Fatal Flaws in A.5261-B (Paulin) / S.5814 (Bonacic)
Assisted Suicide Legislation (The "Patient Self-Determination Act")

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 contains a weak standard for determining capacity.**

    - The bill contains a very loose definition of capacity -- "a patient has the ability to understand, make and communicate health care decisions to a physician" (section 2899-D (4)).

    - No standard is set for making this determination. Requiring only an opinion about capacity from the attending physician is a much lower standard than analogous New York laws, such as the Family Health Care Decisions Act, where a physician must make determinations "to a reasonable degree of medical certainty." (Public Health Law section 2994(A)(5))

    - There is no requirement that a second physician be consulted about the patient's capacity. This is in contrast to the strict procedural requirements of the Health Care Proxy law (Public Health Law section 2983).

    - The "capacity" standard is clearly inadequate, as the question of whether a patient is "capable" serves as the threshold determination of whether a patient can make a request for suicide drugs.

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. (section 2899-G(1)(A))

    - The patient is only referred for psychological counseling if in the "opinion" of the attending physician (section 2899-H), it is "appropriate" (section 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 (section 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 bill invites coercion and undue influence by others.

- The bill requires two witnesses to a patient's written request for assisted suicide, and one of these two witnesses cannot be 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. (section 2899-F)

- 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 associate associated with the health care facility where the patient is receiving treatment.

- There is no requirement that either witness be an adult or that they know 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 interested in the patient's death, and the other witness may be a minor.

4. Surrogate decision-making by persons other than the patient.

- The definition of capacity also contains a provision that permits a third party to participate in communicating a patient's wishes -- "a patient has the ability to understand, make and communicate health care decisions to a physician, *including communications though persons familiar with the patient's manner of communicating if those persons are available."* (section 2899-D (4)).

- This opens the possibility of manipulation by "persons familiar with the patient's manner of communicating." These persons are not defined, nor is their relationship with the patient defined.

- The bill also 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 person who is mentally competent but incapacitated, who 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.

- A patient is permitted to self-administer a legal dose of medication, although this is not a requirement. (section 2899-M) As a result, it is permissible for another person to actually administer the lethal medicine.

5. The system lacks accountability and transparency.

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

- There is no requirement that the patient be informed of alternative treatments to assisted suicide (i.e., comprehensive pain management, psychological treatment, hospice care, etc.).

- However, the New York Palliative Care Information Act (Public Health Law Section 2997-C), requires physicians and health care practitioners to offer terminally-ill patients information and counseling concerning palliative care and end-of-life options. This could increase pressure on patients to choose suicide, since there is nothing in the Palliative Care Information Act that would exclude having suicide offered as one of these end-of-life options.

- There is no reporting to the Department of Health and no internal review process at the facility.

- There is no oversight as to when, where, with whom, etc. the patient actually takes 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 taking the medicine. 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 coerced into taking the medication at the time it is administered nor who is actually administering the pills.

- The bill requires a false statement to be made on the patient's death certificate about the cause of death. Instead of listing the cause of death as the lethal dose of medication or assisted suicide, "the death certificate shall indicate that the cause of death was the underlying terminal illness or condition of the patient." (section 2899-T) This will prevent any independent evaluation of the incidence and circumstances of suicides, and there will be no way to monitor potential abuses.

6. The bill contains very weak conscience protection for individuals.

- No physician, nurse, pharmacist, or other person is required to "participate in the provision of a lethal dose of medication to a patient." (section 2899-N)

- Participating in the actual administering of the lethal dose of medication is only one narrow provision of cooperating in the assisted suicide as a whole. Nurses and doctors are not exempt from cooperating in the assisted suicide in other ways that may also violate their conscience, i.e., counseling, referring, indirect assistance in the procedure, etc.

- Specifically, individuals are still required to cooperate in the assisted suicide because they must refer the patient to a physician, nurse, or pharmacist, so that the patient may receive the lethal dose of medication. (section 2899-N)

- These conscience protections are much weaker than those contained in comparable provisions of current New York law (see, e.g., Civil Rights Law section 79-i).

7. **The bill contains barely existent conscience protection for health care facilities**.

- Health care facilities must notify physicians in writing of their policy with regards to prescribing lethal doses of medication for assisted suicide. However, the only conscience protection for health care facilities is that they are permitted to prohibit a physician from writing a prescription for a lethal dose of medication to be used on the facility's premises. (section 2899-O)

- Facilities thus cannot prohibit physicians from counseling patients, referring patients, or promoting assisted suicide on premises. They also cannot discipline any physician who participates in an assisted suicide off premises.

- Essentially, this means that a health care facility cannot discipline a physician who recommends an assisted suicide for a patient and then goes off premises to prescribe and/or administer the lethal dose of medication.

- These institutional conscience protections are much weaker than those in comparable provisions of current law (see, e.g., 10 NYCRR 405.9 (b)(10))