've had in the media. It does matter to them that we are -- we are at this point with this budget.

I -- I think it's unfortunate that the Executive would come out prematurely with regard to -- to an announcement if we are not quite there. But taking that number for what it is, $254 billion, which would be 2 billion above the original proposal, about $11 billion above what last year will be, all said and done, that's a lot of money. And at some point, we hope later this week, maybe next week, we'll put the final touches on passing those bills that actually appropriate that over quarter-of-a-trillion dollars. And we'll figure out what is actually going to help middle-class families with affordability, childcare, the rebate checks, tax cuts. But there is any number of things still out there and still really going on behind closed doors on -- on the policy side. We're talking about changes to the public finance system that -- that New York State utilized for the first time in last fall's elections. We're talking, obviously, about the policy issues that have been at the forefront for months; discovery and masking, involuntary commitment. There is word regarding what we're doing with the MTA and a potential another increase in the MTA payroll mobility tax, which is -- I would remind everybody, quite frankly, a tax on jobs.

So we await those details with hope that we'll be discussing them in this Chamber, in the light of day, at some point;

again, maybe this week, maybe next week. But, you know, I -- I think it is emblematic of this process that we probably have all heard from people back home saying, *Great, there's a deal. What's the status of -- of this issue or that issue?* And you have to say, *Well, yeah. That's out there. There's a deal. But I don't know.* We don't have any actual text to look at to share with our constituents, to share with stakeholders so they understand what will be with regard to any number of issues they're concerned with.

With that, you know, I'll be supporting this bill. I -- I have a feeling everybody will, to continue to make sure the State is meeting our obligations as we work towards a -- a full budget. But it -- it is sad that the leadership of -- of -- of this State, in particular, the Executive, wants to go out there, make an announcement, perhaps, prematurely, and actually say things like, when people ask what is going on with X, Y? *Oh, yeah. We have a deal on that.* I'm not gonna -- I don't want that out -- out in the public because I guess the feeling is, the best way to do things is behind closed doors with zero transparency.

This is my 15th budget. It gets worse every single time. And we're going to piecemeal a quarter-of-a-trillion-plus dollars being appropriated, and we're gonna start appropriating those dollars in one bill and we're not gonna know what the -- what the end result is, what the out-year budget gaps are that we're gonna be dealing with. And it's just no way to -- to run a government. It's not transparent. And it's not in the best interest in the long-term fiscal health of this

State.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

Mr. Tague.

MR. TAGUE: Thank you, Madam Speaker. Would Chairman Pretlow yield for a question?

ACTING SPEAKER HUNTER: Would the Chair yield?

MR. PRETLOW: One question? Yes.

ACTING SPEAKER HUNTER: The Chair yields.

MR. TAGUE: Well, Mr. Chairman, I guess the anticipation of there being white smoke out of the Capitol today, tomorrow or the next day may be a little premature; is that correct?

MR. PRETLOW: Yes.

MR. TAGUE: Okay. Thank you very much. I appreciate it.

There's not much more I can say that my colleague, Mr. Ra, has already brought up. To me this is disappointing, disingenuous to the people of the State of New York. Nine extenders, 29 days late on a budget. People in New York State hoping that agencies and their State government would work for them, but nothing, again. And --

ACTING SPEAKER HUNTER: Are you on the bill, sir?

MR. TAGUE: I am on the bill.

ACTING SPEAKER HUNTER: On the bill.

MR. TAGUE: Thank you.

I already excused him. He didn't -- he didn't want to answer anymore questions.

But anyways [sic], he even -- you made me lose my spot. Now I'm gonna have to start all over again, Madam Speaker.

Anyways [sic], as my colleague, Mr. Ra, said, the people of the State New York, they do care about having a budget on time. Here we are. The Executive, the Governor, come out and says there's a deal. But there's no details. Nobody's agreeing whether there is an agreement or not. And here we are no different today than we were yesterday, last week, the week before. It's just ridiculous. Ridiculous. We need to come here, do our jobs -- do our jobs for the people of the State of New York.

I will be voting in favor of this, as I have in the past.

Thank you.

ACTING SPEAKER HUNTER: Thank you, Mr. Tague.

(Pause)

On a motion by Mr. Pretlow, the Senate bill is before the House. The Senate bill is advanced.

Read the last section.

THE CLERK: This act shall take effect immediately.

ACTING SPEAKER HUNTER: The Clerk will record the vote.

(The Clerk recorded the vote.)

Are there any other votes? Announce the results.

(The Clerk announced the result.)

The bill is passed.

Ms. Solages.

MS. SOLAGES: Thank you, Madam Speaker.

Can you please call the members of the Childrens and Families Committee to the Speaker's Conference Room immediately?

ACTING SPEAKER HUNTER: Children and Families Committee, please see Mr. Hevesi in the Speaker's Conference Room. Children and Families Committee, Speaker's Conference Room.

Ms. Solages.

MS. SOLAGES: And we're keeping on rolling.

I draw the members' attention to Rules Report No. 153 by Ms. Paulin.

ACTING SPEAKER HUNTER: Thank you.

Will the Sergeant-at-Arms please get the folks in order? We're gonna be on debate.

(Pause)

Page 3, Real -- Rules Report No. 153, the Clerk will read.

THE CLERK: Assembly No. A00136, Rules Report 153, Paulin, Rosenthal, Dinowitz, Hevesi, Steck, Lupardo, Rivera, Epstein, Seawright, Woerner, Reyes, Cruz, Sayegh, Davila, Stern, Burdick, Gallagher, Kelles, González-Rojas, Mitaynes, Mamdani, Clark, Anderson, Jackson, Septimo, Glick, Gibbs, Tapia, Lunsford, Cunningham, Levenberg, Simone, Bores, Forrest, Shrestha, Shimsky, Raga, Rajkumar, Kim, Hunter, Stirpe, Chandler-Waterman, Lee, Taylor, Meeks, Otis, Alvarez, Lavine, Dais, Jacobson, Kay, P. Carroll, Lasher, Schiavoni, Romero, Valdez, Burroughs, Hooks, O'Pharrow, Dilan, Torres, De Los Santos. An act to amend the Public Health Law, in relation to a terminally ill patient's request for and use of medication for medical aid in dying.

ACTING SPEAKER HUNTER: An explanation has been requested.

Ms. Paulin.

MS. PAULIN: Yes. Of course. Thank you.

The bill would allow a terminally ill, mentally capable adult with a prognosis of six months or less to live, to have the option to request, obtain, and decide to ingest medication for Medical Aid in Dying.

ACTING SPEAKER HUNTER: Mr. Jensen.

MR. JENSEN: Thank you, Madam Speaker. Will the sponsor yield for some questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. JENSEN: I want to thank Chair Paulin for -- for yielding. And -- and before we start today's debate, certainly, as we talked about in the Health Committee yesterday, that this is a topic that -- that there's a lot of emotions on. And, certainly, it's a question of life and death, a question of morality. So I'm sure today's debate will be passionate from -- from both supporters and detractors.

And I do want to recognize -- even though I may not be a supporter of the legislation -- the work and the effort that you've put in and the passion that you've shown throughout the time that we've served together and through your career on this bill.

My questions leading off today's debate are gonna focus on some areas of the legislation that I believe we have not built in enough safeguards in this legislation to ensure that vulnerable New Yorkers will have the protections that they need should Medical Aid in Dying become law. Really -- really focusing on the issues of coercion, the process surround physicians, mental competency, and the terminal diagnosis.

So I want to lead off with questions around coercion. What safeguards exist in the legislation to ensure that there is no coercion throughout the decision-making process should an individual want to utilize Medical Aid in Dying?

MS. PAULIN: So, firstly, the penal statute's very clear that -- that if somebody is coercively attempting to hurt someone, like they would be here, that it would be -- it would range depending on what that coercive nature is, from a Class A misdemeanor to a Class D felony.

We also know that since 1997 when Oregon began and was the first state to do so. So for nearly 30 years there's never been a single case of coercion in any of those other jurisdictions. And we also know that family members typically coerce in the opposite direction. They want their family members to live. And so if there's a treatment out there, an experimental trial or anything of the sort, it's usually the case that they will try to prolong that family member's life and work toward that and not work toward Medical Aid in Dying.

You know, most people who opt for Medical Aid in Dying do so with wanting to preserve their bodily autonomy. And so it's very, very unlikely that they're going to be coerced into this kind of situation.

MR. JENSEN: Well, and I -- and I think, certainly, to your point, when most people bring up the idea of coercion, it is thinking about close, personal family coercion about trying to -- to potentially force an individual who has a terminal diagnose to, for whatever reason, potentially not want to pursue end-of-life decisionmaking. But coercion isn't just about what you say, it's also what you don't say. And other types of coercion don't just include familiar coercion, but it could be practitioner coercion, larger family coercion, self coercion. And I think one of the things that -- that has me -- concerned a lot people, is that there could be societal or systemic concerns where because of the nature of somebody's perceived burden on their family, on their system, access to certain things, that they could say, *Well, I don't want to be a burden to stay in* *a nursing home long for longer. I don't want to have to make my children suffer by having to care for me an additional amount of time.* And that unspoken coercion that may not be the individual's wishes, but it could be saying they don't want to do it for themselves, they want to do it for other people.

And so I guess my question is, you know, understanding the bill, you have to have an attending physician as well as a consulting physician. How would they decide whether all forms of coercion had occurred not just at the initial decision-making process, but throughout the process?

MS. PAULIN: So, there's no safeguards like the safeguards that we have in this bill for any other medical process, including whether or not there's coercion to come off of dialysis or whether there's coercion to stop eating and drinking at the end of your life because there's no other way to -- to end it if you're in such pain. We don't have the kind of safe -- those safeguards. Here we have enormous safeguards. Two doctors have to attest to the fact that there's no coercion. There is a mental health evaluation if necessary who has to, again, attest to the fact that there's no coercion. If there's any suspicion of coercion it's prosecuted. And, again, we've seen no data. We've seen no prosecutions. We've seen one referral to a district attorney in one state where it was decided there was no coercion.

So I don't -- I think here we had -- can be very sure that when someone's opting to end their life through this, they're doing it from their own self. They have to self-ingest. They have to make that decision for themselves. Those are very powerful.

MR. JENSEN: Yeah. And -- and -- and for me, I -- it's not surprising to hear that in -- in other states, the 11 jurisdictions of -- of the U.S. where -- where this is a legal means of ending one's own life, that there isn't coercion because I -- my belief would be that most people who are coercing someone aren't putting it in writing or doing something that can be demonstrated as evidence in a court of law. It's going to be through their actions. And once somebody ends their life through government-assisted death, it's tough for them to allege coercion.

And so I think that's why we have to have larger safeguards at the beginning of the process and throughout the process to ensure that if this becomes law, it is the individual and the individual alone choosing to be the one to make the decision to end their life, and not doing it because of ulterior belief that it may benefit someone else or lesson the harm to other people rather than, through your intent of the legislation, to end the pain and suffering somebody may have through that terminal illness or disease.

So it would be the attending and the consulting physician to determine whether or not coercion is taking place before the medication has been prescribed or throughout the process?

MS. PAULIN: So, certainly, the attending physician has a relationship throughout the process as you're describing. So, yes, I would say that they have a relationship, and -- you know, with that patient. And, you know, again, if somebody was trying to coerce them to actually take the medication after they got a prescription, that doctor could -- would be able to report that to the authorities.

MR. JENSEN: So the mechanism would be -- so if somebody believed, whether it was the doctor, another family member, that there may have been coercive behavior in somebody either requesting Medical Aid in Dying or, in fact, following through with their own death, the process would be that anybody can make a referral. Would it be to the local district attorney?

MS. PAULIN: Absolutely.

MR. JENSEN: Okay. So that would be judged in a court of law. There wouldn't be -- I guess, what would happen if there is somebody who makes that -- that allegation before the individual would -- they've been prescribed the medication, you have two siblings. One sibling alleges the other sibling is coercing their parent into an end-of-life decision through Medical Aid in Dying. The individual has been prescribed the -- the end-of-life medication but has not taken it yet. Sibling B alleges that the -- sibling A is coercing the parent. Would there be a mechanism to delay or stop the individual from taking the medication until the legitimacy of that coercion is determined or that the individual sees a mental heath provider to determine whether or not they're of sound mind and independent decision-making?

MS. PAULIN: You know, these are people of sound mind and decision-making. These are not -- you know, that's one of the things that both doctors have to attest to. And if they think there's a different -- if they think there's any suspicion of -- of not being able to make a decision regarding getting a prescription or using the prescription, then they have to make a referral to the mental health provider.

So -- so I think that what we've seen, you know, over the course of the nearly 30 years, as there is no coercion. And people get this medication to fear -- or in the -- in the -- in the possibility that they're going to have excessive pain at the end of their life. It gives them great comfort to be able to know that. And -- and, hopefully -- you know, we also know that nearly 40 percent of people never use the medication who get a prescription. So it just gives them that enormous comfort to -- to know that they have that just in case.

MR. JENSEN: Okay. So I do want -- you talked a little bit about the relationship between the doctor and the patient. I want to dig a little bit deeper into that.

Would the attending physician have to have a preexisting medical relationship with the patient?

MS. PAULIN: Well, they would have to have some relationship with the -- you know, with the patient, certainly, in order to be the attending physician, to whatever the disease is that they're -- that they have. I mean, they would -- what we know is that the attending physician has to be able, has to be competent to be able to assess terminal illness.

MR. JENSEN: So the reason I ask that question is, trying to figure out if somebody is -- is seeing the physician they've been seeing for that illness, for that disease, and they do not grant them that terminal diagnosis. Could an individual who -- who believes that their own pain and suffering is unimaginable, that they cannot carry on, that they want to utilize, but their doctor who's been treated them for a set amount of time disagrees with giving them that six month or less diagnosis, could an individual essentially doctor shop to find a provider with the expertise for that disease or illness, but a willingness to give them a diagnosis despite their primary provider, who they have a relationship with, disagreeing with that diagnosis?

MS. PAULIN: I would say it's less about the diagnosis, because doctors who are similar in specialty -- I know in New York, I have a good friend right now that has cancer. And she says all the doctors in New York seem to talk to each other. She has a unique cancer. So I -- I think it's less about the diagnosis than it is about a doctor's willingness to participate in this program. Especially at the outset of passing a bill like this, we may see some doctors willing and other doctors not. So if the patient desires to get this prescription, I could obviously see a doctor saying, *Look, I'm not comfortable yet in prescribing this, but at Mount Sinai or at Sloan they are. So I'm going to give you a referral to another physician that has the same expertise.* That we have seen.

MR. JENSEN: So -- okay. So is there anything -- knowing that we could have doctors referring their patients to other doctors who be -- may be more likely to assist with prescribing end-of-life medication, are we concerned about the development of a new subset of providers who may exclusively treat or see patients who wish to end their lives and develop that expertise in these types of illnesses to cater only to individuals who are in the end-of-life terminal stage, and hit -- essentially, create a cottage industry of doctors who are essentially helping to utilize end-of-life suicide?

MS. PAULIN: I do think we will see some doctors willing to prescribe and other doctors not yet willing, as we've seen with other states. But to create a cottage industry I think is -- is an extreme.

MR. JENSEN: Okay. Would doctors be prohibited from being the one to raise the possibility with a patient about utilizing medical aid in dying upon a terminal diagnosis with less than six months to live? Would the doctor be prohibited from saying, *Hey, have you thought about this?*

MS. PAULIN: No. I think that that would -- just like any option, I think that it would be a doctor's obligation to -- to share any and all --

ACTING SPEAKER HUNTER: Thank you, Mr. Jensen.

MR. JENSEN: Thank you, Madam Speaker. Thank you, Madam Sponsor.

ACTING SPEAKER HUNTER: Ms. Solages.

MS. SOLAGES: Madam Speaker, will you please call the Education Committee immediately to the Speaker's Conference Room?

ACTING SPEAKER HUNTER: Education Committee to the Speaker's Conference Room. Education to the Speaker's Conference Room.

Ms. Septimo.

MS. SEPTIMO: Will the sponsor yield for --

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MS. SEPTIMO: So, who is eligible for this medication?

MS. PAULIN: You have to be terminally ill, diagnosed by two independent physicians, the attending and the consulting, to be -- and you have to be 18 to be eligible.

MS. SEPTIMO: And who determines the six month or less diagnoses?

MS. PAULIN: The -- the doctor who's an expert in the -- in the -- in the -- in the illness.

MS. SEPTIMO: Okay. So someone who had gained access to this medication by visiting with a doctor who is specialized in the illness that they are suffering from, and that doctor would have to determine that that person has six months or less left to live; is that correct?

MS. PAULIN: Yes.

MS. SEPTIMO: And my understanding is that another doctor would also have to agree, separate from that doctor, that that person only has six months or less left to live?

MS. PAULIN: Yes.

MS. SEPTIMO: Two separate doctors who have taken two separate oaths, correct?

MS. PAULIN: Yes.

MS. SEPTIMO: Okay. And who would be able to administer this medication?

MS. PAULIN: It has to be self-administered.

MS. SEPTIMO: Okay. So what if you were unable to communicate that you would like to take this medication, but your family members or your caregivers are absolutely certain that you would want to take this medication?

MS. PAULIN: You would not be eligible.

MS. SEPTIMO: Okay. So you are the only person who is able to say that you would like to access this medication.

MS. PAULIN: Yes.

MS. SEPTIMO: And let's say that you are able to communicate that you want to take this medication, that you find two doctors who agree that you have six months or less left to live. You get the medication, but you are too ill to take it yourself. What would happen in that case?

MS. PAULIN: If you can't self-administer -- and there's lots of ways you can self-administer, so that would likely not be a problem -- but if you can't self-administer, then you cannot take the medication.

MS. SEPTIMO: Okay. So you'd mentioned an evaluation of someone's mental state before they're able to take this medication. Who is able to decide that you are of sound mind?

MS. PAULIN: The two -- the two doctors; the initial doctor, the attending, and then the consulting doctor.

MS. SEPTIMO: Is there any space in that process for, again, your family member, your caregiver, your home attendant, for anyone to weigh in on your state of mind or how you feel about your illness in the process of the evaluation of your mental health?

MS. PAULIN: They can certainly talk about it, but they have no impact.

MS. SEPTIMO: Okay. And how can we know -- going back to the self-administering, how can we know that the self-administration, when someone is taking the medication, how can we know that that is how it will actually happen? Is there a mechanism in place to make sure that when it is happening there is someone there to see it?

MS. PAULIN: There's always -- you know, when the doctor prescribes, there's a list of things that we advise the doctor to advise the patient, and one of them is that they shouldn't do this alone. They should have other people there.

MS. SEPTIMO: And with respect to those other people, are there any safeguards in terms of who those other people must or may or may not be?

MS. PAULIN: No. It's up to the patient to have -- to choose.

MS. SEPTIMO: Are there any witnesses that are able to be there that have an interest in seeing this person end their life?

MS. PAULIN: Certainly, anybody by the choice of the patient could be in the room.

MS. SEPTIMO: Great.

MS. PAULIN: What they can't do is, they can't witness the request if they have any financial interest.

MS. SEPTIMO: Okay. So just to make sure that I have it straight. If someone has a financial interest in someone dying, let's say turning to the example of a child and a parent, the child is not able to be the legal witness with respect to their parent requesting the -- the medication --

MS. PAULIN: Right --

MS. SEPTIMO: -- correct?

MS. PAULIN: There could be no familial person signing that witness statement.

MS. SEPTIMO: Okay. And so they would not be able to coerce in that moment to say, *Sign this paper,* because they would not be able to be the witness --

MS. PAULIN: Right.

MS. SEPTIMO: -- in that moment? Okay.

Now turning to disparities for a moment. Do you know what the racial breakdown is with respect to access to this medication across the country and other places where it exists?

MS. PAULIN: We know that 92 percent across the 11 jurisdictions are White. I think it was 5 percent were Black, and then with all the other minorities filling in the gaps. My -- I think it's actually less Black than 5 percent. I think actually Hispanic were higher. You know, I think 3.9, if I'm remembering right. So it -- it -- there's a range for the remaining. And it depends on the state, too.

MS. SEPTIMO: Uh-huh.

MS. PAULIN: You know, California only has 87 percent White. So you have a more diverse state, you have more diversity for the remainder.

MS. SEPTIMO: Okay. Thank you.

And has there been any effect on additional access to end-of-life care in other states where this medication is available?

MS. PAULIN: So, they have found in other states that hospice care goes up. You know, we are one state that does not have -- there isn't a high utilization compared to other states. And that utilization has really taken off in states where they have this.

MS. SEPTIMO: Okay. So it would be safe to say in -- in effect of passing this medication, is that more people have access to end-of-life care options like hospice care?

MS. PAULIN: Yeah. And let's remember what hospice care is, too. It -- it allows someone to get palliative care, pain relief. So, yes, it's a very good option for people in an end-of-life situation. And -- and it's great that, you know, this bill may provide an avenue to do that. We have a provision in the -- in the bill that requires the attending physician to -- to say exactly what the hospice options are, and palliative options are, as well as all treatment options.

MS. SEPTIMO: So, to the earlier point that was raised, when -- when a physician is communicating about this medication, they will also be communicating about every other end-of-life care option that exists here in the State?

MS. PAULIN: Yes.

MS. SEPTIMO: Okay. And we know that healthcare is a business in this country, and certainly in the State. Are insurance companies able to make money off of the prescription of this medication or the administration of this medication in any way?

MS. PAULIN: No. They're prohibited from even letting all their -- their -- you know, we all have health insurance. You know, you get that book, you know, in the beginning, that none of us really look at the detail, maybe some, I didn't. You -- they can have the information in that kind of book, but they can't just mail out -- you know, for example, you -- with -- typically with these severe illnesses like cancer, you get a lot of denials, unfortunately. And so in that denial you can't say what else is available. Like this one. We specifically prohibit the ability for someone to do -- for an insurance company to do that. But if a patient asked the insurance company or the attending physician asked on behalf of a patient, then the insurance company could provide that information.

MS. SEPTIMO: Okay. Just so I have it straight. The insurance company can't be in a position where someone is denied care for a terminal illness, and then turn to that patient and say, *But here is this medication that will end your life and end your suffering*?

MS. PAULIN: No. And as a matter of fact, most patients at that stage are on Medicaid and Medicare, and they don't offer this. So we're talking about very few patients that would even have the commercial insurance to be able to ask. But, you know, in New York, where, you know, we know that very few people will be able to even have the insurance to cover it. But if they did, those insurance companies would be prohibited from giving that information.

MS. SEPTIMO: Great. And I just want to make sure there's no financial incentive for an insurance company to suggest, recommend, share information about this medication with a patient.

MS. PAULIN: Absolutely none.

MS. SEPTIMO: Okay. Great. And last couple of questions.

This medication, to be clear, is reserved exclusively for someone with a terminal illness; is that right?

MS. PAULIN: Yes.

MS. SEPTIMO: Is there any type of illness that is not terminal under which someone could gain access to this medication?

MS. PAULIN: No.

MS. SEPTIMO: Okay. So to borrow from the earlier example again, if someone is living in a nursing home, with a chronic illness, was going through a moment where they felt like they no longer wanted to be a burden to themselves, to their family, to their community, to the nursing home, did not have a terminal illness, would that person be able to opt in to this medication?

MS. PAULIN: No.

MS. SEPTIMO: Okay. Thank you.

ACTING SPEAKER HUNTER: Mr. Durso.

MR. DURSO: (Inaudible) -- Speaker. Would the sponsor yield for some questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. DURSO: Thank you, Ms. Paulin.

So I want to get into the definition when it comes to this bill in regards to "terminally ill". You're saying someone has to be -- said to be terminally ill with less than six months or less to live, correct?

MS. PAULIN: Yes.

MR. DURSO: Now would that terminally ill diagnosis include if there was medication to extend your life? So, in other words -- I know, obviously, when it comes to this bill we talk a lot about cancers. If you have cancer and you're saying, *If you don't treat it you have six months to live. But if you do receive some types of treatments you can live up to ten years*. Would that include something like this?

MS. PAULIN: No. If there's a treatable -- just like dialysis, right? You use dialysis, you -- it's a treatable illness. If it's treatable then you're not eligible.

MR. DURSO: So where does it say in the bill that if it's a treatable -- I'm just curious --

MS. PAULIN: A challenge. Okay. Okay. So I'll just read until I find it here.

MR. DURSO: Sure.

MS. PAULIN: "Terminal Illness or Condition" -- it's in the definitions on page 3 -- means an incurable and irreversible illness or condition that has been medically confirmed, and will within a reasonable -- within reasonable medical judgment produce death within six months.

So, we can go back to "medical condition" because I know that's also a definition in here. And --

MR. DURSO: We're gonna get to that part of it.

MS. PAULIN: Okay.

MR. DURSO: But -- but my -- my question is, it -- it's saying if it's irreversible, right. But --

MS. PAULIN: Right.

MR. DURSO: -- if you have a diagnosis of whatever the -- the terminal illness is, and you're able to take medications or have a procedure done that extends your life, it doesn't reverse the illness, what it does is pro -- really prolong your life.

So couldn't you argue to say that if I had some type of from of cancer or anything else, or even dialysis, which the dialysis is what is keeping me alive because my kidneys no longer work, right? If I don't do dialysis, if I decide that I don't want that treatment, do I then fall under this and say, *You know what? I know there's a treatment in place, but I don't want it. And without that treatment I have six months or less to live*, I would technically qualify.

MS. PAULIN: If there's a treatment in place then, no, you would not qualify.

MR. DURSO: But it -- but it doesn't specifically say that. It says "irreversible". But it's not reversing it, what it's doing is prolonging it.

So, I'm not an attorney --

MS. PAULIN: You know what? That's the term we're using to mean that, though.

MR. DURSO: I understand we're not using it to mean that --

MS. PAULIN: But we're creating legislative intent right now.

MR. DURSO: But -- but we're -- I understand the legislative intent, but we've been working on this bill for two decades and it's not in the bill. So my concern would be, why wouldn't that language be in there saying if there is medication or procedures available to extend your life, you do not qualify for this?

MS. PAULIN: You know, we have a lot of provisions in the bill that one might argue were duplicative because we didn't have the wording that, you know, a member thought was clear or strong enough. So for members who brought those to my attention prior, mostly, they were saying, if you do this, then feeling comfortable with the bill, I was open to making that change. Unfortunately, you didn't come. I raise that --

MR. DURSO: I wasn't invited --

MS. PAULIN: Nope. Honestly, a lot of members came uninvited and said, *I want you to add a provision to make sure that the insurance provision is strong enough. I want you to add a provision to make sure that there was a no liability on a health practitioner if they did or did not use this* -- make -- you know, use the option of the bill to provide for their patients.

So I'm gonna say right now that that way we had termed it was intended to mean that if there was a treatment available -- and I will add, we've had nearly 30 years of using that same word across the 11 jurisdictions, and that word has meant that and has held up to mean that. So we -- that's we did in New York.

If you think that you -- if you tell me now you're prepared to vote for it, I'll offer you an amendment to the bill down the line.

MR. DURSO: How about we just amend it now?

MS. PAULIN: Obviously, that's not in the cards.

MR. DURSO: Oh. Well, then, neither is my vote.

MS. PAULIN: But it's strong enough. I can assure you that that's the language that's used across the --

MR. DURSO: And I understand what the intention of it is, but the fact of the matter is --

MS. PAULIN: And the practice of it --

MR. DURSO: Well, I understand. But we're putting into law that fact that someone's allowed to choose the -- to end their life, essentially. And I understand the angst with it and I understand the pain that people go through. I've witnessed it myself with my own mother. I understand it personally. But my concern would be that this is obviously a very important piece of legislation, which a lot of us, you know, wrestle back and forth with. I mean, there's -- there's advocates in the room. There's -- there's people here that have been pushing this for a long time. And the fact of the matter is, is that that's just a simple piece of language that could have went into this bill to say, if there is a treatment, if there's a way to prolong your life, right -- someone could actually come in an argue say, *I don't want dialysis*. Because, listen, it -- it's tiring. It's painful. It's -- it's uncomfortable, right, and I want -- and now, if I don't do dialysis it'll be less than six months that I won't live. So, therefore, they could fight in a court of law and say, *I deserve this option to end my life*. And I understand it. But the fact of the matter is the language isn't in the bill.

MS. PAULIN: It is in bill.

MR. DURSO: No, no, no. It -- it's -- you just said it isn't --

MS. PAULIN: Maybe not that word --

MR. DURSO: You said you would actually offer an amendment.

MS. PAULIN: Well, to add, to your satisfaction, as I did with other members, things that we knew that we covered, but they wanted it -- a word changed. They wanted to --

MR. DURSO: So I'm the first one to bring this up?

MS. PAULIN: What?

MR. DURSO: I'm the first one that brings this up?

MS. PAULIN: Yes, you are. Because everybody knows that across all of these jurisdictions those words have meant that, and in practice that's what happens.

MR. DURSO: I -- I completely understand the -- my concern is it's not in the legislation, which makes me concerned. But I'll move on to the next portion of it --

MS. PAULIN: Sure.

MR. DURSO: -- which is attending physician. So you had said that if you were diagnosed with an incurable disease, that you have less than six months to live, by your attending physician, would that mean that it's the physician that finds what the disease or incurable disease that you are -- are saddled with, is that what "attending physician" means? Or, so, if you're my doctor and you say, *Mike, you have brain cancer. You have less than six months to live*. And I say, *I don't like your diagnosis. I'm gonna go to this doctor*. Is that now my attending physician, or is it the person that first discovers it?

MS. PAULIN: So it's the person who is responsible for the care of the patient, and the treatment of the patient's terminal illness or condition.

MR. DURSO: So in other words --

MS. PAULIN: If you change doctors to do that, then that would be your attending physician.

MR. DURSO: So if my attending physician who finds my terminally ill --

MS. PAULIN: They may not be the one that treats you or cares for you, though.

MR. DURSO: Right. But they also might say, *You have two years to live*. And I can go to another doctor and they can say I have six months. Is that now my attending physician?

MS. PAULIN: You know, we do know that doctors, for the most part, studies have shown, tend to overestimate how long someone's gonna live. So we know that's about 85 percent of doctors who make incorrect because they err on the side of trying to give the person a longer life, frankly. And so it's unlikely that a -- that two doctors in the same field, diagnosing the same kind of cancer, who are specialists, they usually do confer with each other if they have any --

MR. DURSO: Well, what if it's a different practice?

I mean, if it's a different doctor -- if I'm on Long Island and one doctor says yes and I come to Albany and another doctor says, *No, you have more time to live*. Or less time.

MS. PAULIN: The doctors in these fields, again --

MR. DURSO: I understand --

MS. PAULIN: -- I know from firsthand experience, they talk to each other --

MR. DURSO: I understand (inaudible/crosstalk) --

MS. PAULIN: -- and they're gonna make a joint decision.

MR. DURSO: And I don't mean to speak over you, ma'am. I apologize. But obviously we're limited on time.

Really, my question is, it's not the initial doctor, right, it's just who you decide is your attending physician, correct?

MS. PAULIN: To treat your terminal illness.

MR. DURSO: Yes.

MS. PAULIN: Yes.

MR. DURSO: Right. So, again -- so, essentially, you could doctor shop. Because if I don't like one doctor's diagnosis -- just like you always go to get a second opinion. If one doctor tells me it's two years, one doctor says it's six months, I now choose that to be my doctor, that's my attending physician, correct?

MS. PAULIN: Yes. Because --

MR. DURSO: That's a -- yeah --

MS. PAULIN: Yeah. Okay.

MR. DURSO: -- so it's doctor shopping.

MS. PAULIN: Yes.

MR. DURSO: So, with that being said, you said two doctors have to decide that you have six months left to live or -- (indiscernible) -- correct?

MS. PAULIN: Yes.

MR. DURSO: Can they be two doctors in the same practice?

MS. PAULIN: If in that practice there were two doctors that had that same specialty, which is very unusual, but possible, yes.

MR. DURSO: Okay. So -- so, as my colleague had said, you could have doctors that basically start a cottage industry to say, okay, *We are the one-stop shop; that we're gonna have two oncologists in this office that are both gonna say the same thing*, correct? So it doesn't have to be separate practices, it doesn't have to be separate hospitals, it doesn't have to be anything. It's just two doctors?

MS. PAULIN: It's two doctors. But I would argue that --

MR. DURSO: I'm just -- I understand we could argue it --

MS. PAULIN: Okay.

MR. DURSO: -- but it's just -- it's two doctors --

MS. PAULIN: It's two doctors.

MR. DURSO: Okay. And then you had said also mental health check if necessary. Who makes that decision, if it's necessary?

MS. PAULIN: The doctor and the consulting doctor independently.

MR. DURSO: So the same two people that I shopped for will decide whether or not I'm mentally competent.

MS. PAULIN: Why, if you want to live, would you shop for a doctor who's gonna --

MR. DURSO: But if you want to die you will.

MS. PAULIN: Yes. If you want to die you can overdose on aspirin.

MR. DURSO: Yeah. You -- well, that would take a lot of aspirin. But -- but I'm just -- I'm just trying to understand the legislative intent that's actually not in the bill.

So, also, my other colleague had stated that you have take this medication yourself, correct?

MS. PAULIN: Yes.

MR. DURSO: Okay. Now, you have to physically be able to take it.

MS. PAULIN: Yes.

MR. DURSO: So, now, I get diagnosed with an incurable disease, my doctor then says, *You qualify for this*. I see the two doctors. I don't need to see a mental health professional. They give me the medication. You bring it home, correct?

MS. PAULIN: Right.

MR. DURSO: I don't have to take it in front of anybody, correct?

MS. PAULIN: You don't have to.

MR. DURSO: But you need to be mentally competent to take it.

MS. PAULIN: Yes.

MR. DURSO: Physically competent to take it.

MS. PAULIN: Yes.

MR. DURSO: So, now, obviously -- and I'm just going by my own personal story, which many people do. My mother had brain cancer, right. Over a five-month period she lost the ability to walk, to use her arms, to swallow on her own. Now, if that medication is sitting at home, right, and I know my mother wanted to end her life that way, obviously, I cannot give her the medication, correct?

MS. PAULIN: That's correct.

MR. DURSO: But she also can't take it herself.

MS. PAULIN: She could.

MR. DURSO: How? She can't move her arms --

MS. PAULIN: There are other ways to ingest --

MR. DURSO: How is that?

MS. PAULIN: So, for example, there's four ways to ingest. They are -- I'm gonna --

MR. DURSO: Well, she can't use her arms.

MS. PAULIN: Well, there's a -- there's rectal ingestion as well.

MR. DURSO: How is she gonna do that?

MS. PAULIN: You can push a button.

MR. DURSO: You can -- oh. Oh. So -- but it would have to be set up prior to that, correct?

MS. PAULIN: Someone else could help set it up as long as she was actually --

MR. DURSO: Who is that person that's allowed to set it up?

MS. PAULIN: Anybody could set it up if she asked them.

MR. DURSO: Oh, okay. So it's not just a pill form, correct?

MS. PAULIN: No, it's not just a pill form --

MR. DURSO: Oh, okay.

MS. PAULIN: In fact, it's mostly --

(Crosstalk)

MR. DURSO: Who would push that button?

MS. PAULIN: She would have to.

MR. DURSO: What if she can't?

MS. PAULIN: Then she wouldn't be eligible.

MR. DURSO: Okay. So what is the mechanism in place to -- to protect those people or make sure that doesn't happen? Essentially, you're -- you're sending someone home with a life-ending drug, but there's no mechanism in place to make sure that that person administers it to themselves willingly, correct, if, at that point, after two months?

MS. PAULIN: If -- so you're saying that -- you know, because remember if there's coercion or someone is actually murdering someone --

MR. DURSO: Absolutely.

MS. PAULIN: -- right? That you believe that this could happen, when we know there's been never a case that this has happened --

MR. DURSO: How do we know it's never happened? This -- there's no -- you don't send them home with a camera and a pill.

MS. PAULIN: You know, in 82 percent of the cases there's a medical provider there. So we know in 82 percent of the cases there's some other person there, right, that is outside the family unit. I'm thinking you're suggesting that some family member is gonna kill someone --

MR. DURSO: No. That's not what I'm suggesting --

MS. PAULIN: Well, then -- then what are you suggesting?

MR. DURSO: I'm not suggesting that they're gonna kill someone. What I'm suggesting is, you're sending them home with a -- with a life-ending pill, right. Someone could --

MS. PAULIN: Well, a series of medications --

MR. DURSO: A series of medications --

MS. PAULIN: -- yes.

MR. DURSO: -- however you want to call it. But once they're home with it, there is no guarantee and no mechanism in place to make sure that they're the ones taking it, they're the ones giving it to themselves, that they're mentally competent at that point, because, again, personal story --

MS. PAULIN: They have to self-ingest, right? So if they're self-ingesting, you know, then --

MR. DURSO: Why couldn't they do it at the doctor's office?

MS. PAULIN: They -- they could if they wanted to.

MR. DURSO: Why -- why shouldn't that be part of the legislation to say that it has to --

MS. PAULIN: Because people want to die at home.

MR. DURSO: I -- I understand that. Believe me. But my concern is that if my mother's wishes were to take this, and then at that point she's not mentally competent and can't use her arms and legs, how is she getting it? You said you could take it rectally. I don't know how she's doing that without her arms or legs. Or you could push a button. You can't do that without your hands.

MS. PAULIN: So, there are technology advances now. So, for example, with a blink of the eye you can -- you can trigger something. You know, if -- if you held the cup with a straw and she could sip, the sipping would be --

MR. DURSO: If you held a cup with a straw and you [sic] sipped it, aren't you helping them? You cannot aid --

MS. PAULIN: She has to be the one to do the sipping --

MR. DURSO: -- but you cannot aid them in doing it --

MS. PAULIN: You can -- you can hold the cup --

MR. DURSO: -- but it's specific -- it says that? Because as far as I'm concerned that -- that's -- that's helping someone --

MS. PAULIN: Well, we have 30 years of experience to show that this has been --

(Crosstalk)

MR. DURSO: With 30 years of experience and we still don't have the language in the bill, Ms. Paulin.

MS. PAULIN: Why does the language have to be sipping a straw?

MR. DURSO: Because you're -- because you're allowing someone to end their life --

(Crosstalk)

ACTING SPEAKER HUNTER: Thank you, Mr. Durso.

Ms. Solages.

MS. SOLAGES: Madam Speaker, can you please call the Social Services Committee to the Speaker's Conference

Room?

ACTING SPEAKER HUNTER: Social Services Committee to the Speaker's Conference Room. Please go see Member Davila in the Speaker's Conference Room for Social Services.

Ms. Walsh.

MS. WALSH: Thank you, Madam Speaker.

On the bill.

ACTING SPEAKER HUNTER: On the bill.

MS. WALSH: At the outset, I want to say that I have listened to individuals and groups who both support and oppose this bill, and these have been among the deepest and most meaningful decisions that I have had as a legislator.

It's clear from the debate that we have had so far today that all of us share a deep concern for people and their anxiety, their pain, and their suffering. I've experienced personal family losses that come to mind whenever this topic is discussed, which I can't share now for fear that I would not be able to get through it. Rather than using -- or -- or talking about my own personal stories, I want to first highlight specific portions of the bill that I find problematical.

The bill provides that you must have a terminal illness or condition; meaning an incurable and irreversible illness or condition that has been medically confirmed and will, within a reasonable degree of medical certainty, produce death within six months.

The advocates for this bill cite terminal cancer, most often. But in New Jersey's Medical Aid in Dying Statute, which the New York legislation parallels, there are other terminal illnesses or condition besides cancer; neurodegenerative disorders, which could include Alzheimer's, MS, ALS, or Lou Gehrig's Disease, Parkinson's, Huntington's Disease, just to name a few. There is concern in the literature that something like anorexia nervosa could be classified as terminal anorexia, and does qualify for Medical Aid in Dying.

In New Jersey around 25 percent of medical aid in dying (inaudible) were for neurodegenerative disorders, but when I had met with advocates for this legislation I was assured that neurodegenerative disorders would not qualify because you couldn't certify death within six months. Which is it?

The whole idea of the six months is a fiction. Sometimes you could tell roughly when someone is about to die, but for most of the time you're making an educated guess. Some patients live far, far longer than that. If a patient really, really wants to die, I could see doctors adjusting the six-month estimate to accommodate. Or if they won't, finding a doctor that the patient finds who will.

There's no requirement that the patient is a New York State resident. The bill says that the attending physician must examine the patient, but doesn't specify whether it could occur over telehealth or whether it has to be in person. There is no explicit prohibition regarding sending the prescription for lethal meds out of State, as is allowed with abortion drugs.

There is no requirement that the death be attended. If it is unattended and unwitnessed, you have the potential trauma to the family members or people who discover the body. You don't know if the person died naturally or from the lethal dose. If there is no medication present, and you know that a prescription was issued to the patient, you don't know what has happened to it. Was it given to someone else? Would that someone else have qualified for medical aid in dying? Who has it? That medication is as dangerous as a loaded gun, but precautions for its safekeeping are absent in this legislation.

The checks in place to look for informed consent, capacity, and absence of coercion all precede the issuance of the prescription. After that there are no further checks. This is a huge problem for me. In other countries there are repeated further checks on the patient to make sure that the patient still has capacity, still consents, and still is not being coerced. In -- I think it was Canada -- there are no fewer than eight check-in points with the patients during the process. That additional scrutiny is necessary, in my opinion, and is absent from this legislation.

For example, what do you do with a patient who has Alzheimer's and has capacity at the time a prescription is written, but who doesn't take it until far later when capacity has been lost? There is no requirement that the death is attended by anyone. There is nothing that says, *Hey, this prescription was written six months ago and the person is still alive. We should take back that lethal prescription or we should reevaluate for capacity*. Or, *This person* *died unattended and we don't know whether or not they used the prescription and now we can't find it.* The entire chain of custody for what is by its very nature a lethal dose is very concerning to me, particularly since the sponsor has indicated that 40 percent of the time the patient never uses the medication.

The bill lays out ground rules and protections from outside coercion. That is good, as far as direct pressure from interested parties or family members, but I don't think that that's as big of a problem compared to you pressuring yourself as the patient. You don't want to see your savings depleted taking care of you in your final days, give the money to the grandkids. You don't want to be a mess in the end for your loved ones to see. The legislation doesn't address that kind of internal coercion or societal pressure, nor can it, really.

The bill doesn't require any real counseling. A mental heath professional only needs to be brought in if either the attending or the consulting physician feel that capacity is a question. Otherwise, two physicians without mental health credentials can make the call. These two physicians do have to issue certain warnings and cautions, but how hard are they going to try to redirect the patient to hospice or palliative care instead of suicide? There is no requirement that a patient try palliative or hospice care first.

Then there is the part of the bill that prohibits calling the patient suicidal and self-administering medication under this article shall not be deemed to be suicide. Well, then, what is it? Suicide is defined as the act of intentionally causing one's own death.

Isn't that exactly what we're talking about? If this is such a dignified, autonomous decision, then why are taking such pains in the bill to conceal it? It reminds me of the way abortion of a fetus is described as a clump of tissue or fetal tissue. Like it's nothing. Like it doesn't matter. I don't find that particularly dignified or respectful.

I'm aware that the reason we don't want to call it suicide is because we want to make sure that insurance companies will still have to pay out to beneficiaries on life insurance policies. But we should call this what it is, it is government-sanctioned suicide.

This bill even says that on the death certificate suicide won't be listed as the cause of death, but rather the underlying terminal illness or condition. Arguably, that's been discussed as perjury to commit a fraud on the insurance company.

The last thing I'll say about the bill language itself is that the effective date is immediately. And I was surprised by that. Even in New Jersey there was a four-month delay before it became effective. I can appreciate the desire to help some of the advocates, some of whom may have less than six months already to live. However, there will almost certainly be court challenges to this. I think it would be a better course to acknowledge that and build in some time for that to be resolved. Better still would be to pull this bill now and hold some hearings. There haven't been hearings on this since 2018. I find it impossible to believe that there is nothing new to be learned in the last seven years, especially after a COVID pandemic, when all we seem to think or talk about was disease, death, and dying.

Yes, we are voting on the specifics of this bill, but we are also voting on a principle. And we are not just responding to the impassioned pleas of advocates with deeply personal, individual stories, we are legislating for all New Yorkers.

I don't believe -- this is me talking now -- I don't believe that this State should be a part of taking a life. We haven't had capital punishment in New York since 2004 when the Court of Appeals said that it was unconstitutional. I do think that the State has an obligation to protect our most vulnerable New Yorkers from predatory relatives, from the State itself, and from themselves.

I think that instead of medical aid in dying, we in the Legislature should be doing a far better job of showing that we can provide for assisted living before legislating assisted dying. What does that mean? Well, New York currently ranks last nationally in terms of hospice and palliative care. And, my colleagues, that is absolute disgrace. It is under-sourced, understaffed, and underutilized.

Before I voted on this legislation, I would want New York to be number one in hospice and palliative care. If we approve this today and this becomes law, I believe we can all forget about making hospice and palliative care number one. It will likely fall by the wayside. We will skip right past it. This bill doesn't require that all reasonable means of treatment have been made, nor does it require that people try high-quality hospice care first.

One person told me, *Oh, but we should not hold* *people hostage because our medical system has failed*. What a sad commentary. I don't want desperate people to choose to kill themselves because we as a state offered a poor excuse for hospice care.

I want to confine my comments to the bill that we're talking about today, but I'm not naive. The legislative process, as we know, is incremental and extremely imperfect. So right now this bill is specifically confined to adults with a terminal illness or condition with six months or less to live, who can get informed consent and who can self-administer the lethal dose -- dose of medication.

Folks who advocate for people with intellectual and developmental disabilities have shown concern with this bill and, I believe, with the entire concept of assisted suicide because just simply having it devalues them in a society where they fight to live. Look at our CDPAP system and the unholy mess that's been caused by switching to a single fiscal intermediary. Look at the way we pay our direct care workers, giving them increases that they never actually get, forcing them to load up their folks and go to the War Room each budget cycle and beg to be treated with dignity and respect. And look at how this State fails them every single time.

Could any of us be surprised if this assisted suicide bill becomes law, that people with intellectual and developmental disabilities are coerced by others or by themselves to just give up and die? For God's sake, we heard the new Health Secretary say something during Autism Awareness Month, for God's sake, no less, that people with autism can't contribute meaningfully to our society, can't hold jobs and will be a burden. I regret that he said those things because I know that they are not true.

Each and every life has value. Progress may not be on a straight line. It will look different to each of us. But this idea of giving up and dying is not excelsior, ever upward. It's incredibly sad.

As Pope Francis said in 2019, euthanasia and assisted suicide are a defeat for us all. We are called to never abandon those who are suffering, never giving up, but caring and loving to restore hope.

We need only look at the example of our neighbor to the north, Canada, to understand the risk. That country passed a similar law to New York's bill in 2016. Within a few short years it was expanded to allow not only those with terminal illness, but also those with chronic illnesses such as arthritis to end their lives. In 2027, the law is set to expand further to those whose only underlying condition is mental illness such as depression, anxiety or anorexia nervosa. It is that so-called "slippery slope" that is real. We as legislators know that this is true. We have witnessed time and time again in our legislative work the gradual, continued modification, some would say erosion, of our law. Any major issue from guns to abortion to voting have all seen continued changes made. In our State now you can get an abortion on demand, legally buy and consume marihuana, engage in online sports betting, and now apply for the State's suicide service.

Is this the state that we wish to become? That is in part what this vote is about today. Yes, nine other states have done it, but 41 have not. There is a reason for that. Don't discount those reasons, no matter how heart-wrenching the personal stories. Consider not only what this bill does, but that by passing it we are opening the door to the next thing and the next.

We are being asked to require the State to sanction suicide at the same time, my friends, that the State calls suicide a major public health problem. Evidence shows that contrary to expectations and jurisdictions where medical aid in dying has been legalized, rates of general suicide have increased. The epidemic of depression and other negative ideations, particularly among our young people, makes this perhaps the worst possible time for lawmakers to legitimize and sanction suicide.

I say this: Let's take all of our energy, our love, and our compassion and say no to this bill today. Let's instead work steadfastly to make our hospice and palliative care system the best in the nation. Let us find the resources to do so. I truly believe in my heart that once we do that, the need for medical aid in dying would go away for the vast majority of patients.

To para -- to paraphrase H. L. Mencken: For every complex problem there is a simple, easy answer. And it's wrong.

We can do better, my colleagues, than this bill. And I will vote no.

Thank you, Madam Speaker.

(Applause)

ACTING SPEAKER HUNTER: Thank you.

Ms. Solages.

MS. SOLAGES: Madam Speaker, can you please call the Mental Health Committee to the Speaker's Conference Room?

ACTING SPEAKER HUNTER: Mental Health Committee to the Speaker's Conference Room. Immediate committee, Mental Health, the Speaker's Conference Room.

Mr. Epstein.

MR. EPSTEIN: Will the sponsor yield?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. EPSTEIN: Thank you, Sponsor.

You mentioned 82 percent of the time there are medical professionals on site for the Medical Aid in Dying. How -- where do you get that statistic from?

MS. PAULIN: In some states, not all, but in most, they actually have data that's required, as we do in our bill for New York, to monitor and record exactly what has taken place. And that's -- that 82 percent is from Oregon, which has the longest standing experience.

MR. EPSTEIN: Yeah. And besides the 82 percent in those Oregon cases of medical professionals, there are other people who are in the room at that time as well? Does that study --

MS. PAULIN: It's -- yes, in almost all cases. I imagine there's been a few, but honesty, we haven't heard of any where there has been no witnesses present.

MR. EPSTEIN: So beyond medical professionals, there may be loved ones and family members who might be present in that moment?

MS. PAULIN: Mostly, yes. Because what the medication does is it gives that opportunity for a patient not to die alone.

MR. EPSTEIN: And so you -- you mentioned two doctors, a requirement to have two doctors. I know we heard earlier about the two doctors in practices. Why do you -- why is it such a really compelling requirement to have two doctors who have medical licenses to make that determination?

MS. PAULIN: Because we understand the seriousness of making a decision like this. And we want to be sure that the person who is getting that prescription is as comfortable in making the decision as possible.

MR. EPSTEIN: And what's at risk for the doctor who makes the decision -- you know, like, we've heard about (inaudible). Is there anything at risk for that medical professional who might go down that alleged path?

MS. PAULIN: No, there's no liability. We say so in the bill.

MR. EPSTEIN: And -- so you may -- you talked about potential referrals for mental health professionals. Why -- why is that in the bill? Why do -- why do we outline that?

MS. PAULIN: Because we want to make sure the person has the decisionmaking capability of making this kind of decision.

MR. EPSTEIN: And so there's been some claims around coercion from family members to -- down this path. And why do you think this bill protects against that level of coercion?

MS. PAULIN: Because the patient has to, firstly, orally ask, and then the written ask is -- has to be witnessed by two people who have -- who are not in relation at all with the patient and would also have no financial gain from that patient. So they cannot be known to be in the estate or will. So those witnesses are independent, and have to attest there's no coercion. So you have multi-levels and multi people attesting to the fact that there's no coercion.

MR. EPSTEIN: And you mentioned witnesses. What's the -- what's -- why do you think that role of witnesses plays an important role in this?

MS. PAULIN: You know, we require witnesses through the law to -- you know, on documents. And this is one such important document.

MR. EPSTEIN: And -- so the doctors who are involved in this kind of care --

MS. PAULIN: I've talked to many people involved with this issue, yes.

MR. EPSTEIN: And what have you heard from the medical professionals?

MS. PAULIN: We've heard that, as was stated by the prior speaker, the Assemblymember, that most people will not avail themselves of this. Most people are -- are very -- that only 1 percent of the people who are gonna die in any one state are going to get or want this prescription. So it's very small numbers. And the reason it's small is because hospice and palliative care do a good job for most patients, but they don't do a good job for all patients, even admitted by my colleague. So those -- but those people who are in such agony, who are in such pain, this is the way they can relieve themselves of that distress. And so we know most people are not gonna avail themselves. Most people who get it are going to die their natural course. But for the few, for that 1 percent of New Yorkers, this becomes paramount for them to die peacefully.

MR. EPSTEIN: Thank you.

On the bill.

ACTING SPEAKER HUNTER: On the bill.

MR. EPSTEIN: I want to thank the sponsor for her leadership on this issue. I think a lot -- I thought a lot about this bill over the years. I remember a few years ago when my mother-in-law passed away and the months of pain and agony that she went through and talking to my wife every day about her only goal really was to die. She was in pain and suffering. And even over the last two weeks of her life, every breath seemed like it was gonna be the last and it was -- it was horrific and horrible to watch. And then you never knew when the end was in sight, and all she was in the end was in pain. All she was in the end was looking to end her life. And if this was made available to her, knowing who she was she would have loved to have died with her family members around her, in that loving embrace in the moment where she was ready to go. But instead, her end and her last breath was that of pain and tragedy and horror. And for those who want to choose this, for those whose families -- individuals want to make that decision who can at that last moment know that their family members can be with them, surrounding them and go in peace - which is all our ends, we're all at some point gonna pass - it is something really loving to be able to give that to someone who is dying, to let them choose their own path out and to allow that suffering that they're going through to be over.

Death is not something we all look forward to, it's not joyful. But it is some people who are at the end of their lives with terminal illness who want to make that decision, and we should respect those choices. Like the sponsor said, the vast majority of New Yorkers are not gonna use this. The vast majority of New Yorkers don't want this. But for those who believe this is what's best for them, for those who believe while at the end of their lives, under the supervision of doctors, probably seeing a mental health professional in consultation with their loved ones and family members, we have to be thoughtful and responsive to their concerns.

I have a constituent up here today who is a prominent doctor in his field, ran a large hospital system in New York City and, unfortunately, has ALS. And he spoke just a little while ago about his struggles about whether -- he's not sure whether he would use it or not, but felt so heart-warmed by the moment that were -- we are at today that he would have this as an option for him. And for him and the thousands of other New Yorkers, this is an option that we should not take lightly, but honor their request. This is an option that should be available for people who want to make their life decision along with their family and loved ones about what's best for them.

And I want to thank the sponsor for her dedication and leadership on this issue; this was no easy task. But this is a bill worthwhile for the New Yorkers that deserve it.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

Mr. Gandolfo.

MR. GANDOLFO: Thank you, Madam Speaker. Would the sponsor please yield for some more questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Absolutely.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. GANDOLFO: Thank you, Chair Paulin.

So, first I want to go back and kind of touch on the two-doctor requirement here. So you have the attending and the consulting physician, and in -- in my reading of the bill it looks like the attending physician would refer the patient to a specific consulting physician; is that correct?

MS. PAULIN: Yes.

MR. GANDOLFO: So that -- that is the sole process for it? It could be someone that they might have a somewhat working relationship with, they might refer all their patients over to this consulting physician?

MS. PAULIN: I -- I think that, you know, since we know most of the people who are opting to get this medication are -- almost 70 percent are cancer. Each cancer is very unique. So usually those physicians have a relationship with one another and know who they are and know who to refer someone to.

MR. GANDOLFO: Okay. Are there any safeguards in place from preventing this -- to just use a term one of my colleagues used -- from becoming a cottage industry? I'm almost looking at it like everyone knows a personal injury attorney who you call him up and he says, *Hey, go see my doctor and he'll evaluate you*. Is there anything preventing that second doctor from almost becoming a rubber stamp for the attending physician? I know people keep bringing up the fact that two doctors have to confirm, but if you're an attending doctor and you believe you -- you have a patient who wants to go through with this, you're going to send them to the consulting physician you work with who is probably going to back up your diagnosis, no?

MS. PAULIN: I would think if you're a medical professional of any worth that -- and you take a medical oath, that you are going to be looking at those same x-rays and charts and -- and making your own independent decision. So I'm not really concerned that, you know, we're gonna see a lot of doctors out there that are just going to rubber stamp. That's not what doctors do.

MR. GANDOLFO: Okay. So there's -- so they could use the same consulting physician every single time if they so please the attendant?

MS. PAULIN: I would say that each of their patients is gonna be unique and maybe those consulting physicians would have to vary by the type of illness that they're presented with.

MR. GANDOLFO: Okay.

Is there any requirement -- I know we were talking about treatment and refusal of treatment. Is there any requirement to exhaust multiple treatment options before being eligible for assisted suicide?

MS. PAULIN: So I would say that the people who avail themselves of this, they want to live. So if there's a treatment option and you're told, you know, you'll have six months if you do this, they're gonna take advantage of that. If they're told that same treatment is going to deteriorate your -- your quality of life, then maybe they're not gonna take advantage of it. But these are people who want to live. They're not looking to die. They're looking to live as long as they can with a strong quality of life. So I'm not concerned that -- that someone isn't gonna look for those treatments. They are, they're doing it now. They only take this and want this and have this prescription if they're desperate, if they know it's the end. You know -- and they know that they're in suffering pain.

MR. GANDOLFO: Right. But like was mentioned before, there's nothing precluding a physician from letting the patient know that they have this option. So if you're -- if you're -- you've been battling an illness, a cancer for such a long period of time -- and I understand it's emotional, it's exhausting -- and you're -- you're faced with a choice, you could go for another treatment and it's going to be difficult but it might get you more time or, you know, if you're tired of fighting you can go the assisted suicide route. I could see how the assisted suicide route might be attractive for someone who's been fighting a -- a -- a diagnosis for so long. But it -- it's a little troubling that there's no requirement to exhaust any of these potential options that could prolong the life longer than the six months. And -- but I guess we have some different opinions on that.

MS. PAULIN: So I -- I would -- in New York, you know, we are -- we're not first here. You know, we're 12th. And the 11 other places already have a 30-year experience in some cases, so that we already know that those who are opting to take the medication, not those options to get the prescription, that's often people who just want to have that peace of mind. People who are opting to take it are at the very, very end. They are at the time when they're in such great pain. They are -- they are at a time where they know that they only have not months to live, but weeks or days to live. So if they think that they can extend their life with a treatment or if there is an experimental treatment or if there is a trial that they can use, they're going to use it because they want to live.

MR. GANDOLFO: But they don't have to use it, they could go right for the assisted suicide option?

MS. PAULIN: They could, but they're not.

MR. GANDOLFO: Okay. Okay.

Now, why isn't there -- I know there's the requirement of a mental health evaluation in the event that competency is in question. Why isn't there generally a requirement of seeing a mental health professional when you decide to pursue this option?

MS. PAULIN: We don't require that for anything else. We don't require it for any other end-of-life option, and there are end-of-life options now. For example, at the end of my sister's life she chose not to eat or drink anymore. We don't say at that point, *Oh, is she equipped to make that decision and we have to send her to a psychiatrist in order for her to make that decision.* We don't. So why would we require it here? You know, we require it more so than anything else because we want to -- because people are doing it in advance of making that final decision but there are other end-of-life options and we don't require it for those so we're not requiring it for here.

MR. GANDOLFO: Okay. It just seems like this one's a little more unique, which is why it's currently not legal here in that you're asking a doctor to prescribe a medication that will -- that is intended to lead the person to death.

And I'm almost curious as to -- we had the discussion earlier about coercion. What about maybe not coercion, but are there any safeguards to ensure that someone -- well, they might not being -- they might not be coerced, that they're not being just influenced with comments from maybe some of their family who are tired of having to care for a sick loved one, unfortunately, or who might have a financial incentive? They might not be coercing that person, but certainly they could make comments and have conversations that's influenced someone toward a certain path. Are there any safeguards?

MS. PAULIN: I -- everyone is influenced by their family. Everyone is influenced by their loved ones, and most loved ones, in fact, the vast majority of loved ones want to see someone's life prolonged. That's the experience. And I think if we search in our hearts we know that's true.

You know, I took care of my mom at the end of her life, for the last ten years of her life, and when they told me it was -- it was over and that -- I -- I remember they took away the meds that they we're putting in her body and they said, *You know what? She's dying. It's the end.* And I remember thinking and saying, *No, I just want her to keep the meds*, you know, because I wanted to even prolong the -- the -- this woman who was my mom. So that's not the experience that dying people face. Their experience from their loved ones is that they want them to live.

MR. GANDOLFO: I understand that, and I think the vast majority of people are good people who love their family. But there are outliers and people who have nefarious actions. If there weren't, we wouldn't have a criminal court system and we wouldn't have people committing matricide and patricide and, you know, taking advantage of elderly family members, which we do see happen. So I think it would stand to benefit if there were -- to have some more guardrails here to make sure that this person might not be being coerced, but they're not having people lead them to a -- a place where they might not have gotten otherwise. But we can move on from that topic.

Another question I did have was about the potential for telehealth. In the -- the attending physician responsibilities, the attending -- the attending physical shall examine the patient and the patient's relevant medical records. There's no specificity that it has to be an in-person examination. Is there any prohibition in the language that would prohibit telehealth services from diagnosing someone from an attending and then a consulting physician?

MS. PAULIN: Well, the attending physician is someone who is gonna be, you know, seeing the person in person. The consulting physician may be someone in Ohio that has the expertise in this particular disease. So no, there's no -- there's no provision that precludes telehealth and, in fact, telehealth is used widely in the other jurisdictions for the consulting physician.

MR. GANDOLFO: For assisted suicide?

MS. PAULIN: For Medical Aid in Dying. Suicide is illegal -- or assisting suicide is illegal in New York and will remain so.

MR. GANDOLFO: Okay. So you could have patients from out-of-state, then? Is that possible, a patient from out-of-state utilizing a medical aid in dying telehealth service and being prescribed the medication?

MS. PAULIN: You could have someone who if the presiding doctor is -- the -- the presiding doctor would require that patient to actually be physically in -- in our State because it's, you know, that's what a presiding doctor is, right?

MR. GANDOLFO: But there's no requirement in the bill.

MS. PAULIN: The presiding doctor could be someone that is somewhere else because based on their expertise that's who the -- the doctor who is referring them to and the patient believes is gonna give them the best diagnosis.

MR. GANDOLFO: Is there a residency requirement outlined in the bill that the patient would have to live in New York State?

MS. PAULIN: No.

MR. GANDOLFO: Okay. So out-of-state patients, then, could see New York doctors via telehealth for Medical Aid in Dying purposes?

MS. PAULIN: No. How could they be a presiding doctor if they are living out-of-state? Wouldn't they have to --

MR. GANDOLFO: The -- the attending physician -- it just says the attending physician shall examine the patient. It doesn't say --

MS. PAULIN: And be treating them.

MR. GANDOLFO: I'm sorry?

MS. PAULIN: And be treating them for their cancer or for their other terminal illness.

MR. GANDOLFO: Well, we established earlier you can kind of doctor shop and leave your current physician that might have been treating you to find a physician who would be more apt to recommend you for --

MS. PAULIN: I don't think that -- people are going to be looking for the best doctor for their illness. They're not gonna be looking for the best doctor to prescribe Medical Aid in Dying. If you have a condition that is so severe and you get diagnosed, the first thing you're gonna think about is finding the best doctor to help you live the longest life possible. So could that be a doctor in New York from a resident coming from Ohio or other places? Yeah, because we have some of the best doctors in New York, thank goodness. But most often, then they're going to be moving here. Or, you know, we've had, you know, one colleague, for example, that lived up in this area who -- whose family member went down to -- to get treated in Sloan. You might see someone from New Jersey coming to New York to do that. But it's not gonna be the norm.

MR. GANDOLFO: Is there any concern that if you have an out-of-state patient come to New York, get prescribed the medication and take it back to their home state where it might not be legal, are there any legal ramifications for that patient bringing this medication back home, taking it and dying in a state where this is not legal from that medication?

MS. PAULIN: No, nor should there be.

MR. GANDOLFO: So someone could come from a state where this is prohibited, get prescribed the Medical Aid in Dying prescription, go back to let's say, you know, Connecticut -- I don't know, I'm just using that off the top --

MS. PAULIN: That's up to the laws there --

MR. GANDOLFO: Okay.

MS. PAULIN: -- you know, right, to -- to -- not up to our laws.

MR. GANDOLFO: Could that put the doctors at risk who make this prescription thinking that they were going to take the medication in New York State --

MS. PAULIN: We hold them harmless. They're not liable, we hold them harmless in the bill.

MR. GANDOLFO: Is there any -- harmless from who? From --

MS. PAULIN: From our laws. They're not criminally liable, not civilly liable, they're not professionally liable.

MR. GANDOLFO: But they could -- okay, so they're not civilly liable at all, which actually brings me to another question.

Is there any process for a third-party to contest the diagnosis of the attending or the consulting physician?

MS. PAULIN: Wait, say that again.

MR. GANDOLFO: Is there any process for a third-party, let's say a child, to contest the diagnosis of an attending or consulting physician?

MS. PAULIN: There's always -- if a family member questions a diagnosis, you know -- you know, in most cases you have your family members there mostly because you want someone else when you're foggy and hearing that your -- your life is at risk because you have a terminal illness, your family members are there taking notes, recording the information --

MR. GANDOLFO: Right, but could they formally contest it?

MS. PAULIN: -- that they learned.

They would argue with the -- with the doctors right -- right there or they go to --

MR. GANDOLFO: Okay, and --

(Crosstalk)

MS. PAULIN: -- they -- people have the option if they feel that they've been misdiagnosed to go to another doctor. They do that all the time.

MR. GANDOLFO: But I'm -- I'm looking for safeguards in the event that you might have someone who is looking for a way to end their life and using this as a vehicle to do it.

MS. PAULIN: They have to be terminally ill and --

MR. GANDOLFO: I know --

MS. PAULIN: -- that has to be diagnosed --

MR. GANDOLFO: I see that.

MS. PAULIN: -- by two independent competent doctors.

MR. GANDOLFO: Independent from who? Because the doctors could be working together all the --

MS. PAULIN: Independent from the -- from the patient.

MR. GANDOLFO: Independent from the patient, okay.

I -- I believe I'm about out of time, but I appreciate you answering my questions.

MS. PAULIN: Sure.

MR. GANDOLFO: Thank you, Mr. Speaker.

ACTING SPEAKER TAYLOR: Ms. Solages.

MS. SOLAGES: Mr. Speaker, can you please call the Corporations Committee to the Speaker's Conference Room?

ACTING SPEAKER TAYLOR: Corporations to the Speaker's Conference Room. Corporations to the Speaker's Conference Room.

Mr. Ra.

MR. RA: Thank you, Mr. Speaker. Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER TAYLOR: The sponsor yields.

MR. RA: Thank you.

So I have some questions that I just want to follow up on what my previous colleague was talking about. Just in terms of if there is a telehealth situation, the person's in another state. That -- I mean, it would have to be a state where it doesn't violate that state's medical laws for -- for that doctor to participate in that decision, would it not, or how would that work?

MS. PAULIN: Yes. Yes, if there were laws in another state that said don't participate, I would imagine that doctor would not participate.

MR. RA: Okay. And does the bill address in any way, you know, that type of situation?

MS. PAULIN: No. Because we want patients to be able to get advice and treatment from patient -- from doctors across the country if they had to, to help them if there are treatment options.

MR. RA: And this -- this bill, the entirety of the text amends the Public Health Law, correct? There's no provisions that are amending the Penal Law in any way?

MS. PAULIN: I'm sorry?

MR. RA: Are -- are -- does this bill amend the Penal Law in any way or it just is --

MS. PAULIN: It -- it creates some additional -- well, I guess amend is a - it -- it'll -- there's -- there are penal penalties. You know, I'm using statutes in the Penal Code, so coercion, certainly if you -- if you attempted to murder someone by -- as was -- has been suggested, they -- you know, some family member goes rogue and decides that they want the inheritance and they, you know, mix the cocktail and give it to them, they would be subject to the criminal codes, yes. They'd be -- you know, for murdering someone. So there are Penal Code penalties but I -- we don't have additional adds to the Penal Code.

MR. RA: Okay. So --

MS. PAULIN: -- we're using the Penal Code as it stands.

MR. RA: So on I believe it's either page 5 or 6, sometimes I -- I have trouble figuring out where the numbers are when I'm looking at it on the tablet. But where it talks about that the physician or another individual can't administer the medication to -- to the individual who has -- who has chosen --

MS. PAULIN: Yeah.

MR. RA: -- this path. So, right, presumably if a physician were to take that action they are now really, I would say, would you say, violating their scope of practice because they're not permitted to do that?

MS. PAULIN: They'd be violating the Penal Code, actually. They'd be violate -- they'd be committing a crime.

MR. RA: Okay. So you're -- so that would be a criminal -- because that -- that was my question, as opposed to some other individual who did it --

MS. PAULIN: Same penalty.

MR. RA: -- obviously, they're not concerned with -- they're -- they don't have a medical license. They don't have a medical license that's at risk if they were to violate, say, the Public Health Law.

MS. PAULIN: Well, they're all violating the Criminal Code and they would all be -- I think it's -- it was said yesterday at the committee meeting, there's one statute, Penal Code -- wait, I'll find it. I have -- I have it somewhere. It's -- it's 120.30, which is promoting a suicide attempt. And it's up to -- it's a Class E felony and up to four years in jail. That's would they would be subject to.

MR. RA: Okay. Thank you.

So I want to take a step back now. Some -- some of that just came into my head as I was listening to the previous speaker. But I just have some -- some questions, and a lot of it stems from the fact -- I mean, you've talked about other jurisdictions. I think the one that we have the largest, you know, track record of -- of evidence would be, obviously, Oregon because it's been the law there for many years, and I just have some questions as to how this bill maybe differs. Because my understanding is that some of the things that we're talking about as not allowable or things we're trying to prevent have really occurred in Oregon. So, like, for instance, my understanding is that patients in -- in Oregon have self-reported financial implications of treatment as a reason they request lethal drugs.

MS. PAULIN: Wait, say -- say that last thing again.

MR. RA: That people in Oregon have -- have listed financial implications of treatment as a reason they request the option of -- of assisted suicide.

MS. PAULIN: I think that it was 5 percent of the cases. Something like that.

MR. RA: Okay. So would -- would that potentially be something people would be considering in New York as well?

MS. PAULIN: I -- it's possible that there might be some people who, you know, are weighing that very expensive treatment against this at the very end of their life. I -- I presume that there might be some people like that, but it was found that very, very small numbers of people had that concern.

MR. RA: Okay. And there -- there is some interesting studies that have been done with regard to this, and a lot of those types of things have increased exponentially over -- over time. There was a study that was -- was put out a couple years ago that I had found.

Now, another thing in Oregon that -- is that chronic conditions are allowed under what I understand to be similar language to this bill. Your intention is that chronic conditions are not an allowable reason for requesting these drugs.

MS. PAULIN: They're not allowed in Oregon, either. Anywhere that you got that from is just not correct. But there -- all of the 11 jurisdictions, they have exactly the same language on requiring someone to be terminally ill within six months to get that diagnosis.

MR. RA: Okay. And I know you spoke with one of my colleagues about treatment, right, and I know treatment isn't required but there are many treatable conditions that would produce death within six months, perhaps, and other states have listed conditions like diabetes, high blood pressure. Those are not allowable under this legislation?

MS. PAULIN: It depends on the stage. For example, you know, so dialysis, right? You know if you get off it you're gonna die. So if you decide you're no longer gonna be on dialysis, yeah, you would be eligible. But, by the time you've got your consulting doctor, you would be dead. So that's not a -- a possibility. With diabetes, it's not a terminal illness, but it does lead most often to end-stage renal disease. If you have end-stage renal disease you would be eligible, so could you say it came from diabetes initially? Yes. But what would be listed on your death certificate would be renal disease. I know it was referenced, anorexia nerosa -- nervosa before; that would not be eligible.

MR. RA: Okay.

So with regard to the physician, the -- the attending physician, one of the things that a study on Oregon listed was that when this law first took effect there had been often a very lengthy relationship between that attending physician and the patient. Now the median length of time is only five weeks. Are we envisioning that this may be somebody that -- that has a very short-term relationship to the patient as opposed to somebody who maybe is a doctor that they have been seeing for many years and have a long-term relationship with who might have a better ability to know that patient, know their history, know that they're of sound mind when they're coming and making this type of request?

MS. PAULIN: I haven't seen that data on five weeks. I am -- I don't know where it's come from exactly. But I can tell you that, you know, as medical science gets better, you know, we see treatments that prolong someone's life longer, even for these very severe illnesses. So five weeks seems a little strange to me. But we also know that some people do get diagnosed and then die relatively quickly, so it could be because of that. But I just find the five weeks a little suspect.

MR. RA: Okay.

So what I also want to understand now is when you get the prescription. So there's an attending physician, there's a consulting physician. Now, could there be another physician that actually writes the prescription or does the prescription have to be written by either the attending or consulting physician?

MS. PAULIN: It has to be written by the attending or consulting.

MR. RA: Okay. And --

MS. PAULIN: And just the -- the -- good question. I think the -- it has to be written by the attending, not the consulting.

The consulting is consulting to the attending.

MR. RA: Okay. Now, then the individual, right, gets this, fills the prescription. Is there any continuing part of this process once that -- that prescription has been filled and given to the individual who has requested it?

MS. PAULIN: The process is ongoing care, you know, on the part of the attending physician and the -- and the patient. That's the process that you -- that's used for any treatment option.

MR. RA: But -- well, my understanding is, you know, in states that have done this like Oregon, some patients have held on to these drugs for -- for years. If, you know, the person takes the drug -- takes the drugs home and holds onto them, is there any specific requirement that there be some type of follow-up in the future on -- on an individual to --to assess whether they're still in the right mental, you know, frame of mind and -- and things of that nature? Because they now have that sitting in a cupboard and -- and maybe have a rough day in -- in treatment or -- or from -- as a result of their illness. Is there any follow-up that's required?

MS. PAULIN: Again, the follow-up is the ongoing relationship of the attending physician with that patient. And if you have an illness like cancer or ALS or Huntington's Disease, you have that ongoing relationship. And that relationship is not just assessing your physical condition, it's often someone who you're talking to about your fears, about your concerns. I mean, these doctors are remarkable, and they are -- become part of the family in a lot of ways.

An extension of -- of the family. And they are involved in a lot of decision-making, and they obviously would be able to talk to that patient with the -- with the -- the heart and the sensitivity and the knowledge that would be required, knowing that that patient has that medication in their cupboard, which is giving them comfort.

MR. RA: Okay. Thank you, Ms. Paulin.

Madam Speaker, on the bill.

ACTING SPEAKER HUNTER: On the bill.

MR. RA: You know, as many colleagues have already said, this is a very personal, emotional issue for so many of us. But I -- but I want to be very clear about -- about something. There are plenty of us who will be voting against this bill who have had those experiences as well with -- with loved ones and dealing with long-term illnesses. So I don't think that anybody should be under the impression that -- that our objections to this bill come from a lack of compassion for any individual or -- or a lack of understanding, even, why somebody might want to avail themselves of this option. But we've seen other things we -- we've done in this Chamber, and just I guess society as a whole continues to really in a lot of ways devalue life. And there are opportunities with regard to this legislation and that we've seen in other states where it opened up Pandora's Box and people with chronic conditions, people with disabilities, ended up being in a position to decide, *Maybe I'm a burden on my family. I'm gonna take advantage of this. Maybe it's better for my financial circumstances or that of my family to -- to just end my life*. And there are a number of organizations that work on behalf of our disabled community and they are very, very scared of what this legislation is gonna mean for those individuals that -- that they serve.

Many years ago when we had a hearing with regard to this, I was a member of the Health Committee and I participated in it all day. We heard lots of stories from individuals on both side [sic] of it, but I -- I just think this takes the idea of a doctor who -- we think of doctors as people whose job is to make you better, at the very least make you comfortable, and I think we're jumping over to a place where they're now facilitating death. So I'll be voting in the negative.

ACTING SPEAKER HUNTER: Thank you, Mr. Ra.

Ms. Cruz.

MS. CRUZ: Thank you, Madam Speaker. Will the sponsor yield for a couple of questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MS. CRUZ: Madam Sponsor, I want to hammer on the process a little bit. Let's say I'm diagnosed with cancer, I go through the treatment and eventually I'm told that I no longer have any other treatment choices. I make the decision in consultation with my doctor that I no longer want to live. What happens next?

MS. PAULIN: So you would -- you made that -- first you would have to make an oral request for the medicaid [sic] in dying drugs. Then your -- you could either get your consulting physician in line or you could go straight to your written request. But you have to do both, not necessarily in a certain order. So let's -- the consulting physician referral by the residing or the attending or maybe you find your own, you suggest it, you give me a referral. So you get a referral, you go to the consulting physician and then they decide, yes, you only have the same six months or less to live. Then as far as the written, we have actually in the statute the written form that you would need to attest to, and then that written form would have to be witnessed by two people who are not family members and have no financial interest in your estate, and they witness your statement that you were not coerced, you say you're not coerced in your statement. And it's penalty of perjury if either of the witnesses are doing this incorrectly. And -- and then you submit that to your attending physician and then you're eligible to get the meds. You get the prescription, then you decide when you want to self-ingest them.

MS. CRUZ: Let's say once prescribed, am I required to take it within a certain amount of time?

MS. PAULIN: No. And most -- unless -- people -- you know, we know from experience a lot of people are procrastinators, so we also know that a lot of patients request them kind of late. So could they take them right away? Yes. And in fact, states that have had waiting periods have had to waive them to allow for that. But many, many people just want to have the comfort and knowledge. You know, in having met so many advocates and meeting people who are -- have a disease, meeting one woman and having her say, *I just worry about the pain at the end. I worry about the pain, that I'm not gonna to be able to take it*, you know? And so having those meds gives that patient comfort.

MS. CRUZ: And let's say I decide not to take it and the medication is there. Are there safeguards around what to do with this medication if I decide not to take it?

MS. PAULIN: Yes, just like any of the other medications that we have out there that are addictive and dangerous like, you know, morphine, other controlled substances. There are guidelines that -- Federal guidelines that they have to follow. We also offer in the bill an option for the Commissioner to establish regulations specific to this, but otherwise, they would follow the same options. And as my colleague who is a pharmacist mentioned to me earlier, we passed a bill that -- almost unanimous, if not unanimous -- that allows you to bring those meds back to the pharmacist and would require a family member to do that.

MS. CRUZ: And let's say it's not cancer. Let's say what I have is dementia. What happens then?

MS. PAULIN: Dementia is not considered eligible for this because you can't tell when someone is actually gonna die.

MS. CRUZ: And we heard some of our colleagues earlier mention the concept of feeling like you're a burden on the family. Let's say instead of cancer or a terminal illness what you have is some sort of disability because of an accident, because of some other reason, let's say. In a situation like that, what then?

MS. PAULIN: So, if you have a disability you're actually not -- we say in the statute that you're not eligible solely because you have a disability or because of age. That's actually explicit in the bill. So you would not be eligible unless you also had a terminal illness.

MS. CRUZ: Thank you.

On the bill, Madam Speaker.

ACTING SPEAKER HUNTER: On the bill.

MS. CRUZ: I want to thank the sponsor of this legislation. The experience of watching a loved one die I think has colored our decision-making process for many of us. And I want to say that I respect and honor whatever side of the vote you end up on today because this is a very personal decision for many of us. For me, it was colored by having to be at the bedside, actually by getting the honor to be at the bedside by my father when he passed away. For me, this was colored by the idea that anyone who is in that process should have a choice about when their life and how their life ends.

About 15 years ago I took an emergency trip to Columbia after almost seven years of my father having battled cancer. He reached the end. I didn't know it then, but it had -- it was the end. He had been an avid soccer player, he never drank, he never smoked. And when he was just 46 years old he was diagnosed with an extremely rare form of osteosarcoma and had taken over his life completely. It changed who he was and the life that our family lived.

From the beginning of the diagnosis, all of the decisions regarding his treatment were made as a family with his medical doc -- with his medical team; from when to have chemo, to when to stop chemo, to when to try homeopathic medications, to when to have his leg amputated, actually, so that he could walk me down the aisle.

After his initial treatment he went into remission and he was cancer-free for a couple of years. But then in December of 2020 the cancer came back and it came back with a vengeance. It came back as lung cancer. Remember that I said this man had never smoked a cigarette in his life. So I made the emergency trip in hopes that once again as a family we could choose treatment, that we could have some sort of miracle happen and have an informed decision with his doctors that could save his life. But a few days after I arrived, he became so ill that we had to put him in the hospital and less than 24 hours later my father was gone. When we were at the hospital, the doctor informed me that my father was basically alive by a pure miracle. All he had left was 25 percent of one lung, and it would be a matter of days or perhaps hours. My father wanted to live. He went through years of treatment because he loved my sister, my brother, my step-mom, because he loved me, and he wanted it to work. But he also did not want to live or die as a vegetable. He did not want to suffer. Now this former union organizer-turned profit -- non-profit banker was a shell of a man. He could no longer walk, he could no longer eat. He barely spoke. He was the vegetable he always said he never wanted to be.

A day after we entered the hospital he died, but he was brought back to life. And again, as a family we made the decision that if it happened again, we would let him go. That if his heart stopped, we would let him be free. My father did not have a choice. In Columbia, Medical Aid in Dying, otherwise known there as "dignified end of life", did not become a nationally, constitutionally-protected right until 2022. I saw my father drown alive. When he could no longer breathe, when liquid got into his lungs. When his eyes turned completely black and his fingers blue.

I've spoken to my step-mom actually right before I came in here, and I told her we were taking this debate up and this vote. And she said to me, *I am so glad you're doing this because no one should die like your father did*. People should have a choice. And we suspect that had he had that choice he would have taken it.

Sometimes the most loving choice you can make for someone who is dying is to let them go with dignity. This bill has placed protections to ensure that people choosing to end their lives are not pressured into it, that insurance companies aren't making bank from it, and that every day we allow people to make that choice. My vote today is for that so that people can make that choice. I understand that it's only covered by private insurance right now and I'm hoping that once we change Federal leadership it could become something that everyone has access to. Many treatment choices right now are not covered by insurance because that's the way that it is.

The concept of internal coercion as we heard earlier, to me I look at it as simply that choice-making process that you go through where you're thinking about, *What's best for me? What's best for my family? What's best for me, whether to live or to die with dignity?* That choice, as elected officials we often think of in terms of what do our voters support. And 74 percent of Americans, that's Republicans and Democrats, are actually in support of Medical Aid in Dying. That's from a 2020 poll.

To me, again, this is about choice. As a legislator, a key part of my job is to open up the doors so that people can make decisions for themselves, and that's what we're gonna do today. And thank you again, Madam Sponsor, and I'll be voting later in the affirmative.

Thank you.

ACTING SPEAKER HUNTER: Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: Madam Speaker, if you would please call the Ways and Means Committee to the Speaker's Conference Room.

ACTING SPEAKER HUNTER: Ways and Means to the Speaker's Conference Room. Ways and Means Committee members to the Speaker's Conference Room.

Mr. Sempolinski.

MR. SEMPOLINSKI: Thank you, Madam Speaker. Will the sponsor yield for a couple of questions?

ACTING SPEAKER HUNTER: Will the sponsor

yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. SEMPOLINSKI: Thank you, Madam Sponsor, for yielding.

Would you concur that this law is giving new powers to doctors and those that are in this chain of process? They have things they're allowed to do they were never allowed to do before.

MS. PAULIN: I would say they're being given more treatment options.

MR. SEMPOLINSKI: But there are things that they can now do they were not allowed to do before should this pass.

MS. PAULIN: They can write this prescription, yes.

MR. SEMPOLINSKI: Okay. And as you mentioned to Mr. Ra, there's no change whatsoever to the Penal Law anywhere in this text.

MS. PAULIN: There's -- I don't -- so we don't amend the Penal Code, but we do say that some things in here are crimes, yes.

MR. SEMPOLINSKI: Okay. So there -- but there's no change in the Penal Code.

And in Section L, which is on page 9, there's an extensive list of protections and immunities. So, what physicians cannot be held liable for is -- is enumerated in that section. In Section R on page 12, which is the penalty section, there's no such enumeration. It just says, as you just sort of implied, that the existing civil and criminal penalties for any particular offense could apply. There is -- the penalty section of the bill does not produce anymore penalties. It merely says that we're not going to reduce the penalties that already exist in statute. Am I interpreting those two sections correctly?

MS. PAULIN: I'm not exactly sure what you're saying. However, I will -- if someone is guilty of coercion or they're guilty of attempted murder or they're guilty of perjury, we already have statutes on those. We don't need to write a new one.

MR. SEMPOLINSKI: Well, that's where sort of I'm going, because you've mentioned over the course of the debate a couple different crimes, perjury and coercion, which are Class D felonies, which is two to seven years. You mentioned promotion of suicide, which would remain in law for other circumstances. That's a Class E felony, that's up to four years.

So we create new crimes all the time, things that you can't do. We're creating new things you can do, and if you were to abuse that power there's no enhanced penalty that's not worse to perjure yourself to lead to someone's death. It's not worse to coerce someone that leads to their death. It's not a worse type of promoting suicide, you're just gonna dump it back into the current Penal Code. Why didn't we enhance penalties or produce a crime here since we're now dealing with a far more serious topic, life or death? Why are there no enhanced penalties in any way, shape or form in this law?

MS. PAULIN: I think -- I think if you looked at the statute, you know, particularly the one on suicide, right, there is already an enhanced penalty. It's 120.35, promoting suicide attempt; when punishable as attempt to commit murder. So we already have two statutes on the books that would cover it, and the second one is a Class B violent felony, which is pretty serious.

MR. SEMPOLINSKI: So -- so -- what -- but am I correct that we are giving new powers to people over life and death and not creating any new crimes or enhanced penalties if that is abuse?

MS. PAULIN: So, I've been in this Chamber for nearly 25 years, and I have seen bill after bill, statute after statute where we simply say it's a Class A felony. It -- or we refer it back to a --

MR. SEMPOLINSKI: But you don't -- you don't say anything is a Class A felony.

MS. PAULIN: Well, because we don't have to because these are --

MR. SEMPOLINSKI: Are -- are you -- why are you hesitant to change to law to increase penalties?

MS. PAULIN: I mean, do you want us to say that it's -- that 120.30 would apply if you're -- you know, if it was promoting a suicide attempt? I mean, honestly --

MR. SEMPOLINSKI: I think the penalty should be enhanced. I think they should be increased. I think there should be new crimes. If you're a doctor that abuses the powers of life and death that we're about to give you, I think that should be a new crime in the State of New York. It probably should be Murder 1, frankly, because we're giving people a massive amount of power and not putting any teeth on it. And -- and I --

(Crosstalk)

MS. PAULIN: If the --

MR. SEMPOLINSKI: I will rephrase the question by way--

MS. PAULIN: Murder 1 is very clear. And if the --

ACTING SPEAKER HUNTER: Colleagues, can we please ask and answer?

MR. SEMPOLINSKI: I will rephrase the question by way of a case study. And the reason I'm concerned about this, I have a daughter with profound disability, profound developmental disability. She has multiple congential heart defects. I'm 42 years old. I think I'm in pretty good shape, I hope I'm around for at least another 42. Who knows? She's six. Whether I live a long life or not, she's gonna reach a point in her life where I'm not gonna be there to protect her. What's gonna protect her from being abused, as far as this statute is concerned of being coerced, are your words. And if your words don't have any teeth behind them, how am I supposed to feel confident when I'm in the hereafter that no one will trick or induce or coerce or push my daughter, who's in a very vulnerable situation, into killing herself? How am I supposed to feel confident of that if you won't put any penalties in the law, they're just words on paper?

MS. PAULIN: Well, unfortunately, penalties come after the fact. What we've put in the law, though, is preventive. And what we have in the law is that a disability is not -- cannot be the sole reason for this. That -- I don't know the condition of your daughter, but if she doesn't have decision-making capability, she couldn't get it. So those are preventive. If someone, God forbid, murders your daughter, then they would be subject to very high penalties in the Penal Code already.

MR. SEMPOLINSKI: So -- but I'm talking -- I'm not talking about murder, I'm talking about coercing her into this. But there are no enhanced penalties. She simply has to live under the circumstance that these words will protect her.

MS. PAULIN: Coercion -- coercion rises to a Felony D. That's pretty serious.

MR. SEMPOLINSKI: Coercion to kill somebody would be 2 to 7. So in theory, if you coerce somebody into killing themselves, two years potentially.

MS. PAULIN: No. If you coerce someone into killing themselves you would be guilty of -- you'd probably be guilty of promoting a suicide attempt that's -- that would be a Class B violent felony, which is 25 years.

MR. SEMPOLINSKI: I have one final question. I -- I do appreciate you answering my questions.

My final question is, there is no -- am I correct that there is no explicit ban on those with developmental disabilities from using this? It just says solely it cannot be -- be -- you cannot be put into this program because of a disability and you have to make sure somebody has capacity. But simply by having a developmental disability, that does not prevent you if, say that person had a terminal diagnosis and two doctors said they were capable.

MS. PAULIN: That's correct. And in fact, the disability community in New York has spoken loud and clear. Seventy -- 73 percent of New Yorkers that identify with a disability support Medical Aid in Dying. That's a higher number than the rest of New York State, which is at 72 percent in the last study that was done just last year. So we know that people with disabilities want to be able to have the same options as everybody else.

MR. SEMPOLINSKI: I'm gonna go on the bill. And I appreciate the --

ACTING SPEAKER HUNTER: On the bill.

MR. SEMPOLINSKI: -- sponsor being willing to answer my questions.

I think part of the reason, and -- and Mr. Ra eluded to this -- why there's so many loopholes and problems and concerns is for the entirety of civilization, doctors' sole role has been to promote, extend life, to provide health. And now we are taking that profession and asking it to do the exact opposite of the reason that it exists. And so when you try and pervert that and reverse that, it simply doesn't work and you run into all these reasons why you're gonna have people fall through the cracks, all these problems that my friends keep bringing up. All these loopholes. So we're trying to take an entire body of law and thousands of years of history and flip it.

And I mentioned my most pressing concern, which is what happens to my daughter when I'm not here to protect her and what happens to thousands of people like her. If history shows anything, when we open a door like this we know who gets shoved through first, and it's those that cannot defend themselves. And my concerns are not merely simply a slippery-slope argument, though I think it is very apt. And we see what happens in Canada, a jurisdiction that's closer to my district than this building is. But it's my concerns with the bill itself without having any enhanced penalties. We're giving the power of life and death to people and not increasing the penalties and not creating new crimes. That makes no sense.

The reason this bill has not passed up to this point is because of Majority members of conscience have not wanted it to come to the floor. We haven't voted yet. I ask those same Majority members of conscience to vote no. Thank you very much.

ACTING SPEAKER HUNTER: Mr. Manktelow.

(Brief pause)

Ms. Glick.

(Brief pause)

Mr. Slater.

MR. SLATER: Thank you, Madam Speaker. Will the sponsor yield for some questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. SLATER: Thank you very, very much. I appreciate it. And thank you for taking the time for answering so many questions today.

I just wanted to see if we can just focus in a bit more on the mental health aspects of some of the things that have been said today. So just to make sure I'm clear, the individuals who determine whether a patient has the mental competency to receive the medication or to, I guess, ask for the medication and then receive the medication would be the attending and consulting doctors, correct?

MS. PAULIN: (Nodded in the affirmative)

MR. SLATER: Great. And is it possible for an individual's mental competency to change based on their diagnosis and the progression of their disease?

MS. PAULIN: (Inaudible/mic off) -- they're all different. So I don't know whether someone's competency deteriorates because of their illness. I just can't speak to that.

MR. SLATER: But the attending and consulting physicians are expected to be able to, correct?

MS. PAULIN: Yes.

MR. SLATER: Now, do the -- does the legislation require the attending or consulting physicians, presumably both, are they required to receive some type of mental health training? Are they -- because they are not mental health experts, correct?

MS. PAULIN: Right.

MR. SLATER: So are they required to receive some form of training to deal with the question I previously posed about one's competency?

MS. PAULIN: So, doctors all the time are required to assess someone's decision-making capabilities for every single treatment that -- that someone has. For example, you know, when we have treatments we have to sign a form, you know, right? Everybody signs the consent form for whatever the treatment is. Minor ones. And doctors have to assess whether our signature is valid based on our competency to have signed that. So every day, doctors have to make these decisions.

I don't understand why this decision is different, you know than -- than a decision to go on dialysis, to get an experimental treatment. We expect doctors to be able to determine, and if they have any doubt, any doubt, they can make that referral.

MR. SLATER: But to make sure I'm clear, there is no requirement stated within the legislation that the -- that the attending or consulting doctor must take some form of mental health training in order to be the attending or consulting doctor?

MS. PAULIN: I'm not sure, but I would -- I believe that, you know, when doctors go into medicine that they're required to do rotations in almost everything, and probably this as well.

MR. SLATER: Well, I just -- just to dig down deeper into it, because I was looking to see what type of requirements were there and I didn't see any in the legislation. That's why I'm continuing to ask the question. So I understand from -- what you're saying, but within the text itself, in order to be either the attending or consulting, making a very important decision, there is no requirement stated about a mental health training for those individuals?

MS. PAULIN: No, there's no requirement.

MR. SLATER: Okay. Thank you. I -- I appreciate that.

So if -- if an individual's competency occurs after they've been prescribed, if their competency deteriorates based on their diagnosis after they've been described [sic] end-of-life medication, what happens?

MS. PAULIN: You know, these are people who are dying within six months. The -- the odds of their mental capacity changing so severely are probably very remote. I would think that if a doctor saw the one individual in -- in the numbers that they were doctors of, you know, that they were -- that they had patients, that they would maybe, you know, suggest to that patient that they shouldn't be using this treatment option. But it's just not been the experience of -- of the nearly 30 years. We just haven't heard of one case, not even one of the 10,211 cases where people used this medication or availed themselves of it that -- where we've seen that happen. So we're really worrying about nothing.

MR. SLATER: Are there -- are there any statistics related to the number of cases that you just cited that those individuals were referred to mental health experts by their consulting or end -- or their attending physician?

MS. PAULIN: Since every state is a little different in terms of how they structure that and each state is a little different in terms of the data they collect, it would really be nearly impossible to figure that out.

MR. SLATER: I mean, there -- I -- I was seeing some statistic that showed less than 5 percent of individuals who went to a doctor for end-of-life medication were ultimately referred for a mental health evaluation.

MS. PAULIN: That -- I -- I vaguely remember that statistic as well, so that could be the case. And that just shows you that these illnesses that are end-of-life type illnesses like cancer, like ALS, are ones where you keep your medical faculties.

MR. SLATER: But doesn't it also raise a concern that those who are being empowered to be the attending or consulting physicians are just not properly trained and able to refer an individual to a mental health professional? Are they not properly able to identify the difference between end-of-life and an emotional or mental distress?

MS. PAULIN: I would argue that they absolutely have that -- that ability. These doctors are highly trained and highly sensitive to patients' needs. They are treating the most vulnerable patients and people that -- that are in our -- in our State, in our -- in our world and our country and our life, and they have those expertise. I -- I am not concerned in the least bit.

MR. SLATER: But again, just to make sure we're clear, according to your legislation there is no requirement for mental health training in order to be an attending or consulting physician. Patients are often provided or seek mental health help and assistance when they are diagnosed with a cancer -- cancer diagnosis; is that correct?

MS. PAULIN: They can be. If they're depressed and they want to seek someone, absolutely they could -- they could do that.

MR. SLATER: But cancer patients are also encouraged to seek mental professionals to help them through that -- through that process of battling cancer. Is that -- is that a fair statement?

MS. PAULIN: Perhaps. I don't know. You know what? Again --

MR. SLATER: Well, I know someone specifically who was -- several people who were diagnosed with cancer and they were all provided with mental health options to go through that process.

MS. PAULIN: I think that there's support groups and other situations where someone can --

MR. SLATER: My question is if someone is provided with or seeks a mental health therapist to help them through their treatments, is that person brought into the discussion of end-of-life medication at any point in time?

MS. PAULIN: Wait, say that one more time.

MR. SLATER: If a cancer patient seeks a mental health advisor or expert to help them as they're getting treatments, as they are battling through their diagnosis, but ultimately their condition deteriorates to the point where they're within that six-month window. Does that therapist that that individual has been seeing while they're receiving treatment, are they brought into the discussion at any point in time if that individual seeks end-of-life medication?

MS. PAULIN: They are if it's determined by either the preside -- the attending physician or consulting physician that it's necessary to assess someone's decision-making capability.

MR. SLATER: But that -- but those -- again, those attending and consulting physicians may not be aware that the individual has been seeking mental health assistance during that process, nor is the individual required, I'm guessing, to divulge that fact. Is that an accurate assumption?

MS. PAULIN: That is, except that by your own admission earlier you said that they are usually encouraged by their attending physician to seek that mental health evaluation, and they usually have a very open, honest relationship with their attending physician. So it's likely they would know, but even if they knew or they didn't know, the evaluation that the attending physician is making is on their decision-making capacity on medication that they would be giving them. They are making a decision on whether they were fit in terms of their decision-making capability to assess medical issues, not on any other -- any other circumstance.

MR. SLATER: I -- I understand that and I appreciate your answer. I guess it just boils down to why are we not making it mandatory for all individuals? And since, again, the attending and consulting doctors don't need mental health training, why are we not making it mandatory for all individuals who are seeking end-of-life medication to be seen by a mental health professional before they're prescribed any life-ending medication?

MS. PAULIN: Because very simply, we don't want to distinguish this from other medical options that someone would have. So you don't make those determinations.

MR. SLATER: Is there -- is there any -- is there any right of -- of an appeal if an individual's family believes that they do not have or no longer have the mental competency to make this decision?

MS. PAULIN: I would argue that they -- they could tell the -- the attending doctor of their belief.

MR. SLATER: The family can tell the attending doctor --

MS. PAULIN: Yeah. Or the consulting doctor --

MR. SLATER: Or their consulting doctor --

MS. PAULIN: -- that they don't believe that someone has the ability to have decision-making power over their health decisions. They could go to court.

MR. SLATER: What happens if they've already been prescribed the medication and it hasn't been taken and the family does not believe that the individual obtained it in the right mindset?

MS. PAULIN: That -- it's self-determination. It's up to that person. You know, I don't know that I want my children to decide whether I'm able or capable of doing anything. I want to be able to make those decisions for myself. And this is the most important decision that you're gonna make. So I want that decision. I don't -- I don't want others to decide that for me. And if a doctor believes that I can't make the decision, then he or she is gonna refer me to a mental health professional. But I -- I don't know that I want my children or my husband to make that determination for me. I want to -- I want to be involved. I am a competent human being, as are the patients and all of the people who wore yellow shirts in this Chamber for so many years.

MR. SLATER: I appreciate that.

My other question is regarding since we don't have the doctors being mandated to seek mental health training, would the doctors who wish to participate in prescribing end-of-life medication have to take any continuing education or professional development to ensure that they are prepared for all eventualities with assisting their patient with -- with ending their life?

MS. PAULIN: Again, they're not assisting. They're providing a prescription.

MR. SLATER: Is there any continuing education requirements for them to prescribe --

MS. PAULIN: No.

MR. SLATER: -- those prescriptions?

MS. PAULIN: No. Just, you know, doctors have the prescription ability and this is just another prescription that they -- (inaudible/crosstalk).

MR. SLATER: So no mental health training and no continuing education requirements --

MS. PAULIN: No.

MR. SLATER: -- to -- to prescribe.

Is there any review process to ensure that doctors have followed the law for a patient who utilized Medical Aid in Dying?

MS. PAULIN: The process by which someone would review are that there would be medical records that they have to keep, detailed medical records, and the Health Department has the authority to review those records. So that's the review.

MR. SLATER: Understood. Well, thank you very much for answering my questions. I appreciate it.

Madam Speaker, on -- on the bill if I may, quickly.

ACTING SPEAKER HUNTER: On the bill.

MR. SLATER: You know, I think based on the answers that I just received, I have significant concerns regarding the way that this legislation's written, specifically as it relates to mental health. We continually say that there's a mental health crisis, but yet here we are, enabling doctors to prescribe end-of-life medication without any mental health training and I think that's very concerning. I'm also concerned over the fact that we just heard that there is no requirement for continuing education in order to be a prescriber. And so this is a very serious issue that requires that level of scrutiny and that level of training.

I do recognize the fact that we have great doctors all over this State, doctors who I believe do have their patients' best interests in heart. But when we're talking about something as serious as end-of-life medication, making sure that we continue to hold up a high bar I don't think is too much to ask for.

And so again, I want to thank the sponsor for answering my questions. I'll be voting in the negative because of the concerns that I have articulated. Thank you very much.

ACTING SPEAKER HUNTER: Thank you.

Ms. Glick.

MS. GLICK: Will the sponsor yield to a couple of questions?

ACTING SPEAKER HUNTER: Does the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MS. GLICK: Thank you very much.

If someone goes into the hospital, their cardiologist suggests to them that they, you know, need open heart surgery; is it reasonable practice that people might be asked to either have a healthcare proxy or a DNR before they undergo serious surgery?

MS. PAULIN: Absolutely.

MS. GLICK: And so in the event -- and does any -- when they're at the hospital and they've talked to a cardiologist who may not have any mental health training, does anybody suggest that before they write a DNR, a Do Not Resuscitate, that they see a mental health professional?

MS. PAULIN: No, they do not.

MS. GLICK: When somebody has been in the hospital or in a nursing home for a long period of time, can they at some point when they feel they're failing, can they refuse hydration?

MS. PAULIN: Absolutely.

MS. GLICK: Does anybody require them to see a mental health professional before they make that decision?

MS. PAULIN: No.

MS. GLICK: Now, it's my understanding that it's actually quite -- that it's essentially, you know, starving yourself to death and that's pretty uncomfortable. But nobody requires anything. Nowhere in the law, nowhere in medical -- that we have that requirement, right?

MS. PAULIN: Absolutely correct.

MS. GLICK: Okay.

If you have a loved one who has a -- you've given a healthcare proxy to somebody else. They can make a decision to determine that you not be resuscitated if you are on -- if there's a problem in the course of surgery and you are in a coma, somebody else can make that decision once you've assigned them the -- as your healthcare proxy; is that --

MS. PAULIN: Correct.

MS. GLICK: Okay. Thank you very much.

On the bill.

ACTING SPEAKER HUNTER: On the bill.

MS. GLICK: You know, if I could just ask you one more question. I'm sorry, if you would yield to one more question.

ACTING SPEAKER HUNTER: Does the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MS. GLICK: We talked about the other possibilities in end-of-life care, which includes palliative care. What is involved in palliative care? Is that, like, pain relievers and -- to what extent can somebody be provided pain relief?

MS. PAULIN: To the extent -- maximum extent based on what we have available. You know, typically morphine when someone is in severe pain, which you can take until you're comatose, which many patients don't want to do because they actually want to converse with the people in the room. But they -- they could do that.

MS. GLICK: So if they said, *I -- I'm -- I really -- I've said my goodbyes and I may or may not, but I can ask you to really snow me under and at some point I will succumb and that's fine*, they can do that? They don't have to have the mental health people come in and check?

MS. PAULIN: I think it's very common.

MS. GLICK: Okay. Thank you.

On the bill.

ACTING SPEAKER HUNTER: On the bill.

MS. GLICK: Most people want to take whatever possible treatments available to them. Although a lot of people don't have a lot of options because, you know, the healthcare system isn't free and we've had restrictions. And so not everybody can avail themselves of every clinical trial. In fact, I think recently some clinical trials for cancer and other med -- have just been cut off. So people, by Executive Order, were denied access to clinical trials that might have extended their lives and might be facing their demise unexpectedly because they were trying desperately to find a way to stay alive. So I -- I find it a little bit ironic, some of the conversation today. But, you know, nobody wants to face their own mortality, and it's a difficult thing. And those of us who have had any religious upbringing may feel that everything should be focused on extending life, whether that life is the quality of life that we really would want for ourselves. But that's our impulse as people to try to stay alive. But when the doctors have told you, *There is nothing else we can do for you* and you are facing a situation where either you will experience suffering or you opt for the palliative care that slowly snows you under so that you're not really living a life, people deserve dignity and options. And they deserve to make a decision about themselves. They may decide, in the consultation with the doctor, and this requires them to do that. And if -- this actually requires them to see a couple of doctors, even though they may know in their heart that there's nothing else that can be done.

So it was very uncomfortable to sit with a friend who was sitting in their apartment in a what I would refer to as sort of a beach lounger because that was the only comfortable chair available to them, and just sort of said, *I'm sitting here waiting to die*. I think -- I think Ellen deserved another option. I think Ellen was compassed. I think she knew what was happening to her. I think she knew absolutely that there was no turning back, no miracle that was going to show up on the internet that was going to pull her back to full health and full life. And she deserved to make a decision not to just sit in her living room in a beach lounger, waiting to die.

And of course, you know, many people, they had family members, as I have, who -- you know, there was a gentleman who had a sign about, you know, now they want to kill old people. Well, you know, not everybody is old when they face a terminal diagnosis, and they wish that they could get to be old but now they've been told there are no more options. And they decide, and they are free to decide, that they're not gonna take anymore chemotherapy that's making them sick every day. They've been through the hair falling out. They've been through the pain. They've been through not being able to get up. They've been through having to have the indignity of bodily functions in their bed. They -- they deserve compassion and empathy and dignity.

And I want to thank the sponsor for the years of work, and I want to thank the advocates who have spoken for their friends and their family members who deserve the dignity and the grace to leave this life by their own decision. Now, there are probably people who have made that decision ahead of time and they don't really need the New York State Legislature to say to them it's okay. Because they have -- they knew what was coming and they stockpiled medication ahead of time and took a chance that nobody in their family would be arrested for helping them.

I respect that there are people whose religious beliefs bar them from supporting this. But I object to having other people's religious beliefs force people without those beliefs to live that way and die that way.

So I want to thank the sponsor. I want to thank the advocates. And I want to say that finally we are doing the right thing for the people of New York who have faced painful lingering and are being given an opportunity to say goodbye to their families with the knowledge that they can end their lives with dignity.

Thank you. I vote in the affirmative.

ACTING SPEAKER HUNTER: Thank you.

Mr. Manktelow.

MR. MANKTELOW: Thank you, Madam Speaker. Would the sponsor yield for a couple of questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. MANKTELOW: Thank you, Ms. Paulin.

As I was reading the bill text, I do have a couple of questions. The part with the declaration of the witness on line 38, 39 and 40 it says, "I further declare under penalty of perjury that the statements made herein are true and correct and false statements made herein are punishable." Why is that in there?

MS. PAULIN: Because we want to be sure that the witnesses are asking the right questions, that they're -- that they're informed on, you know, all the elements that the witness or that the patient is signing, and -- and to be sure that they are appropriately signing that document and not just making assumptions, essentially.

MR. MANKTELOW: Okay. So I'm assuming it's really to cover the whole process, making sure things are done right.

MS. PAULIN: Legitimate, yes.

MR. MANKTELOW: So also on page 12, lines 9 through 14, it talks about the death certificate. It says, *The cause of death listed on a qualified individual -- or individual's death* *certificate who dies after self-administering medication under this article will be the underlying terminal illness or condition*. What does that mean?

MS. PAULIN: So just like with any procedure, right, for example, my colleague spoke about, you know, perhaps taking or having a -- you know, have a Do Not Resuscitate order if you have heart surgery and then you go into a coma and you have to be put on a res -- you know, any kind of gizmos, right? The underlying fact is that you had a cardiac condition.

MR. MANKTELOW: Okay.

So we talk -- we talk about cancer a lot here. So if I had cancer and I decided to do this, the underlying issue would be the cancer --

MS. PAULIN: Yes.

MR. MANKTELOW: -- which would go on my death certificate.

MS. PAULIN: Yes.

MR. MANKTELOW: Okay.

So when the individual takes the pill, when the individual takes the very last pill, what -- what happens to their body? How do they end up dying?

MS. PAULIN: They die in their sleep of what --

MR. MANKTELOW: But what -- what causes them to die?

MS. PAULIN: There's medication -- first they're --

they're given an anti-nausea and absorption medication. About 45 minutes later they're giving --

MR. MANKTELOW: I'm familiar with the process.

MS. PAULIN: Okay.

MR. MANKTELOW: I just wanna know what's going to kill my body?

MS. PAULIN: What's gonna to kill your body?

MR. MANKTELOW: Yeah. When I take --

MS. PAULIN: You know, I -- I would say that I would ask some of my colleagues who are either a pharmacist or a nurse to talk about the specific drug. But I can give you the names of the drugs, and among them, one of them is -- is going to put you to sleep and then others are going to slowly stop the rest of your organs from functioning.

MR. MANKTELOW: Okay. So it's probably like a barbiturate or something they're gonna give you (inaudible/crosstalk)?

MS. PAULIN: Barbiturate is definitely part of it.

MR. MANKTELOW: All right. Perfect.

So my next question is, as I was reading about the death certificate and what they were going to put on there, I -- I took a look at the New York State death certificate and it's quite, quite lengthy. A lot -- a lot of things to put in there. And I was reading about the certifier, the one that's actually gonna certify the death, and under 25(a) of that box it says to the -- to the certifier's name, *To the best of my knowledge death occurred at the time, date and place and* *due to the cause(s) stated.*

MS. PAULIN: And due to the what?

MR. MANKTELOW: Due to the cause(s) stated. Why -- why I died.

MS. PAULIN: Mm-hmm.

MR. MANKTELOW: Underneath that, in box 27 there are six options there. Option number one is natural cause. Option number two is accident. Option number three is a homicide. Option number four is a suicide. Option number five is an undetermined circumstances. And the last one is option six, pending investigation. So in this situation, what box do they check?

MS. PAULIN: I don't have the form in front of me, but I do know that death certificates are used to essentially track and understand trends in diseases. So whatever the box is that you would then put heart attack or you would put -- what are some other causes of death? Um --

MR. MANKTELOW: But -- well, let's -- let's rule them out. So it's definitely not natural cause because they just took a pill to end their life. It's not an accident. We've all heard that today, they have to make the decision to do that. It's not a homicide. It's not from undetermined circumstances because we know exactly how they died. And pending investigation is probably for a murder trial or something like that. But the other box that's there is suicide. This is suicide. This is assisted suicide. So why would that box not be checked?

MS. PAULIN: It's not assisted suicide. Assisted suicide is against the law in New York and will remain so.

MR. MANKTELOW: So that's why we word it "Medical Aid in Dying?"

MS. PAULIN: As did all the other states that have already done this, yes.

MR. MANKTELOW: So -- okay. So it's not a suicide.

MS. PAULIN: No.

MR. MANKTELOW: Okay.

So if I drop down to the next box, cause of death, there's three -- there are three responses. Part one, what would be the immediate cause of death?

MS. PAULIN: It would be the underlying cancer, ALS or any of the other diseases or that that person might have.

MR. MANKTELOW: So what would -- what would be the consequence of the death?

MS. PAULIN: The -- the same thing. That's the -- it's -- the underlying cause of death is whatever -- like, for example, if, you know, in the case of my sister who had cancer at the end she didn't eat or drink. The underlying cause of her can -- of her death was ovarian cancer and that's what was listed on the death certificate.

MR. MANKTELOW: Okay. So under those two boxes we just talked about, we're asking either a doctor or a coroner to sign off on this that it's an underlying issue that actually caused them to die.

MS. PAULIN: Just like we do for all of the, you know, Do Not Resuscitate orders. For the -- for all the times if someone doesn't eat or drink to, you know, to -- to expedite their death. The -- the morphine, the overdose of morphine, you know, but it's not the main cause. Those are all the exact same circumstances as this.

MR. MANKTELOW: Okay. So we can't use the word "suicide." So, you know, I talked to a young person this morning about the bill and they used the word, you know, "It's suicide." And this was a junior in high school. It -- it is suicide. There -- there's -- anyways [sic], we'll -- you can call it what you want. It's like putting lipstick on a pig. I don't care how much lipstick you put on that pig, it's still a pig. But I'm just saying.

So my next question is, if there's an autopsy report that -- that's asked to be done. If it's -- if it's an individual that takes that at their house, you said earlier that the individual could go home and take it at any time. How -- how would you answer an autopsy report at that point? What -- what would be the cause of death for an autopsy report?

MS. PAULIN: It's the same thing. You know, if the underlying cause of death is cancer or ALS or --

MR. MANKTELOW: But -- but --

MS. PAULIN: -- another terminal illness --

MR. MANKTELOW: Those three terminal illnesses that you just said, without taking this medication they don't die. If -- if the cause is cancer, if the cause is diabetes, if the cause is heart attack, whatever, then why do we need the pill?

MS. PAULIN: It's the same thing as if someone took morphine. You know, are you gonna suggest that if you're in dire pain you don't take morphine because morphine overdose is gonna be put on the death certificate? No. Death certificates are used for certain purposes. They're used to track diseases. They're used for insurance purposes. They're used -- they're -- they're used to protect patients' confidentiality on issues like this, and morphine and not eating or drinking.

MR. MANKTELOW: So -- so like with the morphine, I -- I don't know of any doctor or anyone else that prescribes morphine to take someone's life. They prescribe morphine to ease the pain. This is -- this is not the same.

MS. PAULIN: If you've ever seen anyone dying --

MR. MANKTELOW: I have.

MS. PAULIN: -- like I have, and on morphine, you know that it can be the -- the -- it could be the lead cause of someone actually dying. It is just a very, very toxic drug that absolutely leads or expedites someone's death, absolutely.

MR. MANKTELOW: So with this -- with this certificate of death, if we put on there that the death was caused by cancer and we're asking someone to sign off on that, a licensed physician or a licensed coroner, how is that not -- how is that not skirting the truth? It's blatantly saying does -- he or she doesn't know that cancer actually caused it. That may be the underlying issue, but how do they know?

MS. PAULIN: You have to remember what a death certificate is used for. We are already going to know and track these cases of -- of this -- of the use of Medical Aid in Dying, so we already have that information. Death certificates would be -- we would be doing a disservice to -- to the rest of the population if we didn't put that underlying disease because we want to know, are there more breast cancer in New York. You know, is there more breast cancer in Manhattan compared to Brooklyn. You know, we want to look at environmental factors, we want to look at --

MR. MANKTELOW: Sure.

MS. PAULIN: -- family factors. So death certificates have a purpose, and we would be not conforming to that purpose if we didn't put the underlying disease.

MR. MANKTELOW: All right. I -- I think we're gonna differ on that. I think that's a question that really needs to be answered. Like my colleague talked about earlier, there are a lot of -- a lot of questions that are very gray and we don't really know how that all works out. All I know is if I was a coroner and I knew that the individual took the drugs to end their life, there's no way in good conscience I could put on that certificate that they died from natural causes such as cancer.

I -- I appreciate the -- the time to -- to answer my questions, Madam.

Madam Speaker, on the bill.

ACTING SPEAKER HUNTER: On the bill.

MR. MANKTELOW: So I got a chance to ask a few questions and much like we've talked about here in this Chamber, we are constantly in Chamber about life. And we have professionals that can probably guess how long we may live, even with a terminal illness. But it's just a guess. There's only one person that actually knows when our time is up and we all know who that is. So are we going to be a Chamber of life or are we gonna continue to be a Chamber of death? What is -- what are our choices? Where are we going to go? We talk about gun suicide. We talked about individuals that OD. We talk about what our young people are doing. What do you think a young person's gonna think about when this Chamber goes ahead and okays, they're gonna see it as suicide. We can call it what you want, Medical Aid in Dying. It is what it is. What message are we sending to our young people?

And as you said earlier on the bill, Madam Chair, that you sat there with somebody. I have, too. I sat there with my dad whose lungs filled up with fluid every other day. But every single time, he wanted us to drain his lungs so he could live longer. Was he in pain? Absolutely.

I just feel that once we pass this, if it passes and is signed into law, what's next? What amendment's gonna come out? What's the next step we're going to do here as legislators? That's not our job. Our job is to save the lives, whether it's painful or not. We tried to save those lives. And as a veteran, talking with men and women in service that have lost their limbs, laying on the ground, wanting to make sure that they live and get to see their family again. You want to talk about pain? Those individuals are in pain every single day.

So let's think about life instead of death. Let's be positive instead of negative. As my -- my -- my fellow Assemblymember said earlier, let's give them the proper care to extend that life. Let's do everything we can to comfort them and that family. I think that's the thing we need to do.

So Madam Speaker, thank you for allowing me to say a few words on this, and I -- I hope and pray that we vote this down. Thank you.

ACTING SPEAKER HUNTER: Thank you.

Mr. Molitor.

MR. MOLITOR: Thank you, Madam Speaker. Would the sponsor yield?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. MOLITOR: Thank you. I know you've been doing this a long time without a break. I've gone to the bathroom twice, so I appreciate it.

I just want to start, if I could, on page 3 of the bill, lines 20 through 22. And it's my understanding that the doctor, the attending physician or that a physician has to diagnose the person, the patient, with an incurable and irreversible illness or condition. That's step one, right?

MS. PAULIN: Mm-hmm.

MR. MOLITOR: And then step 2 they have to, within reasonable medical judgment, determine that that illness or condition will produce death within six months; is that correct?

MS. PAULIN: Yes.

MR. MOLITOR: And so my first -- or my third question, I guess, to you is what does "within reasonable medical judgment" mean?

MS. PAULIN: I think doctors in this situation do this all the time. You know, they know and have the experience that, you know, they're being presented with a patient with one or -- you know, with one type of, you know, what -- let's use cancer, right, what type of lung cancer -- as one of my colleagues said, her -- her father had -- versus another type of lung cancer versus a type of breast cancer. And, you know, we all hear, you know, Stage 1, Stage 2, Stage 3, Stage 4. You know, I'm not a medical professional, but we've all heard that terminology. So we know when we hear Stage 4 we know it's much more serious. And so, therefore, that doctor is assessing that stage by looking at the records and examining that patient. And then they're making a further determination that that person is going to live a certain amount of time. I know recently a good friend of mine was diagnosed with lung cancer, and -- and she was diagnosed with 4th stage lung cancer. And they said to her, *You know, you could live for five years. You know, you're -- you're treatable, you know, for five years*. And they're making a determination then and they're telling her that information.

MR. MOLITOR: So -- well, I'm sorry.

MS. PAULIN: No, go ahead.

MR. MOLITOR: So wouldn't you agree with me, though, that that determination is made based upon the doctor's, you know, evaluation of medical records and -- and experience, right?

MS. PAULIN: Yes.

MR. MOLITOR: But even then -- and, you know, I've heard this from doctors. They'll usually say, *That's my best guess*, right?

MS. PAULIN: Right.

MR. MOLITOR: Because -- because scientifically, doctors do not have a crystal ball, right?

MS. PAULIN: Absolutely.

MR. MOLITOR: And, you know, wouldn't you agree with me that if someone was told by a doctor that they only had six months to live and they -- and this option was legal to them and they took it, that it would be a tragedy if, in fact, that doctor was wrong?

MS. PAULIN: That's not the experience of -- of the 11 jurisdictions and 30 years.

MR. MOLITOR: I understand, but it could happen, couldn't it?

MS. PAULIN: A hypothetical, it could happen. But if you're told you have six months to live, you want to live for as long as possible. You're gonna ask the question, *What can I do to make that longer? Are there treatments? Are there experiments? Are there clinical trials?* You're gonna ask those questions. And if you're told there are none and you're told that no, there is nothing out there that's gonna make you live longer, you might get a prescription. But I bet you're not gonna take it until you are faced with distress and pain like you have never encountered. You're not gonna take it until they say, *You have a week to live. You have two days to live*. You're not gonna take it until the end. That's the experience that we've seen over 30 years. People just don't, *Oh, I am -- I've been diagnosed. You know, I've got six months to live, but I feel great*, and then decide they're gonna take that medication. That just doesn't happen.

MR. MOLITOR: But even saying all of that, right, let's say they get to that point where they find that it's necessary for them to take that medication. The day after they take it, right, they're gone. Or that the moment they take it they're gone, right?

MS. PAULIN: Within a few hours.

MR. MOLITOR: Within a few hours. And so if that doctor was wrong, it would be a tragedy, wouldn't it?

MS. PAULIN: Again --

MR. MOLITOR: Wouldn't it be a tragedy?

MS. PAULIN: -- you know, we're -- we're saying that the person would likely get a prescription earlier, but until they're faced with the pain and the prognosis that their death is more imminent, they don't take the meds.

MR. MOLITOR: I understand.

MS. PAULIN: So yes, it's a tragedy when you lose someone in that circumstance. It's a tragedy. But what you're suggesting is never gonna happen, it doesn't happen.

MR. MOLITOR: Well, I would hope that it wouldn't because none of us have a crystal ball, right?

MS. PAULIN: Correct.

MR. MOLITOR: Surely, you don't.

I would like to go -- I'd like to stay on page 3 and go down to line 30. This is the request process.

MS. PAULIN: Mm-hmm.

MR. MOLITOR: So as I understand this, a patient has to first request orally that they wish for that medication; is that correct?

MS. PAULIN: That's correct.

MR. MOLITOR: And then they have to submit a written request, but that written request can come sometime after the confirming doctor makes their determination; is that correct?

MS. PAULIN: It could come before the confirming doctor or after.

MR. MOLITOR: But it -- but the written request has

-- has to be done before the medication can be prescribed; is that correct?

MS. PAULIN: That's correct.

MR. MOLITOR: Okay. And the -- the two adults, the two adults that have to witness the -- the application or the -- the -- they have to witness the -- the request, those can be any two -- any two adults in the world except for the people that are listed in the statute; is that correct?

MS. PAULIN: That's correct.

MR. MOLITOR: And I -- I noticed through the course of the debate that you stated that those two individuals can have no financial gain; is that right?

MS. PAULIN: The exact words is "entitled to any portion of the estate of the patient upon death."

MR. MOLITOR: So as a patient, I could pay a couple of my friends to sign that document, couldn't I?

MS. PAULIN: You could, I guess. Yeah, you could -- you could -- I don't know what point that makes, but yeah, you could get a couple of your friends. In fact, that's usually who would sign this.

MR. MOLITOR: Or I could pay a couple of strangers, couldn't I?

MS. PAULIN: You could.

MR. MOLITOR: Or the secretary of the attending physician could sign -- could be one of the people that signs it, couldn't it?

MS. PAULIN: Well, we actually preclude anyone in that, you know -- well, you know, anyone that's part of that healthcare facility. You know, that we don't allow.

MR. MOLITOR: Where is that in the statute?

MS. PAULIN: That's on page 4, lines 1 and 2 and 3. An employee.

MR. MOLITOR: Okay. Thank you for clarifying that.

Looking now at page 5, line 3 -- oh wait, I'm sorry. Just going back to the written request. Now, the two people that sign the written request, their signatures do not have to be notarized; is that correct?

MS. PAULIN: Right. They don't have to be notarized, but they -- they're signing it under penalty of perjury.

MR. MOLITOR: Okay. And who then will confirm that the -- that the signatures on that document are actually the people signing them, signing the documents?

MS. PAULIN: If they weren't and it was found out, they would be committing forgery, which is subject to a criminal penalty.

MR. MOLITOR: What if this person committing forgery was already dead? In other words, what if the patient said, *I'm gonna go home and fill out this written request and make up a couple signatures and then give it to my doctor?*

MS. PAULIN: So in other words, the patient themselves was committing forgery?

MR. MOLITOR: Sure. Couldn't that be possible?

MS. PAULIN: I -- I presume, and they would be subject to the same criminal penalties.

MR. MOLITOR: Oh. Okay. But they'd be dead, wouldn't they, after they take the medication?

MS. PAULIN: If -- if they took it and wasn't found out beforehand, yes, they -- they would be dead.

MR. MOLITOR: Okay.

Okay, looking at page 5, line 3... I think it's line 3... I'm sorry. Line 10 through line 13 --

MS. PAULIN: On page 5?

MR. MOLITOR: Page 5, I'm sorry, yes. The attending physician has to inform the patient's family of the patient's decision to request and take medication that will end the patient's life; is that correct?

MS. PAULIN: What -- can you just point it out again what line it was? I missed what you said.

MR. MOLITOR: Yeah, I'm sorry. It's lines 10 through 13.

MS. PAULIN: Ah, okay. Informed -- yes, mm-hmm.

MR. MOLITOR: And then after that, after the semicolon it says a patient who declines or is unable to notify family shall have -- shall not have such patient -- patient's request for medication denied for that reason. Does that mean that the patient can basically say to the attending physician, *I don't want my family to know?*

MS. PAULIN: So if you look at page 7 which is the, you know, the -- the written request and you look at lines 7 through 11, you see a check box, you know, and yes, you can say, *I have informed or intend to inform one or more members of my family, I have decided not to inform any member of my family*, or *I have no family to inform*. So you can check that.

MR. MOLITOR: Okay, thank you.

Now, once the -- once the physician prescribes the medication -- I -- I think we've been over this more than once, but there's -- there's no way for -- or -- or -- I mean, it's possible, I guess, for the doctor to do this, but it's not necessary that anyone make sure that this medication is secured in any way, shape or form; is that correct?

MS. PAULIN: Well, there's obligations to -- like there are any obligations with medication.

MR. MOLITOR: Right. But this is a lethal dose of medication, right, and there isn't -- there isn't any -- any provisions under the law that would make sure that these medications, if taken, were taken in a way that was safe?

MS. PAULIN: There's lots of very toxic medications that are given. For example, hospice medications are toxic and most hospices at home. So you would -- you'd have that circumstance already.

MR. MOLITOR: But hospice doesn't -- doesn't hospice come into the home to take care of the person?

MS. PAULIN: But the medication is there. My mom was on hospice twice in my -- in her -- you know, in our house and -- and the medication was left there.

MR. MOLITOR: Okay, thank you.

Looking at page 10, line 21 -- it's lines 21 through 24. And it specifically states that nothing in this section shall limit civil, administrative or criminal liability or penalty for any professional -- professional disciplinary action or employment, credentialing or contractual liability or penalty for negligence, recklessness or intentional misconduct. If an attending physician misdiagnoses somebody, a patient who then ultimately takes this medication, would this section permit the family to file a lawsuit against that attending physician for medical malpractice?

MS. PAULIN: Well, that's why we have the consulting physician so that doesn't happen.

MR. MOLITOR: But what if both of them commit malpractice?

MS. PAULIN: If they both committed malpractice, yes, of course. Malpractice is still against the law.

MR. MOLITOR: Okay. And you don't foresee necessarily any intervening argument that say that the defense attorney for the -- for the doctors might say, *Well, but I didn't cause their* *death.* Or, *You know, they took this medication*.

MS. PAULIN: You know, everyone will argue whatever they want in court, but if they committed malpractice, that'll be subject to a court decision.

ACTING SPEAKER HUNTER: Thank you, Mr. Molitor.

Mr. Taylor.

MR. TAYLOR: Thank you, Madam Speaker. Will the sponsor yield?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. TAYLOR: Thank you. I just have a couple of questions for you, if I could.

Currently, our there doctors, to your understanding, that currently authorize medicines that potentially could be lethal?

MS. PAULIN: Yes.

MR. TAYLOR: Thank you.

With respect to health proxies. The person that signs a health proxy, do they need to have a medical examination or a mental health before they can sign a proxy?

MS. PAULIN: No.

MR. TAYLOR: Thank you.

Are there any prior legal action required by families that wish to have their person or their loved one removed from life support system?

MS. PAULIN: No.

MR. TAYLOR: So, in -- in -- and in that case, depending on what the illness is that brought that individual to that space, what would most likely their death certificate be? The drugs that kept them alive to that point or would it indicate what it was, why they expired?

ACTING SPEAKER HUNTER: Why they expired.

MR. TAYLOR: Okay. Thank you.

And with respect to one -- one more piece. Does this legislation require patients to potentially negate their rights in any other type of information that they need to secure in turns of making good decisions?

MS. PAULIN: Wait. Say that one more time.

MR. TAYLOR: Does this legislation require patients to waive their rights to get all the understanding that they need with respect to their medical condition?

MS. PAULIN: No. They have to -- they don't waive their rights ever.

MR. TAYLOR: So that means they can get more than one opinion --

MS. PAULIN: Yes.

MR. TAYLOR: -- right? Okay. Thank you.

And I just have a couple of more questions.

Only terminally ill -- terminally ill adults with six months or left qualify for this?

MS. PAULIN: Yes.

MR. TAYLOR: Thank you.

Do they have to have a mental capacity or capability check? Do they have to have someone check them out medically to make --

(Inaudible/crosstalk)

MS. PAULIN: If -- if they -- they -- they don't unless the consulting or the attending believe that they need to.

MR. TAYLOR: And two doctors are required to sign off if --

MS. PAULIN: Yes.

MR. TAYLOR: Okay. Now these doctors are not coming from some foreign country? They're here. They're licensed. They are bonded to do this type of service in the State of New York --

MS. PAULIN: Yes.

MR. TAYLOR: -- correct? Okay.

MS. PAULIN: Yes.

MR. TAYLOR: Thank you.

Can anyone else take the medication that's been given to that patient other than the patient?

MS. PAULIN: No.

MR. TAYLOR: Thank you.

In the last 25, 30 years of this being approved in different states, even in Canada, has there been a single substantial case of abuse under those laws --

MS. PAULIN: No --

MR. TAYLOR: -- to your knowledge?

MS. PAULIN: Not one case of coercion or abuse.

MR. TAYLOR: Okay. Thank you very much.

Madam Speaker, on the bill.

ACTING SPEAKER HUNTER: On the bill.

MR. TAYLOR: Thank you.

As -- as -- as I sat here, and this is not easy under any circumstances, whatever side you find yourself on, it's a difficult place to be. And I stand here and I want to share a couple of things. And in one that -- that -- that really glared at me was at the age of 25, my neighbor informed us -- my family and I, living in -- in the Heights, that she had six months to live because she'd been diagnosed with cancer. We were wrecked. I mean, tears and water everywhere. My sister, her greatest friend, was just inconsolable. In three months my sister was dead from a car accident, and the woman lived six months, you know what I'm saying. We don't know around what corner life is going to end. And we want the best. We want to be able to do those things that make sense.

So I -- I -- I guess -- let me just share a few things in how I got here. I -- I came to this decision not because it was easy. Trust me, when I saw the yellow shirts in the hallway, I was like, I know you're not even thinking about talking to me. Don't even look in my direction. Why? Because I'm a clergy. I have my own for -- format and formation of what I believe. And I still have those beliefs. And I'm standing here today for myself after spending two-and-a-half years of crucial time with my dad whose life was deteriorating. And when I say spend time, I'm not at the doctor and people saying -- I'm talking about changing bandages and doing all of those individually yourself. And having to deal with soiled sheets, washing clothes, and all of that. And you're doing that 14 hours a day at any given time. And my father said this to me, he said, I can't take this. And the first time I heard it I knew what it was but I didn't want to own it. I didn't want to own the idea that my dad is telling me he wants to cash out. And I tried not to own it. And I tried to deny it. But at the end of the day that's exactly what -- and then it got to the point he was -- he was begging.

I'm not here to change anybody's mind. I'm just sharing my travel to this space where I now can stand up here and say, you know what, I'm all right with this. And for the people that have the decisions, and they have this idea of what they think their Creator wants us to do, God bless you, because I had my own struggles with that. But I landed on this space right here.

Medical Aid in Dying is -- is not a bogeyman. It's not inevitable -- it's -- it's -- death's inevitable. It's going to happen. The question is, are we prepared for it?

And I can't tell you as a pastor and a clergy how many times I've been in that room when people are trying to decide, the -- the doctor just gave us this news. Whatever that news is, and the person is lying there, and they're not gonna get up, and then you have someone that says, Do Not Resuscitate, because that's what they wanted. We're not taking anything from anybody. We're saying let's let them have that decision, and they'll do it in a space where they're competent and able to have that discussion. Because one of the things that we don't want to talk about is the idea that me and my special loved one, we never talk about, but it's inevitable, and it's happened. And what does that mean? That person is going to die. But why don't we do it with some dignity? Because truth be known, they could jump off a bridge, in front of a train, in front of a car, all of these things, and they're saying, will you respect what I have to do? And it's a difficult one. And it's gonna take a whole lot of everything to get your mind around it. But will you respect that? And it's -- it's everybody's individual choice. We're not mandating anybody does anything.

In this State that we've done so much, we're saying you have an opportunity to select this if you chose -- choose to. And if you don't want it, it's okay. But if you do find you that you need it, we want you to have it. And not feel any kind of way.

Now I think there's something called a HIPAA Law. And the HIPAA says that you can't tell my business to anybody. And if I still don't want my doctors to tell my children or my spouse what's going on, then doggone it they can't. But it doesn't stop that train from leaving the station if that person have reached that conclusion.

I just want us to encourage us to approach this with an open mind. And, listen, if I am wrong, I have a God that will judge me, but I'm all right with this journey because I spent time with my father. And listened to him beg about how he did not want to live in this condition. And there was nothing I could do. And ultimately he died from cancer, right there in that room. The quality of life changed. And for me it -- it meant a lot. And I didn't start out wanting to support this. But as I spend that time -- I'm not talking about you going by the nursing home and see them, they look clean and every -- but when you're in the trenches, and you're the only person -- or my wife, speaking -- it changes the narrative. And -- and if you've been there? God help you come through. And if you never been there, I pray you never have to have that experience. And my decision is my decision alone. I'm not here to get anybody to change it, but I stand behind what I said.

And I want to commend the sponsor for having the ability to bring this here, and the Speaker for having it come to the floor, because we're in changing times. It's going to happen. It's inevitable. Because we all know what a death certificate looks like. But more importantly, we have a birth certificate, but we don't know the day and the hour, and what's gonna be in the box for us.

But I think that the people in the State of New York, if they want to do this, they should have that option to do it. We done a whole lot of other foolishness. And I'm just saying, give people an opportunity.

Thank you, Madam Speaker. I'll be voting in the -- in the positive.

(Applause.)

ACTING SPEAKER HUNTER: Thank you.

Mr. Maher.

MR. MAHER: Thank you, Madam Speaker. Will the sponsor yield for some questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. MAHER: Okay. Thank you. So I just want to qualify and try to correct a statement that was just made.

So can anyone take the medication even it's not prescribed to them under the law? No. But anyone could take that medication if it's physically there. That's just a matter of fact, would you agree?

MS. PAULIN: Yes. They can take any medication in any medicine cabinet or -- that they could find. This isn't --

MR. MAHER: Okay.

MS. PAULIN: -- something that they could get prescribed.

MR. MAHER: Okay. I just wanted to make that clarification --

MS. PAULIN: Yeah.

MR. MAHER: -- which we all know, but definitely wanted that on the record.

Now, I want to go further into that. Because a statement that you make earlier, correct me if I'm wrong, is that in these cases where the medication is prescribed, 40 percent do not use it.

MS. PAULIN: Thirty-eight percent.

MR. MAHER: Thirty-eight percent. Thank you. Nearly 40 percent.

So wouldn't you agree that it is possible that someone has used this medication, even though it was not prescribed to them, with that much of a percentage out there?

MS. PAULIN: So you're saying among the 38 percent, you think somebody might have found it and used it? Or --

MR. MAHER: Yes.

MS. PAULIN: I see. So we know who has taken or gotten the medication. And we know that it's been returned. Those are tracked and those are available. So we know that it's not among the 38 percent, it -- you know, that you're worried about.

MR. MAHER: So you're saying, on the record, that the 38 percent number, which is -- comes out to thousands of -- of folks that do not use this medication, all of that has been -- was returned, and there's a record of that?

MS. PAULIN: We actually have a requirement in our bill that it is returned. Yes.

MR. MAHER: I understand the bill that we're currently discussing, but out of the 11 in the United States and two different territories in the -- in this country, I assume that's where that 38 percent number comes from, correct?

MS. PAULIN: Yes.

MR. MAHER: So you're saying in all those states and jurisdictions, that there is a record and a process, and that we know for sure that medication was returned?

MS. PAULIN: So I -- I don't know each individual ones. I'm not going to attest to that. I -- I do know that they're tracked. I do know that we worry as we do with any controlled substance that -- that we know who has gotten it. We know that, you know, they have to sign off that they've received it. And they're told, when they do receive it, you know, what the process is for returning it.

MR. MAHER: Okay. Just -- that is very concerning to me. But that's -- that's just one of the questions that I had.

I wanted to chat quickly about -- ask a question about the sixth month. I -- I know that you've talked about -- it's not an arbitrary number. There's some precedent in terms of the legal system on six months being used, as, obviously, the other 11 states and jurisdictions that use it, what would happen if someone did receive a terminal diagnosis with six months or less to live, is prescribed this medication to end their life, does not take it, and actually lives beyond the six months?

MS. PAULIN: Then that's the -- that could easily happen. You know, we know that doctors, 85 percent of the time, tell you that you're going to live a certain amount of time and that, indeed, it's less. But then there's 15 percent of the time where they're -- that, you know, they are people who are able to live longer. So we do know 15 percent of the cases that they are going to live longer. However, because of this medication is used almost always at the very end of your life, when you're in such dire pain, that's the reason people take it; that, it's not going to be taken in those earlier stages.

If, you know -- you know, honestly, if my sister would have had longer to live, she would have been so happy and so would the rest of us. And -- and I know that's the case of my -- of my good friend who has cancer now. We want her, and she wants herself, to live as long as possible. But I also want for my loved ones to be able to decide when it's too much for them, physically, and that they can't cope any longer. I want that dignity for them, to that make decision. And that's what this bill's all about.

MR. MAHER: I certainly can understand the intent of this bill. A lot of my concerns are the unintended consequences that could exist.

And I know during a previous debate you made the statement that this could not happen, would not happen in terms of the doctor being able to say, hey, you have six months to live, and that not really being the case in -- in terms of the localities and states that have had this on the books. But you also just admitted that it could happen that they live past six months. And then you have that 38 percent number where the medication is not used. So are there any records of -- of that 30 -- 38 percent that some did recover medically?

MS. PAULIN: You mean, that they went into remission --

MR. MAHER: Yes.

MS. PAULIN: -- or --

MR. MAHER: Any of the above.

MS. PAULIN: It could easily be the case. I -- I hope for the sake of them and their families. Yes. I don't know, though.

MR. MAHER: Okay. Because -- because I thought I just remembered you telling my colleague that that's never gonna to happen. It doesn't happen. But I'm glad, on the record, for -- for you to say that, because I agree.

I also want to return to another conversation, and this is one that gets a lot of debate, especially in the -- the disability community and a lot of other areas. When we look at the text of the bill, we have these two distinctions: Incurable, not untreatable. So "untreatable" is not in the language. And I know that you say you're setting -- it's setting legal precedent, that that's what this mean, but it's not actually in the bill.

MS. PAULIN: The words that we used are "irreversible" --

MR. MAHER: Right.

MS. PAULIN: -- right? So if the illness is irreversible through a treatment, a trial, which may not be exactly the same, then that's -- that is exactly what we're intending for it to mean.

MR. MAHER: Okay. So when it comes to "untreatable," that word is not in there, but "irreversible," you're saying --

MS. PAULIN: Is that word, yes.

MR. MAHER: -- is the intent --

MS. PAULIN: Yes.

MR. MAHER: -- and that is the practice, you're saying, throughout the country and the states where this exists?

MS. PAULIN: Yes. Yes.

MR. MAHER: Okay. I also have some issues with that, but we'll move on. Thank you for answering my question.

Okay. So I -- I want to get into another statement you made about most people being influenced by their loved ones. I would agree. And when it comes to the issue specifically about someone who maybe has kidney failure and is on dialysis, would it be your assertion that if they were on dialysis but chose not to continue on dialysis, that's their choice, that they should be eligible for, and would they under this law be eligible for this medication?

MS. PAULIN: So they might be eligible for it, but usually when you come off of dialysis, you decide you're not going to take it anymore, the death is pretty quick. So you wouldn't have time for your attending and your consulting and the written, you would be dead.

MR. MAHER: Okay. So you're saying if an individual made the choice to get off of the dialysis, then they would be qualified to receive this medication, even though it's a treatable disease?

MS. PAULIN: I think it's -- you know, we have seen cases like that, yes. But, again, they would be dead. So it's not -- it's not even a, you know, it's never gonna get tested.

MR. MAHER: I understand. But you just said that if it is treatable, they wouldn't be able to qualify. But I just gave you an example of a disease that would be treatable, but you're choosing not to take that treatment, and you said that it would. So I'm a little confused.

MS. PAULIN: So I -- I think it's a debate that -- that people might have. But, again, it's not one based on a reality.

MR. MAHER: Okay. We're gonna agree to disagree again there, but I thank you for answering the question.

I want to ask you about mental health, another colleague -- or several colleagues brought this up. When it comes to major clinical depression, would you consider that medical disorder that could potentially affect someone's competency?

MS. PAULIN: It would be competency to be able to determine or assess your own or -- it would be competency in regards to making a medical decision or health decision for yourself. So it would be identical to -- to making a decision about having heart surgery, or identical to making a decision about having your tooth extracted, or identical to making a decision whether or not -- whatever.

MR. MAHER: Do -- do you -- do you believe that if someone is suffering from a major clinical depression diagnosis, that it affects their competency in making decisions?

MS. PAULIN: I think that it -- it would likely vary. I'm not a psychiatrist or a psychiatric nurse or a psychologist, so I can't say that.

I can tell you that if I was going to die, I would be depressed. Whether I would be depressed enough to impact -- to be -- to be considered so depressed that I couldn't make judgment, you know, then I would get assessed for that --

MR. MAHER: Okay.

MS. PAULIN: -- under this bill.

MR. MAHER: I want to bring up a study and ask a question. This was done in Oregon. It was on 200 terminally ill cancer patients. And the prevalence in this case of depressive syndrome was 59 percent among patients with a pervasive desire to die, but only 8 percent among patients without such a desire. Despite that finding, many health professionals and family members of patients in Oregon who pursue taking the medication generally do not believe that depression influences the choice of facing death. However, a recent Oregon-based study demonstrated that some depressed patients are slipping through the cracks. Among terminally ill patients who received a prescription for a lethal drug, one in six had clinical depression. And of those patients in the study who received the prescription, three had major depression. All of them went on to die by lethal injection but had been assessed by a mental health specialist.

So it begs the question, if we have this process where a psychologist is seeing that someone has a major medical depression condition, and they are still saying they're competent enough to make this decision, doesn't that leave room for some error?

MS. PAULIN: No, I don't think so. I think what you're assessing are two different things. You know, what the assessment that the psychiatrist, nurse -- psychiatric nurse or a psychologist is making is whether you're competent to make a medical decision.

I think we've all been depressed. Members of this Chamber have lost children. Members of this Chamber have lost other loved ones; their -- their spouses, their -- their mother, their father. And, yes, you are depressed when that happens. Are you so depressed that you can't make a medical decision? No. So why is it different if you have -- if you're depressed because of a medical condition?

You know, I don't see any -- any different. You know, I think depression could sometimes be worse, you know, if you --

MR. MAHER: Yeah. I agree --

MS. PAULIN: -- lose a -- lose a sibling, a mother, a father or a child.

MR. MAHER: Okay. My point being that, it -- in my -- it's my belief that a severe case of depression would qualify for someone not being in the right place to be able to make that competency --

MS. PAULIN: It depends on the depression.

MR. MAHER: And I think that's open to interpretation, which is another problem I have with this -- this law as it's read -- as it's written.

Were you able to meet with any of the religious leaders that had another view on this? Did you personally meet with any religious leaders or organizations?

MS. PAULIN: I have met with many, both pro and con.

MR. MAHER: I'm glad to hear that. And I have -- did the same thing two-and-a-half years now researching this issue. I have an open heart and an open mind to really meet with advocates, talk to them, cry with them, hear their stories. And when I got to a place where I could not support it, I remember going face-to-face and -- and having those tough conversations, saying this is why I can't support it. You do support it. So I have one more question.

When it comes to children with terminally, ready illnesses, why are not -- they not part of this bill if this is something that really you believe in when it comes to adults who are terminally ill?

MS. PAULIN: Because we don't allow children to make medical decisions for themselves, and most -- or at least in most instances. You know, 18 is the year that we've chosen in our law to allow people to make medical decisions for themselves. And because this is a medical decision for yourself to self ingest, we chose the same number, 18.

MR. MAHER: All right. Thank you for your questions.

Thank you, Madam Speaker.

ACTING SPEAKER HUNTER: Mr. Dais.

MR. DAIS: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. DAIS: Thank you, Madam Chair.

To enter a hospice care or palliative care, doesn't two doctors have to determine that you have a terminal disease?

MS. PAULIN: Yes.

MR. DAIS: And that's one of your own doctor [sic]? The -- the first doctor is your own doctor?

MS. PAULIN: Yes.

MR. DAIS: And the second doctor has to be, I believe, the medical director of the hospice?

MS. PAULIN: Usually, yes.

MR. DAIS: Usually. So that's similar to the medical -- to -- to your bill right now?

MS. PAULIN: Yes.

MR. DAIS: So over time I think there's been a strong belief throughout this Chamber that no one has an objection to hospice or palliative care. Actually, in fact, I believe we need to make it more compassionate, increase funding, and make it better for all New Yorkers.

MS. PAULIN: Yeah. In fact, we changed the statute in 2021 in New York to allow it to be one year.

MR. DAIS: One year?

MS. PAULIN: Yeah. If -- for hospice care in New York.

MR. DAIS: So you say in this Chamber, though, we have -- we do believe in hospice care. We believe in palliative care. And the system where we have two doctors, who are independent, even, granted, the hospice medical director is one of them, who could say they might have actual -- some type of investment in the decision, but the Chamber has agreed that that is okay?

MS. PAULIN: Yes.

MR. DAIS: So now we have two independent doctors that have no financial -- you have no financial stake in the decision-making in medical aid, which, outwardly, will be even more independent than our current medical -- than our current hospice and palliative care regulations?

MS. PAULIN: Yes.

MR. DAIS: Additionally -- well, one thing I think is clear, it's not only about these -- most of these people, in the majority, have some type of terminal illness, but it's also that the pain and suffering is the number one cause in addition to the terminal disease --

MS. PAULIN: Yes.

MR. DAIS: -- to -- to terminal disease?

MS. PAULIN: Yes.

MR. DAIS: As we have seen, it's to the point where it's such physical impartments where we've had to come up with ways so people can administer the medicine in -- in an effective way or themselves?

MS. PAULIN: Yes.

MR. DAIS: So, to your point earlier, it's not that one we're doing this in the beginning of this determination, but usually as -- as a last option because everything else has ran its course?

MS. PAULIN: That's usually the case.

MR. DAIS: Thank you.

And the last part -- two -- two parts to -- on the discussion, the neutral witness similar to we have in our states -- in our wills, and our trust and estate law, correct, also?

MS. PAULIN: Yes.

MR. DAIS: And the last part, when we're talking to doctors, isn't it true a lot of times families don't even respect the DNRs of their loved ones? Because even if their loved one signed it and they made clear, isn't it often the family that ask the doctors and other medical officials to break the covenant of their loved one?

MS. PAULIN: I think it's extraordinarily hard for a loved one to make that decision.

MR. DAIS: And therefore that's more important why the independent decision should be of that person who has the liberty to make their own decision?

MS. PAULIN: Absolutely.

MR. DAIS: Thank you, Madam Chair.

On the bill.

ACTING SPEAKER TAYLOR: On the bill.

MR. DAIS: To the Chamber, I know this is an emotional issue. Talking about death I can't speak for anyone else but I can speak for myself, death gives me nightmares. To understand our own mortality is the very meaning of life. Without death there is not life. And I truly believe that life is a gift. At the same time someone's liberty and the pursuit of happiness. The one thing I know about New Yorkers they don't like to be told what to do. This is a moment to give someone who's in the most critical part of their life freedom to make their decision. That is not my right to take away from them. I might have a religious belief against this, but my religion should not dictate how someone else lives their life. Freedom of religion is equally freedom from religion. So I can still maintain my morals of how I live my life, but I'm not going to put my religious morals on somebody else because I do not believe that is what we should do as Americans. But most importantly what we need to do is remove ourselves from the situation. We already have palliative care and hospice care that relates to this. We have already approved that. What is the difference of somebody making decisions where a doctor says you have six months to live and they take themselves off the dialysis, they take themselves off the medication by allowing them to live, and force that person to have the right to decide when and where they want to have that moment for themselves. How (inaudible) loss a loved one when you can have that one final goodbye, that one apology to go back and say you know what, I'm sorry what happened to you back in 1995, I wish I could make that up to you. This is an ability to get people to grab back their dignity of life and just make that final decision. When we say 38 percent decided not to use it, that shows that this (inaudible) -- that means they changed their mind, they have the ability to have the freedom to change their mind. However, when that pain gets so excruciating, when their quality of life has deteriorated to such a level where they can no longer take it, who are we to be selfish to take away that decision from them? That's one of the greatest freedoms you can have is to decide how you live your life, especially at the very end.

And this moment means a lot to me because I remember back in 1997 I actually debated this in high school, and the one thing I came back at the end. I want the ability to choose my destiny and I will not take that away from somebody. I'll be voting in the affirmative.

Thank you.

ACTING SPEAKER TAYLOR: Mr. Jensen.

MR. JENSEN: Thank you, Mr. Speaker.

On the bill.

ACTING SPEAKER TAYLOR: On the bill.

MR. JENSEN: Thank you. I appreciate my Conference allowing me to use our Conference's second 15 minutes on debate to -- to further talk about this very important topic and share some of the thoughts that I've heard throughout the debate. And like my colleague to my left just said, this has been a very passionate and emotional debate today and certainly very good questions raised both by opponents and proponents of the legislation.

And in my five years in the Assembly this may be the most influential policy that I may be a part of making, and maybe throughout my career. And I'm glad that today this was not about partisan politics, but rather it's been a conversation about morality. It has not been -- I've been proud that my colleagues despite our strong faith who may be opposed to this bill, I don't think once have used our own faith as a reason why we are opposed, even if there may be reasons for that. This question today on this bill is a question of life and death. And the definition of who would be eligible means terminal. We're all terminal. Living is a key component of dying. No one wants to see anyone they love, especially someone they love, endure unimaginable pain, unimaginable suffering. However, is the government sanctioning the death of those in that pain and in that suffering correct without ensuring that steps are taken to lesson that pain and lesson that suffering.

In the five years that I've been in this Chamber, my heart has broken for every single advocate, including those above me who have come to me to share their story. It is broken for my colleagues who shared their story. It is broken for the sponsor of this legislation who has shared the story of why she's so passionate for this legislation. My heart has broken for my constituents who have come to me and asked me to support this bill. However, my heart breaks for the people who will utilize this if it does become law. My heart will break for the individuals who have and will have to deal with the side effects of they're loved one committing suicide, whether it's through Medical Aid in Dying or through other means. My heart breaks for the idea that as a State we are going to take steps to sanction the giving up of hope. Speaking for myself, hope is what gets me through the day every day. I pray to God for health and strength and hope the rest figures itself out.

We've heard a little bit today and we've heard throughout this debate, I've heard from my colleagues that they have to support this, they feel instilled to support this because of polling. And in politics everything we do, polling can be a tough thing to overlook. While we are all here to represent the interest of our constituents, our constituents also trust us to use our best judgment. And on some issues, on some policies they are too nuanced. And we have to use the trust that our constituents gave us on an issue we may happen to know a little bit more about the long-term effects than they do. And I think a lot people in our State, when they see this on a poll they don't know what it means. They don't know what safeguards are and are not in this legislation.

We've heard a lot of talk about hospice and palliative care, about how this is no different than hospice and palliative care. A few weeks ago the sponsor and I debated legislation that would restrict providers of hospice and palliative care from operating in the State. We are last in the nation in hospice and palliative care with the amount of one provider for every half million New Yorkers. While at the same time you're looking to make it easier for terminally-diagnosed New Yorkers to end their life while simultaneously restricting access to proven steps to lessen pain and suffering.

Right now the United Kingdom is going through this very same debate. And the former leader of the labor party and Prime Minister Gordon Brown said for his country's debate, quote, "We need to show that we can do better at assisted living before deciding whether to legislate on ways to die." I think that's poignant as a part of this debate.

In addition, to palliative and hospice care we hear time and time again from our colleagues in this Chamber, down the hall and on the Second Floor in the Governor's office that we need to do more to support the mental health challenges New Yorkers are facing. And when someone received a terminal diagnosis and are told that they will die, what better time is there for them to not just receive that mental healthcare, so that they can process everything that goes along with that diagnosis.

And let's be honest. A diagnosis is not the end.

Medicine is not an exact science. It is a science of a certainty combined with the art of probability. And for individuals who have just received a terminal diagnosis and hear a doctor say, *your life will end in six months*, they are in a profoundly vulnerable state, and I do not believe that this legislation provides enough safeguards to ensure that they are emotionally and responsibly processing that diagnosis, as well as what it would mean if they decide that they do not want to fight that fight any longer. And that they would be able to have their life ended through their own choice without any requirement to pursue alternative treatment or access palliative care to end that pain and suffering and without any guarantee that they will receive the necessary care that they would need to process that diagnosis.

There's been talk throughout this debate today and throughout this issue that the scope of this legislation can never change. That there's enough language in this legislation to ensure that it will stay six months of a terminal diagnosis forever, but there's no guarantees of that.

On matters of life and death we have seen the New York State Court of Appeals overrule the Legislature before. The Legislature decided that the death penalty was legal and it was the Court of Appeals who stopped it. New York's Constitution now guarantees and prohibits discrimination based on many things. And two of those classifications are age and disability. What is to stop an individual, whether like my learned colleague to my immediate left when talking about a minor, or an individual with a disability that isn't covered under this legislation to challenge the constitutionality of this law and say that why is it restricted only to those with a terminal diagnosis in the eyes of one presiding physician and a consulting physician they may never have met in person? Eleven states -- 11 states in this country have Medical Aid in Dying, but some of them are already looking to expand the scope of their practice. And we haven't talked about the other nations that have Medical Aid in Dying (inaudible) laws on their own books. Our neighbors to the north in Canada have seen their medical assistance in dying expanded to include access for people whose deaths are not reasonable foreseeable, and that there are plans to expand to those with mental illness.

The Netherlands, Belgium, Switzerland, Spain and Luxembourg all allow individuals to commit government-sanctioned death for mental conditions. Do we want to even crack open the door for future expansion in those same ways that we've seen in those jurisdictions? We don't want to get to a point in our State where New Yorkers living with disabilities who believe that they are a burden to their families or to society and believe that death is preferable to life.

Certainly when Caesar crossed the Rubicon it was a shallow little river, but looking what crossing it did. Passing this legislation today could have unforeseen consequences despite the best assurances of the sponsor and the individuals who will vote for this bill. And it's not hard to believe as we've heard a couple times today that no other state where this has been legal that there's been evidence of coercion. It's hard to allege coercion when your heart no longer beats and there's no air in your lungs. New Yorkers will still die alone because of this. Families will still have unimaginable pain and suffering. You take that cocktail of that life-ending medication there are no take-backs. There are no second chances. There are not let's go back on the feeding tube, let's start that treatment again. You choose to end your life and your life is over. What will be the impact on family members whose father, mother, brother, sister, sons and daughters who are so scared of what living will mean with a terminal diagnosis if they choose the uncertainty of death. And what impact will this have on our society as a whole if New York State is a government that sanctions the ending of one's live because of the opinion of two people? This is a hard debate. This is something, my very first meeting when I became a member of the Assembly, was with advocates for this bill. And I understand my colleagues who've shared their own personal stories on why they have come around and believe that through their own experiences they see the wisdom in this. But we are not just talking about the experience of 150 members of this Chamber. We are talking about what it means for the 20 million people who call New York home today and for future generations. And it's tough to legislate on a topic such as this based on assumptions and guesses.

Life is an unexact science. And until we have knowledge and assurances that this bill will be implemented on the way that many people believe it will, I believe it is improper despite the best intentions of all those involved and who want to see it pass to move today.

I appreciate my colleagues' attention. I appreciate the honest feelings that were shared by everybody today and I appreciate and value that we are a serious institution who can discuss an issue like this in good faith and with true hearts. Thank you, Madam Speaker.

ACTING SPEAKER HUNTER: Mr. Blumencranz.

MR. BLUMENCRANZ: Thank you. Will the sponsor yield for some questions?

ACTING SPEAKER HUNTER: Will the sponsor yield?

MS. PAULIN: Yes.

ACTING SPEAKER HUNTER: The sponsor yields.

MR. BLUMENCRANZ: I'm sure you've had a few today, but I'll give you a few more.

MS. PAULIN: I have good shoes on.

MR. BLUMENCRANZ: So given that New York State ranks 51st in hospice utilization, how does this bill ensure that patients are not choosing Medical Aid in Dying due to their lack of access of palliative care and hospice options as referenced in Section D and F of your bill?

MS. PAULIN: So we put a few things in the bill that I think will create more hospice opportunities and provide more access for people. We require that a physician, the attending physician notifies and informs about hospice and palliative care. We require that there's an option or that the DOH puts on their website information in multiple languages about hospice, those things don't exist. And we've seen in other states that have already adopted Medical Aid in Dying that hospice has actually increased.

MR. BLUMENCRANZ: So you say that the bill has some affect on -- on increasing hospice care?

MS. PAULIN: Yes, yes. I believe it will.

MR. BLUMENCRANZ: Can you enumerate how exactly it does that specifically?

MS. PAULIN: It has done that across the country in jurisdictions where there has been Medical Aid in Dying adopted.

MR. BLUMENCRANZ: Okay. So the bill mentions the feasible alternatives as you're talking about and appropriate treatment options including but not limited to palliative and hospice care.

Given the current state of hospice care in New York, what concrete measures are you referencing that will be implemented to guarantee that these alternatives are genuinely accessible and -- and affordable to patients regardless of their socioeconomic and -- (crosstalk/inaudible).

MS. PAULIN: So most hospice patients are on Medicaid or Medicare, so insurance is not an issue for hospice care. For the most part I think it's 88 to 98 percent in different -- depending on the state. So I'm not worried about the affordability. I -- and most hospice is done in the home now. So you don't need a physical environment to do hospice. So it would just be -- and -- and so the current -- the current operators of hospice could simply employ more nurses to go into the homes. I realize that there's a workforce shortage on nurses so we'd have to help that situation, but that's really all we'd have to do to improve hospice.

MR. BLUMENCRANZ: But not just nurses, and I'll tell you. In my exploration of this piece of legislation, and I came in with a very open mind, I discovered in talking to hospice nurses in facilities across the State, there are areas where they basically tell you there is no at-home hospice options, especially in Upstate New York. That's just -- it's not on the table. You'd have to go really far away from friends and family or where your healthcare providers are. It's just not a given. How -- how will this fix that discrepancy? Will we sign a waiver --

MS. PAULIN: I think they'll be more demand. Right now part of the problem is that the demand -- people don't know about hospice and palliative care. When that demand increases, because of the provision of insurance that already exists, we will see this industry grow.

MR. BLUMENCRANZ: Has the provision -- the insurance provision you're referencing, has there been any empirical data to show that has increased awareness and demand --

(Crosstalk/inaudible)

MS. PAULIN: No. That's why we put in the bill that there needs to be more information available to people and it should be in multiple languages and on the website. That was something that we worked on with the hospice advocates and we were very happy to put that in the bill.

MR. BLUMENCRANZ: So no matter the language, though, if -- if at-home hospice is not available, will the information provided from DOH say, sorry. You don't have an option for at home or really much of a hospice option at all, but here's your care options not including --

MS. PAULIN: I -- I think we have seen across the country when this bill is in law it increases hospice. It increases it in areas that you're talking about where there is no current hospice, so I have confidence that that will be the same in New York.

MR. BLUMENCRANZ: So if this legislation -- if this legislation passes this bill, what assurances do you have that we don't further deprioritize addressing the systematic problems within hospice and palliative care infrastructure? We often do things to disincentivize certain hospice avenues. What are we doing here besides just in other states where this happens, there's just more hospice care that --

(Crosstalk/inaudible)

MS. PAULIN: I think as legislators we have a responsibility to bring up -- we're hearing our constituents want hospice care and can't avail themselves of it that, you know, because of a certain reason or inadequate funding or a need for more infrastructure, then it's up to us to bring that forward and collectively we will address it when the demand is there. Right now the demand is not there in New York. This will create a demand.

MR. BLUMENCRANZ: So but how effective can the informed consent process be as detailed throughout the bill when patients may not have a clear understanding of what true comprehensive palliative care can offer? We don't see what the DOH is going to provide. There's no record to show that DOH has to do this before. This is implemented immediately, so is that ready and available? Is it already up online?

MS. PAULIN: Well, we also require for the attending physician to provide that information to their patients. One of the criticisms that we've heard from the hospice community is that that information is not provided. This law requires them to provide that. So, if somebody is facing terminal illness and they say oh, I want to talk to you about the possible provision at the end of this terminal illness when I am in dire pain of Medical Aid in Dying, they will hear about those treatment options as a retirement to get the medication. And just hearing about those options, they may choose to avail themselves of it. They certainly will in most cases try to avail themselves of that before they decided to take medication like this.

MR. BLUMENCRANZ: So in essence what you're saying is only when they're at the decision-making point where they're, do I take the pill or do I continue with care, will they be mandated to hear that palliative and hospice care is available to them.

MS. PAULIN: A doctor can tell them that at any point in the -- in the process, certainly, but this requires them to tell them about that if they inquire about Medical Aid in Dying. So we have -- we have not seen a requirement or that provision of information in our law in any other place expect for this potential statute. So I would argue that this is a good thing that we are requiring information on palliative care.

MR. BLUMENCRANZ: So much of the research and analytics provided surrounding the utilization of hospice and palliative care does show the diverse background and the scale and size of the amount of patients who are in government-funded healthcare. So does this bill adequately address the potential for implicit bias within the medical community which when coupled with unequal access to care could lead to certain populations being disproportionately all for or choosing Medical Aid in Dying without being given the full scope that you're talking about here?

MS. PAULIN: So wait. I'm a little confused by your question.

MR. BLUMENCRANZ: Will -- will -- will -- is there a potential for implicit bias within the medical community because coupled with the unequal access to healthcare that we have in our State in certain areas with completely no option for at-home hospice whatsoever, is there a disproportionate offering here that may lead to give more people choosing it in certain location based decisions versus whether that care is provided or not? Are they weighing the same decisions? Decisions are not the same depending on care options available.

MS. PAULIN: So there's always disparity in healthcare unfortunately. You know, I'm going to see it here. We've seen it as this has gotten implemented. For example, we know that if you have some college and/or greater than that, you will more likely opt for this. We know that if you're white, you're going to more likely opt for this. We know that, you know, that if you're -- so if you're more educated and you have potentially higher wealth, you're going to opt for this. So there's always disparities unfortunately in healthcare and we have to always watch for them. That's why we -- you know as one of my colleagues pointed out that's why we ensure that people have access to insurance health so that the disparities are less, but there will be disparities. There's no question. They exist every day.

MR. BLUMENCRANZ: All right. Thank you so much. Thank you.

ACTING SPEAKER HUNTER: Colleagues, we're coming to almost our close of four hours.

Ms. Reyes, you're up next and you'll be closing the debate.

MS. REYES: Thank you.

On the bill, Madam Speaker.

ACTING SPEAKER HUNTER: On the bill.

MS. REYES: I wanted to entered some things into the record. I've heard some comments about -- I've heard the term palliative care, pain management, hospice used interchangeably and they are absolutely not. Somebody who chooses palliative care is not somebody who is terminal. It is somebody who has a chronic condition that needs pain management who can live for many, many years and that you do in combination with some holistic treatment as well; therapy, visualization, as well as pain management.

Hospice is reserved for people who have about six months to live who we have come to the determination that there is no longer anymore treatment that we can provide for this person and we usually send them home with hospice care so that they can be comfortable at home for the reminder of their days.

The reality that we see oftentimes, though, is that people in hospice care come back and come back and come back to the inpatient setting, because even with hospice care, we have a very difficult time managing their pain. And it is a very unfortunate circumstance. And I appreciate all of my colleagues and all of their concerns and their points of view, but I wanted to speak as somebody who many of you know I am a nurse, but I am a inpatient oncology nurse and I have been tasked with the incredible responsibility of caring for people in their end of days. And when we tell people that they have about six months to live, it's not somebody who can with further treatment maybe longer. I wanted to provide a little color to some of those arguments, some of the cases that I've personally cared for.

I've had women with breast cancer who after multiple rounds of chemotherapy come in with a fungating breast wound where their breast literally falls off. And they -- that wound as this continues to metastasize spreads from the breast to their arm, to their back that we have to dress twice a day. And tell me, please don't touch me anymore. And I can't say to them I won't touch you. I have to care for your wound because if I don't I'm being negligent, and we're trying to prevent any further infection.

I have cared for patients; young men who we see oftentimes with esophageal cancers, who have had multiple resections of their tumors, and the staff can literally fit their fist through their face into their oral cavity. That is not somebody who may want to live any longer. And with all the treatment and interventions in the world they have given up.

I have cared for women in their 90s who have beat cancer two and three times over who say to me, I don't want to get treated. I don't want it, and the pain is unbearable and we don't just give morphine, we administer copious amounts of Fentanyl on the floor every day. Because morphine does not touch cancer pain and any cancer patient will tell you that. We send them home with fentanyl patches that they absorb transdermally. We send them home for those patients who no longer take pills with liquid morphine this big (indicating) that they can ingest orally. And even each with all of that oftentimes we make concoctions of methadone, not people with substance abuse, but to manage their pain; Methadone, Dilaudid, Fentanyl. So when the sponsor says that oftentimes you don't know what the cause of death is and it could be the medication that we are administering, it is very likely that we contribute to people's speedy death because we have to manage their pain. Because to live in constant, agonizing pain is just unbearable and there is no quality of life.

I have had patients who have tumors in their -- in their abdomen, in their colon, in their intestines that don't allow them to eat anymore and are literally starving to death. And because their labs are so out of whack, we can't even give them some calories perennially through IV because it affects their liver function, their kidney function. And at that point there's literally nothing else for us to do. I have patients who are so obstructed by the tumor, the fecal matter is coming out of their mouth and it's intractable vomiting of feces, and all they want to do is make it end.

We have - and I'm going to be clear - every patient, every single patient, 100 percent of them want to live. They want to live. Nobody wants to die. They come to seek treatment because they want us to help them live, but we are limited. We are human beings. We are an imperfect practice with limited science, and we can't always help people. And I have seen how that very treatment can be so damaging. You know, I've had young women that come in with ovarian cancer due to HPV that could've been prevented with a vaccine, but that's not here nor there, who it's so advanced, we do a procedure called a total pelvic exenteration where you remove everything in their abdomen and everything outside of it; rectum, colon, vagina, uterus, ovaries, everything. You give them a colostomy for stool. You give them ileal conduit for urine and you stitch them up. And the women who choose that don't choose that because they want to die, they choose that because they want to live. And all we are doing is prolonging a disease that is just going to come back and kill them anyway.

I have looked too many patients in the eyes who have begged for me to end their suffering and I have no answer for them. And so many, I think, professional who care for people who are dying have similar stories. And that's why I think so many organizations who provide end-of-life care are in support of this, because we know the reality of death and dying. It is a violent, ugly, messy process that is never the same and it's hard for, I think, any legislator, even with a clinical background, to put all those conditions into language because everything patient is different and every circumstance is different and every family is different, every choice is different. So I think that we've done a really good job here to provide the necessary guardrails so that people have a choice, a choice. And if you don't believe in it, then don't avail yourself of that choice. But I think it is inhumane for us to tell people that we have to -- we are forcing them to continue their suffering. And many people choose to end their lives in other ways and we can't prevent that and we can never legislate that. This is just the reality of the people when they come to the end of their -- of their rope. And I think it's dignified to -- to be able to choose this, to do it at the time when you think is right, to be able to have the opportunity to say goodbye to your loved ones, to say all the things that were left unsaid and to just go in peace.

So I commend the sponsor for this. For me it's very personal. I live it every day and I will of course be voting in the affirmative and, you know, I plead to my colleagues, even those who may not support this or who are on the fence, to reconsider that, because the reality is that there are things we're not going to be able to control. Personal choice is one of those, but we have a responsibility to give people choices. And I think that's what we're doing here today.

Thank you.

(Applause)

ACTING SPEAKER HUNTER: Ms. Forrest, we have five minutes remaining left. You have five minutes.

MS. FORREST: I want to -- thank you, Madam Speaker, for letting me speak on the bill.

ACTING SPEAKER HUNTER: On the bill.

MS. FORREST: I want to thank the sponsor for her courage to bring up this very important issue. This issue around compassion and choice. I want to also thank my other nurse colleague for her clinical picture of what it is like to be both at the beginning and at the end of life and I have been there. I have been there when you have the littlest hand is born, baby comes out and I've been there in ICU when I'm taking -- helping a patient come off the vent. But I also want to talk about the reason why I'm a sponsor of this bill. The reason why is because I got to hold my dad's hand. My dad died of pneumonia. When he had pneumonia he was brain dead. But before even being brain dead, my dad's battle with end stage renal disease -- and my dad chose his life and his end, he was a great man. He chose his burial plot. He chose to be Do Not Resuscitate. He chose the songs at his wake and he chose to love us to the very end, and my family are grateful for his choices and we supported him in his choice because we loved him and we still honor his choices today.

Let's be clear. As a nurse, I tell you that this bill is a compassionate bill. It is a bill that is around caring. I cannot go against my code of ethics which says do no harm. But as my other nurse colleague had said, when there is nothing else to do, when the person has no other hope, and trust me, my colleague, I hear you when you say hope keeps you getting up in the morning, but there is no hope when Fentanyl is your only choice. The choice then is how do I do it with dignity? How do I do it with my name and my spirit intact, because that's the enemy of death, lack of dignity. I'm not here to convince you, I'm convinced, but I'm telling you for all of my colleagues here, I pray, I pray that you have compassion, love in your life. And I pray for compassion and love for your family, your neighbors, but as a legislator today, I am choosing to make sure that the same rights that you have in your choices, that everyone gets that same choice as well, that they get to do it in the way that it fits them best.

This bill goes nothing against my Christian identity. This goes nothing against my Black identity. Trust me, my community will be fine when healthcare is excessed [sic], when there are disparities met, that's what you need to do, and we can do that together, but right now we're given the choice, the choice, the compassion, the care, the love that every New Yorker needs.

Thank you so much, Madam Speaker, for allowing me to speak.

(Applause)

ACTING SPEAKER HUNTER: Thank you.

Read the last section.

THE CLERK: This act shall take immediately.

ACTING SPEAKER HUNTER: A slow roll call has been requested.

The Clerk will record the vote.

(The Clerk recorded the vote.)

If you're not in the Chamber you need to make your way to the Chamber to physically vote.

Ms. Lucas to explain her vote.

MS. LUCAS: Thank you, Madam Speaker and thank you to the sponsor for a spirited and thorough debate on this topic.

I do not have the time that I thought I would have to speak on the bill in the way that I want to speak on the bill, but I am rising today not in opposition, the choice. I rise in defense of equity. I rise in defense of dignity. And I rise in defense of my constituents from the 60th Assembly District, some of who are the most vulnerable New Yorkers whose voices, whose fears, whose lives are at times ignored in legislative debates such as this one.

I want to begin by acknowledging that I am proudly pro-choice. I believe deeply in autonomy and compassion and in giving people the ability to make decisions about their own lives and bodies. But choice, real choice must be meaningful, it must be grounded, not in desperation, not in despair, not in the lack of options but in hope and dignity and support. And I ask, how can we call this choice when so many of our communities, communities like my own have been denied the very things that would make a different choice possible? In New York today in the very neighborhoods I represent, end-of-life care is not equally accessible. Palliative care is patchy. Hospice is too often unaffordable, culturally inaccessible. Pain management, mental health support, home care, these are luxuries, not guarantees. If you are Black, Hispanic, low income, the likelihood is higher that you will experience your last days not with comfort, but with suffering, fear and isolation. It is these structural inequalities that concern me, because when a system has failed to provide quality of life, it cannot suddenly be trusted --

ACTING SPEAKER HUNTER: Thank you, Ms. Lucas. How do you vote?

MS. LUCAS: I oppose this bill. I --

ACTING SPEAKER HUNTER: Ms. Lucas in the negative.

Mr. Ari Brown to explain his vote.

MR. A. BROWN: Thank you, Madam Speaker.

If I had the opportunity to debate the bill I would've asked or clarified something about the administration of the drug. From what I understand that it has to be self-administrated. No one can put the drug in the person's mouth or press a button for them. I then would've asked about discrimination. Would there be any particular class of person who would be discriminated from getting this and the answer I'm sure would've been no. And I would then have proceeded with asking if the sponsor was familiar with the Americans with Disabilities Act. And therein lies the problem, because whether it's now, a year from now or two years from now when we would have this discussion in court, if that someone who's mentally competent but totally inable -- unable to move their arms or legs because they're a paraplegic why would they be denied the ability to end their lives specifically when there's supposed to be special accommodations in the American Disabilities Act for those types of people. And that's where the problem is and that's exactly where Canada started. Canada's experience shows us that the so-called Medical Aid in Dying quickly expanded from terminal illness to chronic conditions and even mental illness, anorexia and arthritis. That's about to happen at any moment.

Colleagues, look to Canada. Remember we had the same circumstance. If you like your doctor, keep your doctor. Your medical bill is only going to go down 2,500. I'm a little bit older than everybody. Thalidomide, supposed to be a magic thing so pregnant women wouldn't be nauseous during pregnancies. We know how that went.

In Canada, the so-called Medical Aid in Dying expanded in just a few short years from the terminally-ill to those with arthritis like I said, depression, even anorexia. If we open up this door there's no turning back.

You know, I liked it a couple weeks ago when the Majority Leader and I wore the Donate to Life pin. I hate to see the Pull the Plug on Life pin come out on the rest of us.

Thank you, Madam Speaker.

ACTING SPEAKER HUNTER: How do you vote?

MR. A. BROWN: I vote no.

ACTING SPEAKER HUNTER: Mr. Brown in the negative.

Mr. Lavine to explain his vote.

MR. LAVINE: For much a human history, you and I, individuals were owned by emperors, czars, kings and masters. That began to change with the Humanist Movement which led to the Renaissance which led to the Enlightenment and the result of the Enlightenment was that we believe we have natural rights. We have human rights. That belief led to the American Revolution and led to us having the basic American philosophy that we're entitled to Life, Liberty and the Pursuit of Happiness, but what happens if life is not going to continue? What happens if liberty is not going to continue? What happens if there will no longer be happiness? My friends, pain is the window into hell.

We have the right to determine our futures. I fully support this bill. The State does not own you. The State does not own me. We own ourselves. We have our own bodily autonomy. I commend the sponsor for her long fight to accomplish this noble goal, humane goal. And I simply say I am voting in the affirmative. That is the American way. Thank you.

ACTING SPEAKER HUNTER: Mr. Lavine in the firm.

Mr. Morinello to explain this vote.

MR. MORINELLO: It won't go on. Oh! There it is. Thank you.

To explain my vote, I'm going to read a statement from Victoria Reggie Kennedy, Senator Ted Kennedy's window -- widow on the Death with Dignity initiative.

There is nothing more personal or private than the end of a family member’s life, and I totally respect the view that everyone else should just get out of the way. I wish we could leave it that way. Unfortunately, the so-called “Death with Dignity” initiative, forces that issue into the public square and places the government squarely in the middle of a private family matter. I do not judge nor intend to preach to others about decisions they make at the end of life, but I believe we’re all entitled to know the facts about the law we’re being asked to enact.

Here’s the truth. The language of the proposed law is not about bringing family together to make end of life decisions; it's intended to exclude family members from the actual decision-making process to guard against patients' being pressured to end their lives prematurely. It's not about doctors administering drugs such as morphine to ease patients' suffering; it's about the oral ingestion of up to 100 capsules without the requirement or expectation that a doctor be present. It's not about giving choice and self-determination to patients with degenerative diseases like ALS or Alzheimer's; those patients are unlikely to qualify.

My late husband, Senator Edward Kennedy, called quality affordable healthcare the most important cause of his life. It turns his vision of health care for all on its head by asking us to endorse patient suicide, not patient care. As our public policy for dealing with pain and the financial burdens of care at the end of life were better than that. We should expand palliative care, pain management, nursing home and hospice care. He was given six months or less to live, but even doctors admit it's unknowable. Being that prognosis was wrong, Teddy lived fifteen more --

ACTING SPEAKER HUNTER: Thank you, Mr. Morinello. How do you vote?

MR. MORINELLO: In the negative.

ACTING SPEAKER HUNTER: Thank you.

Mr. Morinello in the negative.

Mr. Steck to explain his vote.

MR. STECK: Thank you very much, Madam

Speaker. I have supported this bill from day one. It is simply common sense. There are many illnesses that cause untold suffering for the patient; relief is an important part of the practice of medicine. Many of the objections to this legislation have their origin in religion, but we have freedom of religion in this nation. If your religion does not permit utilizing this legislation, you certainly do not have to avail yourself of his option. But if your religious belief or non-belief does not prohibit taking this action, you should have the freedom to proceed in accordance with your wishes and your conscience regardless of another person's religious objection.

I vote in the affirmative.

ACTING SPEAKER HUNTER: Thank you.

Mr. Steck in the affirmative.

Ms. Lunsford to explain her vote.

MS. LUNSFORD: Thank you very much, Madam Speaker. I rise today as the daughter of a very proud who spent the last two months of his life in the ICU and then in hospice suffering indignities that I won't share with you because it would be embarrassing to him. And I know that that is not the way that he wants me to remember him. I know he did not want to put me in a position to make the decision about whether or not he stopped breathing, but that was the position I left with. I also stand here as an attorney who handled personal injury, Workers' Compensation and Social Security Disability cases involving people at the end of life, and I've seen them die surrounded by friends and family. I've seem them die alone. I've seen them die suddenly and over prolonged periods of time. And I've seen them make decisions regardless of what our law was to die on their own terms leaving their families without benefits, without legal options that they would've otherwise had if they had not made that choice.

But most importantly I stand here today as a legislator that represents the 135th District, a district that overwhelmingly supports this bill. Since the day I took office I have heard about this bill more than any other. Whenever I speak to a group, somebody asks me about this bill and people have been begging me to pass it since I took office. It is with an incredible amount of pride and respect for the dignity of everyone in this State that I vote in the affirmative today and I commend the sponsor for her tenacity in helping bring this option to everyone in this State.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

Ms. Lunsford in the affirmative.

ACTING SPEAKER HUNTER: Mr. Blumencranz to explain his vote.

MR. BLUMENCRANZ: Thank you, Madam Speaker.

Today I rise to ask the same question I asked at the start of this debate many years ago. What are the bioethical guidelines that doctors often ask; autonomy, beneficence, non-maleficence and justice. This is the guideline I've used as I've debated this bill myself.

This is not an indictment to this bill, but our State and this Body's callous ignorance and misunderstanding of how we are a part of the problem when it comes to palliative and end-of-life and hospice care. We continue to sit dead last at the bottom of the list, 51st for utilization. Autonomy is illusionary without the access to comprehensive options for individuals for hospice and palliative. The beneficence and non-maleficence demand that we prioritize care first, not death, in our responses to creating these options, and justice requires equitable access to all forms of care, not just options that hasten death which disproportionately affects vulnerable populations. We must be more cognizant of how we can create a full solution for people at the end of life. We're never gonna end suffering, even with a bill like this. We need to create a solution that provides options for all New Yorkers.

I vote no and I hope that we look forward to seeing more options for end-of-life care. Thank you.

ACTING SPEAKER HUNTER: Mr. Blumencranz in the negative.

Mr. Lasher to explain his vote.

MR. LASHER: Thank you, Madam Speaker. Thank you to the sponsor for her incredible diligence and championship of this issue and such a carefully crafted bill. And to all of my colleagues on both sides of the issue, both sides of the aisle, I've been enriched by the conversation today. I will confess I've been a sponsor in support of this bill for many months and yet as this day came, I have wrestled with this bill. I have wrestled with the experience in Canada, which I do encourage everyone to read about. It is a horror show. And I have wrestled with the tension between wanting to relieve suffering and not sending a message that we take our lives for granted.

The challenge, I think, with this bill at the end of the day is just how carefully crafted it is. It is not a Canadian approach to medical aid in dying. It is a carefully safeguarded, guardrailed approach. The challenge with that is that it inevitably, in making those guardrails, makes some arbitrary lines. And I do think we will be back here. We'll be back here because the courts tell us to be back here. We will be back here because the politics puts us back here. And I am voting aye on this bill because I think it relieves suffering in the most extreme cases and it's been carefully written to do that. But I don't know that I will be aye the next time we are here talking about expanding it.

So I thank the sponsor for her care and compassion and intelligence and thoughtfulness in handling this difficult issue. I vote in the affirmative. Thank you.

ACTING SPEAKER HUNTER: Thank you.

Mr. Lasher in the affirmative.

Mr. Hevesi to explain his vote.

MR. HEVESI: Thank you, Madam Speaker. Thank you, my colleagues. Just a couple of quick observations.

Number one, I'm really proud to be a member of this

House today. The way --

(Applause)

-- yeah. Yeah. We can give a round of applause for that if you want.

(Applause)

The level of respect and dignity on this very difficult topic is something we should all be commended for.

Number two, for all the new members, if you want to see what perseverance and strength and what being a great legislator is like, Amy Paulin on this one, been watching this for years, you are to be commended.

(Applause)

Thank you for the clapping. You're making me feel guilty about my last point which is a little bit selfish. Here -- here's my last selfish point.

This one's for my old man, and let me tell you why. In the 1970s my father was a member of this House and he wrote the first hospice law in the United States that brought hospice to New York State, and it's with that same level of care and dignity and compassion that I vote aye today. I'm honored and proud to do it.

Thank you for allowing me to speak today.

(Applause)

ACTING SPEAKER HUNTER: Mr. Hevesi in the affirmative.

Ms. Solages to explain her vote.

MS. SOLAGES: Thank you, Madam Speaker. You know, I don't take this decision lightly today. Frequently when I have bills like this I always go to my best source, which is my mother, and she talked about how her sister-in-law suffered when she died, but then she also talked about the moral obligation as legislators that we have.

I am voting no today because we do live in a place where our healthcare system is a business. It's not about a right, it's about if you have money. And access to care, including palliative care and hospice care, is deeply unequal. In a system where people are routinely denied treatment because of their income or insurance or even their zip code, how can we in confidence say that we are supporting this? Poverty, discrimination, a lack of support - these are conditions not of free support but of a system that is unequal, a societal system.

And so for this reason, because of this broken healthcare system that we have, because of the systemic inequalities, because of our commitment to protect the most vulnerable, I must respectfully and firmly vote no.

ACTING SPEAKER HUNTER: Ms. Solages in the negative.

(Applause)

Ms. Septimo to explain her vote.

MS. SEPTIMO: I am extraordinarily proud to be a member of the Assembly today as we vote to advance this critical legislation, and I want to commend the sponsor and the Speaker for championing this issue and allowing all of us the space to find the moral clarity and bravery that is needed to advance a bill like this.

We have a responsibility as legislators to craft legislation that is fair, that is just. But we also have a responsibility to craft legislation that uplifts and honors the reality of the human experience. We have a responsibility to pass laws that uphold and support and maintain the dignity of every single New Yorker and every opportunity possible. That is what this bill does. It gives New Yorkers who have been robbed of their agency by a ravaging illness to reclaim their power and to leave this world in a way that is dignified for them and for their families. And if you have never had an up-close experience of watching someone you love be ravaged by an illness, I hope that you never have that experience. But I can personally tell you that it is gut-wrenching. And what we are doing today is restoring power to people who are going through an incredibly difficult time, bringing peace to families across New York by simply giving them the option.

So I will be voting in the affirmative today for my friend Brian Moffett who was an advocate for this bill who died last year before he could see it pass. For Dr. Boal who is another advocate who is always here pushing as he battles his own illness, and for my constituent Jules Netherland who has also been here several times who is facing her own illness and will now have the piece of mind to know that she will get to make the decision about how her time here ends.

Thank you.

ACTING SPEAKER HUNTER: Thank you.

Ms. Septimo in the affirmative.

(Applause)

Mr. Norber to explain his vote.

MR. NORBER: Thank you, Madam Speaker. I just want to say how proud I am to be a new member here today in the Assembly. The debates that we saw today were really moving on both parts. I want to say thank you to the sponsor, to everybody. Just to witness and hearing all the stories, I completely understand where everybody is coming from. But at the end of the day, we all come back to our own personal experiences in life. My father, who I introduced here a couple weeks ago, seven years ago suffered from renal failure in both kidneys with cancer. Immediately, the nephrologist who was in charge of him said, *He's not gonna make it. Even dialysis will not help him. Within six months we're not gonna have him anymore.* We decided to fight and do whatever we can to make sure he feels comfortable with the dialysis in any way we can, and within a few months, a year or so on dialysis in which we completely forgot what the doctor said, he ended up getting a kidney and he is still with us. So I am thankful for that and thankful that the doctor was ultimately incorrect about what he said. So we just have to always make sure that we have the right tools, the right knowledge to make sure we make the best decisions for ourselves and for our families. Even when the doctors say something, it's not always the word of God. It's just something we all -- I experienced myself so that's how it is. And we have to make sure that other people in our -- in our communities and our State just also have that type of knowledge when making these types of decisions.

And this bill itself, I just feel like there's just one thing that is there that's lacking, and it's the issue of six months which, to me, seems to be very vague and arbitrary. Why six months? Why not three months? Why not one year? I feel like we should come together a little bit more about that issue, and because of that I will be voting in the no.

Thank you very much.

ACTING SPEAKER HUNTER: Mr. Norber in the negative.

Ms. Kelles to explain her vote.

MS. KELLES: So, one of the things that I -- is very hard for me is how much there's fear mongering about what could happen when we have 30 years of data on what has happened. And I will note that there have been no -- been no reported cases where physicians acting in accordance with the state Medical Aid in Dying laws have faced civil or criminal liabilities. That's zero in 30 years, ten states and the -- and Washington, D.C. So I think that it's really important that we avoid doing that fear mongering, and I've heard a lot of that today.

When I first ran for office, the number one bill that was asked of me please, please is the medical aid in dying. That was five years ago. I continue to hear that from people across my district. The nuance protections in this bill are not parallel to what I've heard in Canada. There are phenomenal lists of restrictions that have all been spoken about today that are very important and protections. And the comparison is profoundly disingenuous.

I -- I want to note the importance of what people have said about the dignity, dying with dignity and choosing to die with your family by your side because you can make the choice of when, when you are already dying, you have less than six months to live. That is a really important restriction of this bill. And I had someone say to me recently, *I am a very religious pastor and the thing that matters most is choice, and a person's relationship with God is their own relationship and is no one else's to dictate*. And this preserves that relationship and that choice.

I spent the last, as people know here, couple months with my father. My father died a few weeks ago. He was a beautiful, big football player, 220 pounds, and he died at 100 pounds. I could see every organ, I could see every -- every rib, and I watched my father in profound pain and suffering.

ACTING SPEAKER HUNTER: Thank you, Ms. Kelles. How do you vote?

MS. KELLES: I am voting today in support of and in remembrance of my father and my father-in-law who wants this bill. Thank you.

ACTING SPEAKER HUNTER: Ms. Kelles in the affirmative.

(Applause)

Ms. Walker to explain her vote.

MS. WALKER: Thank you, Madam Speaker. I respectfully request to abstain for the purposes of explaining my vote.

Many of the individuals who I've heard about, they are in uninsured and underinsured circumstances, many of whom would not be able to afford the medication in order to see even if -- even if they did hope for an opportunity here. And so this is about healthcare justice. And I couldn't understand why is this coming through the Codes Committee, because this isn't about stopping someone from committing suicide or giving someone the opportunity. This is about removing the punishment for assisting in someone's death. And that's one of the issues that I have a problem with. Like as a criminal justice reform advocate, we can't on the one hand look for harsher penalties and then remove penalties for the same act that you will give people 28 and 40 years in prison for, and that I have a problem with. And at the end of the day we're still seeing people who are being prosecuted for administering this drug to individuals who do not require it. And they're being prosecuted in this day, in this time, in the Netherlands. I don't know about in Oregon, but I know if something is happening in Oregon, by the time it hits New York State it is gonna be vastly, vastly highlighted.

And so I am concerned. What happens when a person says, *I don't want to take this drug anymore,* and people do it all the time. Is there a safe way to dispose it? Or will this be something that will wind up in a black market and on the streets of communities of color all across the State of New York?

I think that there are opportunities for us to be able to make this circumstance better. Congratulations.

ACTING SPEAKER HUNTER: Thank you, Ms. Walker. How do you vote?

MS. WALKER: I withdraw my request and I vote in the negative.

ACTING SPEAKER HUNTER: Ms. Walker in the negative.

(Applause)

Ms. Shimsky to explain her vote.

MS. SHIMSKY: Thank you very much, Madam Speaker. Everyone's death and the circumstances are different, always have been. But in recent generations our healthcare system has resulted in people wasting away from degenerative diseases and having longer, more painful deaths with more humiliation and less agency. That is why we need a bill which gives people the opportunity to end their lives as they are wasting away.

The partisan divide on this issue is much narrower than it is on just about anything else we talk about. And I think part of that is because whether you're a Democrat, a Republican, member of a third-party or no party, you've had some personal experience with this issue and you know exactly why this bill is needed. And I understand it, too, from personal circumstances and listening to the circumstances of others. And that is why, Madam Speaker, I'm voting in the affirmative.

ACTING SPEAKER HUNTER: Ms. Shimsky in the affirmative.

Ms. Bichotte Hermelyn to explain her vote.

MS. BICHOTTE HERMELYN: Thank you, Mr. -- thank you, Madam Speaker, for allowing me to explain my vote. The purpose of this bill would be to assist certain individuals in ending their life early in certain circumstances. Some people call this choice of passing peacefully while others call it assisted suicide. While I do support the choice of being able to end one's own suffering early, while I do support the freedom to choose and freedom to decide in the pursuit of happiness, my concern and opposition of this bill comes from the great risk of targeting vulnerable communities of color given the historical health disparities that they continue to face.

I did request a study. I request a study as it relates to the misuse, true mental competency determination and wrongful intent, but that request was dismissed. Death is something that I struggle with. Having to lose a baby, having to lose all my brothers, my father and then my mother. And I still cry today for her. I was her caregiver and I wanted her to live longer, but there was a point where she did express that she did not want to continue to be intupated [sic] if she would be intubated. But she told me that when she was mentally competent. And so my concern for the communities, the vulnerable communities that are not informed. That are not given the chance to really see if they are legitimately mentally competent.

Although this bill is rooted in empathy, it raises real concerns for communities that are already struggled to receive fair treatment -- fair treatment, and for this reason in good faith I cannot support this legislation without worrying about how this will affect our most vulnerable populations.

And I do want to say that part of my community --

ACTING SPEAKER HUNTER: Thank you, Ms. Hermelyn. How do you vote?

MS. BICHOTTE HERMELYN: -- of the vast majority do not support this. I will vote in the negative.

ACTING SPEAKER HUNTER: Ms. Bichotte Hermelyn in the negative.

Mr. Burke to explain his vote.

MR. BURKE: Thank you, Madam Speaker. I grew up in a very Catholic family. I'm a part of a very Catholic family. And while -- while I was growing up in the 90's, this issue was talked about a lot. This was a major national issue. We talked about it all the time. You know, my family was Catholic but they weren't dogmatic. I remember sitting with my grandma, Irene Burke, having a cup of tea and talking about this. And I asked her what she thought -- I think might've been 11 years old -- and she pointed to her wall where there was the Beatitudes. And she said, *Blessed are the merciful for* *they shall receive mercy*. And it imprinted something on me that there -- there is -- this is a tough issue to talk about. It's personal for all us. I'm sure most of the people in this room unfortunately have a very painful memory that we attribute to this discussion; I know I do. I don't feel comfortable sharing it. But -- but for me and for my faith and for my family's perspective, this is a righteous cause and this is just. So I will be voting in the affirmative.

Thank you.

ACTING SPEAKER HUNTER: Mr. Burke in the affirmative.

Mr. Maher to explain his vote.

MR. MAHER: Thank you, Madam Speaker. I rise to explain my vote. We had a very spirited debate here today, and as we all can see, this debate transcends party lines.

One of the issues that I brought up was when we have 38 percent of what would be brought about with this medication not used, that is thousands and thousands that we're talking about. And a few minutes later after the debate, I was handed a piece of paper where there actually was an issue in the State of Colorado where this took place. So it's real. And we don't know yet how much has been gotten to. We don't want how to quantify it.

The second thing I want to bring up is Cardinal Dolan and the New York State Bishops put a statement together, and I know earlier this week we had a -- a quote from Pope Francis and I just want to read another one. "Euthanasia and assisted suicide are a defeat for all. We are all called never to abandon those who are suffering, never giving up but caring and loving to restore hope." Now, I read that and I think of the word "hope" because today it was brought about in a way that was very specific to someone who is not going to die, maybe a miracle might happen. But when Pope Francis uses the word "hope" I think of it as a God-fearing man, as hope to have the strength to face what's next. And that's something that we all ought to think about. That word "hope" isn't just about hope to live, but to have the strength to die, to go to that next place the way that they would like to.

For this and many other reasons I will vote in the affirmative. Thank you, Madam Speaker.

ACTING SPEAKER HUNTER: Mr. Maher in the affirmative.

Mr. Burdick.

MR. MAHER: Negative, negative, negative.

ACTING SPEAKER HUNTER: Oops, sorry. Sorry.

Mr. Maher in the negative.

Mr. Burdick to explain his vote.

MR. BURDICK: Thank you, Madam Speaker. I arrived at my position on this bill after considerable thought. It is shaped in part by a very personal experience. Several years ago, my wife's stepmother, a citizen of the Netherlands, suffered a massive stroke which sent her into a permanent vegetative state. Her doctors overwhelmingly concluded that she would never recover. Years prior to the stroke, she had availed herself under the 2002 Netherlands law which allowed for advanced directives to end life under very strict criteria. Her children honored their mother's directive.

In passing this law, New York would join several states who have adopted laws similar. And the overwhelming evidence is that the stringent safeguards under those laws have been successful in preventing coercion and undue influence. As a member of the People with Disabilities Committee, I've considered the bill from that perspective as well. Colleagues on the other side of the aisle have suggested that there's a monolithic deal in the disability community in opposition. As the sponsor mentioned in debate, there is strong support among New Yorkers who self-identify as having a disability.

My view is that government should not interfere with freely-made end-of-life decisions. I commend the sponsor for her tenacity and ensuring the strict criteria and protections in the bill, including for those with disabilities. This bill is founded on compassion and caring for those whom we love. We want to give them the right to make a fully-informed and free choice in ending their life.

I vote in the affirmative. Thank you.

ACTING SPEAKER HUNTER: Mr. Burdick in the affirmative.

Mr. Durso to explain his vote.

MR. DURSO: Thank you, Madam Speaker, to explain my vote. Obviously, this is a very personal issue for everyone in here and it's -- in some way, shape or form we've all an had effect by a loved one who has passed away or if God forbid you've had to watch it in front of you, which I have. It -- it definitely leaves an effect on you and makes you think a different way. I unfortunately had the -- to watch my mother take her last breath directly in front of me. And I understand that she was in a lot of pain and her family, herself, nobody wanted to see her in pain. But the one thing my mother did instill in me is to do what you believe is right. And I believe that she would think that this bill's not quite ready yet. Again, doctor shopping, as we spoke about, the definition of terminal illness. All these things that the guardrails aren't in place at this time, I just don't think it's ready. On top of the fact that we do have a responsibility as a Legislature when it comes to making sure that our constituents and the people of the State understand what the reasons that we do what we do here.

One of the things I just want to speak about quickly is last year alone in the budget we spent $1 billion on suicide prevention. Now, I'm a big believer in that and I support that 100 percent. We have our first responders, veterans who are taking their own lives at an enormous amount. Over 1,700 people a year commit suicide in New York State. How can we sit there and put money towards and talk about education about saving people's lives, suicide prevention, and then sit here and do this bill?

Also, the Senate sponsor of this bill literally has a bill called the Suicide Prevention Act. The bill sponsor here talked about how the numbers say that hospice care has gone up since the implement -- implementation of this legislation in other states, but yet passed a bill two weeks ago (inaudible/crosstalk).

ACTING SPEAKER HUNTER: Thank you, Mr. Durso. How do you vote?

MR. DURSO: I vote in the negative.

ACTING SPEAKER HUNTER: Mr. Durso in the negative.

Mr. Tague to explain his vote.

MR. TAGUE: Madam Speaker, to explain my vote. First off, Madam Speaker, I didn't hear fear mongering today as was suggested. I saw two different -- two different types of people discussing respectfully and debating respectfully a very difficult piece of legislation. People who are deeply compassionately and faithfully committed to their position.

As a devout Irish Catholic, it is God Almighty, the Giver and the Taker of life. It is not for man to take life, but to understand that God is the Giver and Taker of life, and this applies to all.

I vote in the negative.

ACTING SPEAKER HUNTER: Mr. Tague in the negative.

Ms. Levenberg to explain her vote.

MS. LEVENBERG: Thank you, Madam Speaker. We have heard so much today, and I want to thank the sponsor for her incredible perseverance on this and her very hard work, as she does on all bills, but this one especially. I think it's been 20 years; is that correct?

MS. PAULIN: Eleven.

MS. LEVENBERG: Eleven years. Still a very long time.

The -- the bill has a lot of names. It's called Death with Dignity and Compassion and Choices. And when I think about my personal experience with my -- my father, he was -- he had a heart attack in his mid-40s. He was a pack-and-a-half-a-day smoker. The doctor said, *If you quit smoking, you know, you may live ten to 15 years. If you don't, you've probably got five*. He lived 'til he was 88. But in his -- in his later years he developed diabetes and ultimately had renal failure and was on dialysis. And -- and he was a really good candidate for dialysis. He loved to read. And I thought he'd be on dialysis, you know, until -- until he couldn't be on dialysis anymore. But one day he just up and announced he was done. He was done with dialysis. He didn't want to do it anymore. And we were all confused and my step-mom was really upset and, you know, lots of events still to come and lots of -- lots of life experiences still to happen and to share with him. But I think that we have a really tough relationship with death in this country, and I think that this is part of our angst over this legislation. And I think that when people do have the choice, and again without -- as one of my -- as one of my colleagues pointed out -- without having to jump through any hoops he just got to decide to unplug from dialysis and choose his -- his ending. I think that we need to look at these other options that where people are having that ability to do so and to end their lives with dignity and with compassion.

ACTING SPEAKER HUNTER: Thank you, Ms. Levenberg. How do you vote?

MS. LEVENBERG: I vote in the affirmative.

ACTING SPEAKER HUNTER: Ms. Levenberg in the affirmative.

Ms. Giglio to explain her vote.

MS. GIGLIO: Thank you, Madam Speaker.

So, life is a gift from God. I have a personal experience. I lost my first husband at a very lung -- young age of metastatic lung cancer. They gave him three months to live, but he lived for 15 months. And during that 15 months we went to healing masses. I took macrobiotic cooking where, you know -- but at the end when the hospice nurses were coming he was saying the only thing he wanted was a steak. You know, he wasn't asking for a pill to end his life. And the day he died he said, *Today is the day I'm going to die. Bring my family, bring my friends. I want to say goodbye*. And when they all departed at 8:00 p.m., he said, *He's here to get me. I'm going.* He put his head into my stomach and he passed away peacefully. The hospice nurses kept him comfortable. He had metastatic in his lumbar spine, in his -- all over his body it had spread. And the doctors kept him very comfortable and so did the hospice nurses.

So I -- I think that, you know, as I said, life is a gift and one that should be nourished and treasured. I am very worried about the vulnerable community and vulnerable population that it'll just be an option because the healthcare will not be available to them. I -- I worry that there are people that are going to get a pill and they're gonna go home. Maybe they got the pill and asked for the pill because their family members were saying get it because it's an option. I understand that. But they may not be ready to take that step and may be coerced once they get home. And because them physically taking the pill themselves is not something that would be seen by the doctor and there would be no way of enforcing to make sure that that person actually took the pill themselves.

So I -- I worry about a lot of things with this bill that --

ACTING SPEAKER HUNTER: Thank you, Ms. Giglio. How do you vote?

MS. GIGLIO: Thank you. I vote in the negative. Thank you.

ACTING SPEAKER HUNTER: Ms. Giglio in the negative.

Ms. Walsh to explain her vote.

MS. WALSH: Thank you. So, here's where I'm coming down on this after having had so much time over the last few years to really think about this. I think that what we need to understand, anybody who still hasn't cast a vote or is on the fence, is that there's a yes vote for any number of reasons, there's a no vote for any number of reasons. I just think that we can do better. I think we can do better than this. I don't think that a no vote necessarily means that we don't have compassion for the people who have been coming to our offices, who we've been passing through the tunnel who we've been talking to. I'm just saying that I don't think this bill is it. I think that making the best investments that we can to raise New York up from dead last in hospice and palliative care is where we should be putting our energy and our efforts and our money. And this -- and the State's money. That's where we've got to put the effort.

I -- I have enormous compassion for people who are in unrelenting pain, and -- and I, frankly, for all the times that I've read obituaries that thank hospice, I think hospice comes in too late and they don't do enough. They don't do enough. Thank God my sister, who's a nurse practitioner, was there to help both of my parents die. Because I -- I -- I would hate to think that they had to just rely upon a phone call or an occasional visit from hospice. Thank God my sister was there.

I think we can do better than this. I don't think that this is something that can be fixed with a chapter amendment. This bill needs work. The things -- the protections that are in place regarding coercion, consent, capacity, those are all before the prescription is issued. Once it's issued, we have a host of problems with this bill, and I think we need to fix those.

So if you vote no, it doesn't mean you don't care. It just means that this bill is not quite there yet. I'm very uncomfortable with the idea of answers given by the sponsor that (inaudible/ crosstalk) --

ACTING SPEAKER HUNTER: Thank you, Ms. Walsh. How do you vote?

MS. WALSH: -- would make this legislative intent up on the spot.

I vote in the negative.

ACTING SPEAKER HUNTER: Thank you.

MS. WALSH: Thank you, colleagues.

ACTING SPEAKER HUNTER: Ms. Walsh in the negative.

Ms. Rosenthal to explain her vote.

MS. ROSENTHAL: To explain my vote. I first want to thank the bill sponsor for her undying efforts and the tenacious advocates who have been coming up to Albany for years on end to make the passage of this bill a reality.

Many of us in this Chamber have our own stories to share, watching friends and family members suffer incredible pain and grueling illnesses. Being diagnosed with a terminal illness stirs up so many emotions; sadness, grief, regret, anger and the feeling of the loss of control. At a time when so much is out of one's hands, having the option to die with dignity rather than slowly crumble amidst pain is something that should be available to anyone in this position.

We don't know what happens after we die. Some believe that there's a Heaven and hell. Some believe in reincarnation. Some believe that that's the end. And some believe that we continue to exist in some non-physical realm. We don't know. But we do know what it's like to suffer. We do know what it's like to have pain. We've heard the testimony of nurses about the wretched things the body goes through. So who am I to judge how you want to end your life? Who are we to impose our will to forbid people and doctors from helping those who are terminally ill?

I've supported this bill since its introduction. I am grateful to everybody who poured their hearts into its passage. Once again, I thank the sponsor for her tenaciousness and I vote in the affirmative.

ACTING SPEAKER HUNTER: Thank you.

Ms. Rosenthal in the affirmative.

Mr. Gibbs to explain his vote.

MR. GIBBS: Thank you, Madam Speaker. Not only should all New Yorkers die with dignity, I believe they should all live with it. Let's give all New Yorkers the dignity that Robert Brooks didn't get.

Madam Speaker, I stand with my Speaker and I vote in the affirmative.

ACTING SPEAKER HUNTER: Thank you.

Mr. Gibbs in the affirmative.

Mr. Fitzpatrick to explain his vote.

MR. FITZPATRICK: Thank you, Madam Speaker.

It was said a few moments ago that we, as a society, seem to struggle with death. Anyone who believes that has never been to an Irish wake.

(Laughter)

An Irish wake, we celebrate life. We're sad. My mother just died, just as some of my colleagues, their parents have recently passed away. My father died 36 years ago. I still celebrate his life. Both of them suffered. But we don't get to choose when we come into this world. And as my colleague said, I believe life is a gift from God. And you don't reject that gift by choosing to end your life. Suffering is a part of life. In my faith tradition we are taught that suffering is something we all must endure. And yes, some suffer more than others, but suffer we all will. We all must if we want to get to Heaven, and I believe there is a Heaven. But I'm concerned about this being maybe the camel's nose under the tent. I fear expansion of this bill in the future. There will be opportunities to do that. People will want to say I want to be able to choose the end of life because of this affliction or that affliction. And I think we're going down -- we will go down a dangerous path if that happens. But I will continue.

You know, I don't support this bill. I will be voting in the negative. I appreciate the hard work of the sponsor and her dedication to this -- to this effort. I know it's sincere. She has suffered a death of her sister. We all have been through this, at least most of us have.

ACTING SPEAKER HUNTER: Thank you, Mr.

Fitzpatrick. How do you vote?

MR. FITZPATRICK: I vote in the negative.

ACTING SPEAKER HUNTER: Mr. Fitzpatrick in the negative.

Mrs. Peoples-Stokes to explain her vote.

MRS. PEOPLES-STOKES: Thank you. Thank you, Madam Speaker, for the opportunity to explain my vote.

I first want to really honor my colleague Ms. Paulin on -- she has literally brought this bill I would say almost from the graveyard, she's brought it alive. And I want to congratulate her on that because it took a lot -- it takes a lot of work to do that.

There are a number of people, as everyone has said, who have all different sorts of experiences about this, but it's all personal and it's all emotional. And I have from day one when I first heard about this bill was adamantly opposed. I watched my father die. He actually asked me -- he wanted to die two years before he did, but he didn't. And because he didn't my grandson got a chance to know him. And I watched my mom die, I watched my daughter die. And I know that for a fact that none of us are getting out of here alive. At some point or the other, we're all gonna go. But I don't believe that there should be a combination of six drugs offered to someone to end their life. I -- I'm sorry for the suffering. I -- honestly, I know people sometimes suffer and I wish that they didn't have to. But -- and I wish there was other ways not for them not to suffer to get through their illness. Maybe the science is not done on that yet, but I cannot imagine a combination of six drugs roaming around in our society.

When I was in high school I never heard of fentanyl, ever. Now, people literally break into hospitals to steal fentanyl. I don't know where we're going as a country. I don't think we have a handle on how to deal with drugs, particularly as they relate to communities of color, and I cannot support this bill. But I do want to congratulate the sponsor. Great work, Amy.

ACTING SPEAKER HUNTER: Mrs. Peoples-Stokes in the negative.

Ms. Paulin to explain her vote.

MS. PAULIN: Thank you. I have so many thank yous. First, to everyone in this Chamber for putting up with my texts and my calls and my texts and my texts and my texts. Thank you to my predecessor, the Chair of the Health Committee, for helping to write the bill and even helping as of yesterday to brief me on the bill. Thank you to the Speaker who not only when I asked gave me a path to put this before us today, but who guaranteed that path and worked with me to create a path. I am so indebted and appreciative.

And to all the yellow shirts up in the balcony for being here and being here and being here and being here.

(Applause)

For giving us the moral courage to take this vote today.

Everyone has a personal story, whether it's having heard one of the yellow shirts' personal stories and taking that in, or whether it's from your own. For me, my personal story started on March 28, 2012 when my sister was diagnosed with ovarian cancer. I learned about it a day after she was diagnosed, and I was here, it was March. Three years later, 2015, she died on Mother's Day. She lived in another state, so I wasn't there. And her dying wish was that she'd have her sisters in the room with her, which I learned from my brother-in-law after she already died. But I couldn't be there because she died on Mother's Day and my mother was still alive here back in New York and I was with her. The last time I saw her was about today, 2015.

ACTING SPEAKER HUNTER: Thank you, Ms. Paulin. How do you vote?

MS. PAULIN: I vote in the affirmative. Thank you, all.

ACTING SPEAKER HUNTER: Ms. Paulin in the affirmative.

(Applause)

Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: Madam Speaker, would you please call our colleagues on line?

THE CLERK: Mr. Alvarez, for the record please state your name and how you wish to vote.

MR. ALVAREZ: George Alvarez and I vote in the affirmative.

THE CLERK: Mr. Alvarez in the affirmative.

Mr. DiPietro, for the record please state your name and how you wish to vote.

MR. DIPIETRO: David DiPietro. I vote with the God of Abraham, Isaac and Jacob and my Lord and Savior Jesus Christ, I vote in the negative.

THE CLERK: Mr. DiPietro in the negative.

Mr. Mamdani, for the record please state your name and how you wish to vote.

MR. MAMDANI: Zohran Mamdani. I vote yes.

THE CLERK: Mr. Mamdani in the affirmative.

Mr. McDonough, for the record please state your name and how you wish to vote.

(Pause)

Mr. McDonough?

(Pause)

Mr. McDonough.

MR. MCDONOUGH: Yes.

THE CLERK: Mr. McDonough in the --

MR. MCDONOUGH: I vote no.

THE CLERK: Mr. McDonough in the negative.

Ms. Torres, for the record please state your name and how you wish to vote.

MS. TORRES: Emérita Torres. I vote in the affirmative.

THE CLERK: Ms. Torres in the affirmative.

ACTING SPEAKER HUNTER: Are there any other votes? Announce the results.

(The Clerk announced the results.)

The bill is passed.

(Applause)

Mrs. Peoples-Stokes.

(Pause)

Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: Madam Speaker, do you have any further housekeeping or resolutions?

ACTING SPEAKER HUNTER: Yes. We do have a bit of housekeeping.

On a motion by Mr. Weprin, page 15, Calendar No. 96, Bill No. A07038, the amendments are received and adopted.

On behalf of Mr. Jones, Bill No. A06769, Assembly bill recalled from Senate. The Clerk will read the title of the bill.

THE CLERK: An act to amend the General Municipal Law.

ACTING SPEAKER HUNTER: Motion to reconsider the vote by which the bill passed the House.

The Clerk -- the Clerk will record the vote.

(The Clerk recorded the vote.)

The Clerk will announce the results.

(The Clerk announced the results.)

The bill is before the House and the amendments are received and adopted.

We have a number of resolutions before the House. Without objection, these resolutions will be taken up together.

On the resolutions, all those in favor signify by saying aye; opposed, no. The resolutions are adopted.

(Whereupon, Assembly Resolution Nos. 386-394 were unanimously adopted.)

Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: Madam Speaker, before I ask you to introduce our colleague Ms. Clark, I would ask you to welcome our colleague --

ACTING SPEAKER HUNTER: Can we have quiet in the Chamber, please?

MRS. PEOPLES-STOKES: Before we move to our announcement, can I ask you to please welcome our former colleague Marcos Crespo who's in the Chambers with us today?

(Applause)

ACTING SPEAKER HUNTER: Welcome, Mr. Crespo. Welcome back.

MRS. PEOPLES-STOKES: Now if you could introduce Ms. Clark.

ACTING SPEAKER HUNTER: Ms. Clark for the purposes of an announcement.

MS. CLARK: On a very much less dramatic note, there will be Majority conference following Session, immediately following Session in Hearing Room C. Majority conference in Hearing Room C.

ACTING SPEAKER HUNTER: Immediate Majority conference in Hearing Room C.

Mrs. Peoples-Stokes.

MRS. PEOPLES-STOKES: I now move that the Assembly stand adjourned and that we reconvene at 11:00 a.m., Wednesday, April the 30th, tomorrow being a Session day.

ACTING SPEAKER HUNTER: On Mrs. Peoples-Stokes' motion, the House stands adjourned.

(Whereupon, at 5:06 p.m., the House stood adjourned until Wednesday, April 30th at 11:00 a.m., that being a Session day.)