Fatal Flaws in Assisted Suicide Legislation
S.5814-A (Bonacic) / A.5261-C (Paulin)

Proponents of the "Patient Self-Determination Act" argue that it contains safeguards which protect vulnerable patients. Yet a close examination of the bill's language reveals inadequate protections for patients most at risk of abuse, and lower medical standards than elsewhere in the Public Health Law. In addition, the legislation lacks transparency and accountability and contains extremely weak conscience protections for both health care professionals and health care institutions.

1. The bill invites coercion and undue influence.

- The bill requires two witnesses to a patient's written request for assisted suicide, and one of these two witnesses cannot be "a relative of the patient…a person who at the time the request is signed would be entitled to any portion of the estate of the patient…[or]an owner, operator or employee of a health care facility." § 2899-d(12)

- However, the bill does not prohibit the other witness from being a relative, a person entitled to a portion of the patient's estate, or a person associated with the health care facility where the patient is receiving treatment. There is also no requirement that either witness be an adult or even someone who knows the patient.

- This is problematic because patients, particularly isolated elderly patients in long-term care facilities, are vulnerable to exploitation and abuse. In theory, one witness may be a person who has a vested financial interest in the patient's death, and the other witness may be a minor.

- There is no requirement that a patient be determined to be competent and acting voluntarily at the time that they self-administer the lethal drugs. This leaves patients vulnerable to coercion and abuse once they are outside of the direct oversight of their doctor.

2. No psychological counseling, diagnosis or treatment is required.

- The attending physician is responsible for making the determination as to whether or not the patient is acting with capacity and has made a voluntarily request for assisted suicide. (§ 2899-g(1)(A))

- The patient is only referred for psychological counseling if in the "opinion" of the attending physician (§ 2899-h), it is "appropriate." (§ 2899-g)

- The optional psychological screening is very limited in nature. It is only to determine if the person's psychological condition affects their decision-making capacity (§ 2899-h). It does not require an assessment of whether the person might benefit from treatment of their condition (e.g., clinical depression).

- This poses a significant danger to vulnerable patients who are suffering from psychological conditions. Many general physicians lack the expertise to diagnose these conditions. In contrast, trained psychologists or psychiatrists are the professionals best suited to examine a patient to determine whether or not they are mentally capable and acting free of duress.

3. The weak definition of "terminal illness" increases the risk of errors in diagnosis.

- The bill defines a "terminal illness" as an illness or condition which can "reasonably be expected to cause death within six months." § 2899-d(12)

- This 'reasonable expectation' standard is a significantly lower standard for diagnosis than the "reasonable degree of medical certainty" standard, which is used in comparable provisions of the law. *See, e.g.*, Public Health Law § 2994-a(5) (the Family Health Care Decisions Act), Public Health Law § 2963(2) (determining capacity to make decisions regarding cardiopulmonary resuscitation), and Surrogate Court Procedure Act § 1726(4)(a) (relating to health care decisions for persons with mental retardation).

- Given the inherent uncertainty of making a prognosis of the amount of time a person may live, this lower standard puts patients at risk, particularly those who are less informed or who cannot access second opinions.

4. Patients who express a desire for suicide are stripped of existing legal protections.

- Under current law, persons who are at risk of harming themselves are protected under Mental Hygiene Law Article 9. Other vulnerable patients may be protected by the appointment of a guardian or conservator pursuant to Mental Hygiene Law Article 81.

- Under this bill, however, "a patient who self-administers medication under this article shall not be considered to be a person who is suicidal, and self-administering medication under this article shall not be deemed to be suicide, for any purpose." § 2899-l(1)(a)

- The bill states that "a request by a patient to his or her attending physician to provide medication under this article shall not, by itself, provide the basis for the appointment of a guardian or conservator." § 2899-l(2)

- This excludes the possibility of invoking significant legal protections for vulnerable patients, and creates an invidious double standard -- terminally ill patients have no protection under the law, while healthy patients do.

5. The bill requires lies and inconsistencies on death certificates.

- Instead of listing the cause of death as the lethal dose of medication or assisted suicide, the bill states that "the death certificate shall indicate that the cause of death was the underlying terminal illness or condition of the patient." § 2899-n

- However, if there were reasonable grounds to believe that "the patient rescinded his or her request or consent to self-administer medication under this article or communicated a desire that the lethal action of the medication be reversed, and the patient nevertheless died from the self-administration of the medication, the self-administration of the medication may be listed as the cause of death." § 2899-n

- Essentially, this means that if the patient wanted to commit suicide, and took the lethal medication, the cause of death would be documented falsely as the underlying illness. Yet if the patient changed their mind, but somehow still took the lethal medication, the cause of death would be listed as the self-administration of the medication.

- This is a serious legal inconsistency. A patient's cause of death cannot change depending on the patient's intention at the moment of death.

- This will hamper efforts to oversee the implementation of the law, since information on death certificates will not be reliable as to the actual cause of death.

6. There will be no accountability due to ineffective oversight and a lack of transparency.

- There is no requirement of standardized record-keeping. *See* § 2899-f (the Department "may" develop a standard form.) Nor is there a requirement that a report be made to the Health Department. *See* § 2899-o (the Department "may" establish regulations for reporting.)

- The bill does mandate an annual review of a sample of records by the Department, but there is no mechanism for identifying those records, or ensuring that they are a representative sample.

- This lack of genuine record-keeping will make it impossible to track the incidence of assisted suicide, or to oversee whether the law is being correctly implemented.

- There is also no requirement that the patient's family be notified of the patient's decision to resort to assisted suicide.

- There is no oversight as to when, where, with whom, etc. the patient actually ingests the lethal dosage of medication. No physician is required to be present, and there is no standard for the person's mental capacity at the time of ingestion. No timeframe is given as to when the legal dose of medication is to be administered. There is thus no way of knowing whether or not the patient is being tricked or coerced into taking the lethal medication.

7. Health care professionals will be authorized to "facilitate" the patient in taking the lethal medication, which may permit a broad range of conduct directly involved in the suicide.

- The bill states that "A health care professional shall not administer the medication to the patient but, acting within the scope of his or her lawful practice, may facilitate the patient in self-administering the medication." § 2899-g(3)

- There is no definition in the bill, or anywhere in Public Health Law, of "facilitate." In the Penal Law, "criminal facilitation" is defined as providing a person with "means and opportunity" to commit a crime, and in fact aiding in that conduct. Penal Law § 115.00(1)

- This is a very broad definition that could reach many kinds of direct and essential assistance to a suicide, such as insertion of an IV, placement of an anesthesia mask on the patient, or placing medicine in an incapacitated person's mouth so that they might swallow. Each of these actions would provide direct facilitation of a suicide, and none of them would be prohibited by the bill's provision that health professionals may not "administer" the lethal drugs.

8. The bill may permit a surrogate to request a patient's suicide and help them carry it out.

- The definition of capacity contains a provision that patient's wishes may be communicated "though persons familiar with the patient's manner of communicating if those persons are available." § 2899-d (3)

- This opens the possibility of manipulation by a person who claims to be "familiar with the patient's manner of communicating." These persons are not defined, nor is their relationship with the patient defined, nor is there any way to determine if they in fact are familiar with the means of communicating or if they are faithfully doing so. This lack of clarity invites abuse and manipulation by third parties.

- Moreover, the bill does not specifically exclude surrogate decisions by a guardian, health care proxy or a person appointed pursuant to the Family Health Care Decisions Act. Thus a patient who is incapacitated and has handed over health care decisions to a health care agent under the health care proxy law, could have the assisted suicide decision made for them by someone else.

- Health professionals are not permitted to administer the lethal medication, but there is no prohibition of the assistance of others (§ 2899-g(3)). As a result, it may be permissible for another person to actually administer the lethal medicine, and not be liable for assisting in a suicide. (§ 2899-l(1)(b))

9. A problematic definition of "health facilities" reduces conscience protection for institutions.

- The bill defines "health facilities" so that it does not include every "hospital", but instead specifies that it covers only a "general hospital." § 2899-d(5) Other facilities, such as nursing homes, are still included in this definition.

- Yet Public Health Law § 2801(10) defines "general hospital" in a way that would not include specialty hospitals (like Calvary Hospital in the Bronx which cares for the terminally ill), home health agencies, residential care facilities for the mentally disabled, or other specialized facilities.

- This is a particularly grave problem because the institutional conscience protections of the law only extend to "health facilities." This would put a significant number of institutions at risk of having no effective conscience protections.

10. Conscience protection for individuals is threatened by language permitting health care professionals to "facilitate" assisted suicide.

- As discussed above, the bill includes ambiguous language that would permit health care professionals to "facilitate" an assisted suicide.

- This raises concerns for conscience protection for individuals. Under the existing religious protections in the bill, individuals "shall not be under any duty, by law or by contract, to participate in the provision of medication to a patient under this article." § 2899-k(2) Yet it is not clear whether "facilitating" falls under this category of "participation." Instead, it appears to cover a broader range of conduct.

- As a result, if physicians or other health care professionals are not directly administering the lethal medication to the patient, but are being required to "facilitate" the patient in the process (e.g., by counseling, referring, or other indirect assistance), they may not be able to decline participation, based on their religious or moral beliefs.

11. The conscience protections for institutions are insufficient and narrow.

- A "private health care facility" is permitted to prohibit only the "prescribing, dispensing, ordering or self-administering" of the lethal medication. § 2899-k(3)(a) But many more kinds of actions are involved in a request for assisted suicide.

- As a result, a facility cannot prohibit physicians from counseling patients for assisted suicide, referring patients for the procedure, or promoting assisted suicide on the facility's premises.

- In fact, under § 2899-g(1)(2), the facility will be required to allow physicians to counsel patients about assisted suicide -- the bill states that the attending physician "shall… provide information and counseling" pursuant to the Palliative Care Information Act (Public Health Law § 2997-c). Information regarding assisted suicide may fall within the types of information required to be given under that statute.

- A health care facility cannot discipline any physician who participates in an assisted suicide off premises. *See, e.g.*, § 2899-k(4) (permitting a facility to prohibit doctors from assisting suicide "while the patient is being treated or residing in the health care facility")

- A health care facility may still have to transfer the patient to another facility that is "reasonably accessible under the circumstances and willing to permit the prescribing, dispensing, ordering and self-administering of medication." § 2899-k(3)(c)

- As a result, facilities with moral or religious objections to assisted suicide will still be required to cooperate in a suicide.