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Fatal Flaws in Assisted Suicide Legislation

Proponents of the so-called "Medical Aid-in-Dying Act" (S138/A136 of the 2025/2026 NYS Legislative Session) 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. The bill lacks transparency and accountability, and contains extremely weak conscience protections for both health care professionals and health care institutions. In short, it is unsafe for all involved.

1. The definition of "terminal illness or condition" is ambiguous and increases the risk of errors in diagnosis.

- The bill defines a "terminal illness or condition" as "an incurable and irreversible illness or condition that has been medically confirmed and will, within reasonable medical judgment, produce death within six months,"
  Note that it does not specify if this prognosis is with or without treatment. § 2899-d(17)
- Virtually anything could qualify under this definition, including a chronic illness like diabetes or ALS that would cause death if the person declined ordinary treatment. Patients who cannot afford expensive treatments would be particularly at risk due to this definition.
- This is a significantly lower standard for diagnosis than the "reasonable degree of medical certainty" that 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.

2. The standard for determining capacity is too weak.

- The bill contains a very loose definition of capacity – "the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, including medical aid in dying, and to reach an informed decision." § 2899-d(3)
- No standard is set for making this determination. All it requires is that the physician "make a determination of whether a patient... has capacity." § 2899-f(1)(a). This 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 § 2994-A(5). A determination of capacity must be supported by "clear and convincing evidence" in the appointment of a guardian. MHL § 8102 (2)(b)
- The "capacity" standard is clearly inadequate, which is a crucial flaw since this is the threshold determination of whether a patient can even make a request for suicide assistance.

3. No psychological screening, counseling, diagnosis or treatment is required.

- There is no mandatory referral of the patient to a psychiatrist to determine if they are suffering from a treatable mental illness that led to the suicide request (e.g., clinical depression).
- Instead, a referral is only optional and it is limited to determining if the patient has decision-making capacity. § 2899-f(c)
- Even if a referral is made, there is no requirement that it be done by a physician or psychiatrist – the bill only requires an evaluation by a "mental health professional," which includes a nurse practitioner or psychologist.
  §§ 2899-i(1) and 2899-d(11)
- There is no requirement that the patient's family be notified, which isolates the patient from the very people who can provide them with the support they need.
- The bill thus essentially abandons vulnerable patients who are suffering from treatable psychological conditions.

4. There are inadequate protections for patients when the request is made.

- The bill has weak witness requirements. This is problematic because patients, particularly isolated elderly patients in long-term care facilities, are vulnerable to exploitation and abuse.
- There is no requirement that the witnesses even know the patient prior to the suicide request. § 2899-e(3) Instead, the witnesses are permitted merely to certify that the patient "provided proof of identity." § 2899-k
- There is no waiting period between the time of the request and the time when the suicide drugs can be dispensed.
- There is no requirement that the patient be a New York resident. This means that New York could turn into a suicide destination, and death on request will be available to vulnerable people with no connection to our state or to the treating physician.

5. There are no protections for the patient after the drugs are dispensed.

- Once the patient receives the pills, there are absolutely no protections. There is no oversight as to when, where, with whom, etc. the patient actually takes the lethal dosage of drugs.
- There is no requirement that the patient's decision-making capacity be evaluated at the time that they self-administer the pills.
- There is no way to ensure that the patient isn't being coerced into taking the lethal medication.
- While the patient is required to "self-administer" the drugs by "using" them, this definition is weak and ambiguous, and could simply mean the patient must swallow the pills. § 2899-d(16) This does not rule out another person actually giving the pills to the patient, undermining the bill's provision that "A health care professional or other person shall not administer the medication to the patient." § 2899-f(3)
- There is no requirement of any follow-up evaluation by the physician, to determine if the patient's condition has changed or if other treatments have become available.
- There is no requirement of any further evaluation by a mental health professional, to determine if the patient is suffering from a psychological illness (e.g., clinical depression).
- No physician or other health professional is required to be present at the time the patient takes the lethal pills. The patient may thus suffer unnecessarily.
- There is no way to ensure that the drugs are not used or abused by someone in the house other than the patient.

- There is a provision that "a person in control of the unused medications shall personally deliver the unused medication for disposal to the nearest qualified facility…" § 2899-o But there is no enforcement mechanism or accountability for that provision.
- The lack of patient protection at the time the drugs are administered is even more dangerous, given the lack of transparency and oversight in the bill (see Points 6 and 7, below).

6. Intentional false statements on death certificates hide the truth.

- The bill's definition of "medical aid in dying" acknowledges that the medicine is the cause of death, not the underlying illness ("the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death."). § 2899-d(8) This fits any reasonable definition of "suicide."
- But instead of listing the cause of death as suicide, the bill requires that the physician lie on the death certificate. The bill specifically states that the death certificate shall indicate that the cause of death "will be the underlying terminal illness or condition." § 2899-p(2)
- Under any other circumstance, a deliberate false statement on a death certificate would be a crime. Penal Law § 175.30, Public Health Law § 4102(1)(a).
- The failure to identify suicide as the actual cause of death will hamper efforts to oversee the implementation of the law, since information on death certificates will not be reliable and there will be no way to determine if physician-assisted suicides actually have occurred.
- The bill also prohibits insurance companies from denying benefits to any person who commits suicide. Together with the false statement that is required on the death certificate, this creates clear incentive for insurance fraud, and thus for undue influence or coercion.

7. There will be no effective accountability and oversight to prevent abuses.

- The bill immunizes the physician and other health professionals from any criminal, civil or professional liability, so long as they acted with "reasonable good faith." § 2899-l(1)
- There is also a blanket exclusion of any criminal prosecution for anything done under the bill – "Action taken in accordance with this article shall not be construed for any purpose to constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, euthanasia, mercy killing, or homicide under the law, including as an accomplice or accessory or otherwise." § 2899-n(1)(b)
- This "good faith" defense and blanket exclusion clause completely negate the purported penalty provisions elsewhere in the bill and prevents any meaningful oversight by law enforcement officials. §§ 2899-l(2) and 2899-r(2)
- There is no mechanism for a systematic evaluation and oversight by public health authorities.
- There is no requirement that a report be made to the Health Department whenever action is taken under the statute. § 2899-j (requiring only entries in the patient's health record, but not requiring any report to public authorities).
- The bill requires an annual review by the Department of Health of a sample of patient records, but there is no mechanism for identifying those records or ensuring that they are a representative sample. § 2899-q(1)
- Any records collected by the Department are completely shielded from being produced pursuant to the Freedom of Information Law. As a result, if this bill were enacted, there is no possibility for independent evaluation of how the law is being implemented. § 2899-q(1)

- Although the bill does require the Department to issue an annual report, this will have no real value because of the incompleteness of the records and the lack of independent review. § 2899-q(2)
- This lack of oversight capability will make it impossible to track the incidence of assisted suicide, or to ascertain whether the law is being abused.

8. There is inadequate conscience protection for individuals.

- The bill states that "A physician, nurse, pharmacist, other health care provider or other person shall not be under any duty, by law or contract, to participate in the provision of medication to a patient under this article." § 2899-m(1)(a)
- The term "provision of medication" is not broad enough to encompass all religious or moral objections to participating in assisted suicide. For example, many people would have a religious or moral objection to counseling or referring for physician-assisted suicide. The definition also does not adequately protect those who provide indirect assistance, such as the pharmacist dispensing the medicine.
- This is a particular danger, because the Palliative Care Information Act requires that when presented with a terminally ill patient, health care practitioners "shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options appropriate to the patient". Public Health Law § 2997-c(2)(a)
- If the practitioner has an objection, the Palliative Care Information Act requires that they refer the patient to another person who will provide that information. Public Health Law § 2997-c(3) This kind of referral is still morally impermissible cooperation in a suicide.

9. There is insufficient conscience protection for institutions.

- The bill appears to provide some conscience protection for "health care facilities," but defines "health care facilities" only to include general hospitals, nursing homes, residential health care facilities, and hospices. § 2899-d(5)
- This would not include doctor's offices, ambulatory clinics, specialty hospitals, home health agencies, residential care facilities for the mentally disabled, or other specialized institutions.
- This would put a significant number of institutions, including religious institutions and the people who work in them, at risk of having no effective conscience protections.
- In addition, a private health care facility is permitted to prohibit only "the prescribing, dispensing, ordering or self-administering of medication under this article **while the patient is being treated in or while the patient is residing in** the health care facility" (emphasis added). § 2899-m(2)(a)
- As a result, a facility cannot discipline any person on their staff who counsels or participates in an assisted suicide off premises.
- The health care facility can only decline to participate if it informs patients and transfers patients who request suicide to another facility that is "willing to permit the prescribing, dispensing, ordering and self-administering of medication." § 2899-m(2)(b)
- This kind of referral requires institutions to cooperate in suicide, since it involves knowingly providing a person with the means and opportunity to obtain the morally objectionable act.

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