PATIENTS RIGHTS ACTION FUND

Review of New York Assembly Bill 4321 (2021)

***Overview*:**

Neither the New York constitution nor the U.S. Constitution contains a right to assisted suicide; therefore, no individual has the right to authorize another to kill him or her in violation of federal and state criminal laws. *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997). Instead, New York has an "unqualified interest in the preservation of human life." *Id.* at 728. New York's current statutory "prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to [preserving and protecting human life]." *Id.* at 735.

The conclusion that there is no constitutional right to obtain assistance in ending one's life does not change with suicide advocates' deceptive attempts to reclassify assisted suicide as "medical aid in dying." As the Court of Appeals of New York (the State's highest court) recently ruled, "[a]lthough New York has long recognized a competent adult's right to forgo life-saving medical care, we reject [the] argument that an individual has a fundamental constitutional right to aid-in-dying." *Myers v. Schneiderman*, 85 N.E.3d 57, 60 (N.Y. 2017).

Importantly, suicide, including physician-assisted suicide, is not a typical reaction to an acute problem or life circumstance, and many individuals who contemplate suicide, including the terminally ill, suffer from clinical depression or other treatable emotional or mental issues, which frequently go undiagnosed and untreated by physicians. *See, e.g.*, New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 77-82 (May 1994). For this reason and many others, the medical profession as a whole opposes physician-assisted suicide because it is contrary to the medical profession's role as healer and undermines the physician-patient relationship. *Washington v. Glucksberg*, 521 U.S. at 731.

New York Bill A 4321 seeks to obliterate the State's "unqualified interest" in protecting and preserving human life, including the lives of the vulnerable, sick, and disabled. Instead, the bill erroneously accepts a "sliding-scale approach" that claims certain "qualities of life" are not worthy of equal legal protection. *Id.* at 729.

Maintaining New York's existing prohibition on assisted suicide, including physician-assisted suicide, is the only way to protect vulnerable citizens. *Id.* at 732.

***Specific Concerns with A 4321*:**

A 4321 purports to provide a legal mechanism under which certain patients are able to request assistance from the "attending physician" in committing suicide—what the bill fraudulently calls "medical aid in dying." There are many and significant problems with the bill's language that endanger the vulnerable, sick, and disabled.

* Dangerous Policy Decision to Decriminalize Physician-Assisted Suicide: Recognizing its "unqualified interest" in preserving and protecting all human life, New York law currently classifies assisted suicide as a crime. N.Y. PENAL LAW § 120.30 and § 125.15. A 4321 specifically decriminalizes physician-assisted suicide, falsely reclassifying it as accepted medical treatment.

* A 4321 Lacks a Residency Requirement, Opening the State to "Assisted Suicide Tourism": A 4321 does not limit requests for physician-assisted suicide to legal residents of New York. Citizens from other states could travel to New York and receive prescriptions for lethal medications.

* Broad Definition of "Terminal Illness": To qualify for physician-assisted suicide under A 4321, a patient must have a "terminal illness." However, the bill's definition of "terminal illness" is incredibly broad. For example, it does not differentiate between situations where death will occur within 6 months even with treatment from situations where death would not likely occur if the patient sought and received treatment. This means that someone who has a treatable disease or condition (e.g., diabetes) who refuses treatment or who is denied insurance coverage for certain treatments is eligible to request and receive lethal drugs.

Concerns with Process for Requesting Lethal Medication:

* *A 4321 "Fast Tracks" Assisted Suicides*: A 4321 does not include statutory waiting periods between the oral and written requests for lethal medication or between these requests and the issuance of a prescription. The required process for requesting and receiving lethal medications can proceed in haste, effectively denying the patient, the "attending physician," the "consulting physician," and the "mental health professional" adequate time for a thorough medical evaluation and proper reflection. Other state laws typically prescribe a 15-day reflection period and then require the patient to confirm his or her request in writing after the reflection period. Such requirements better protect patients from impulsive, ill-informed, or coerced requests for assisted suicide. These minimal protections are completely absent from the A 4321.

* *No Requirement for In-Person Requests or Mental Health Evaluations*: A 4321 does not affirmatively require that oral or written requests for assisted suicide be made or the optional mental health evaluation take place during in-person consultations between the patient and the "attending physician," the "consulting

physician," or the "mental health professional." This opens the door to the inappropriate use of "telemedicine" for these requests and evaluations and increases opportunities for coercion of the patient and for abuse of the process.

* *Lack of Meaningful Mental Health Evaluation*: There is no affirmative requirement that any patient requesting physician-assisted suicide undergo a complete mental health evaluation or be screened for treatable conditions such as depression. Instead, A 4321 only provides for an optional referral to a "mental health professional" who is charged with simply determining "whether the patient has capacity to make an informed decision." This illusory requirement utterly fails to protect vulnerable patients. Just because a patient has the capacity to make an informed decision does not mean he or she is, in fact, making a voluntary and truly informed decision.

Many patients whose mental health concerns are properly diagnosed and treated change their minds about suicide. For example, in one study of assisted suicide in Oregon, 46% of patients seeking assisted suicide changed their minds when their physicians intervened and appropriately addressed suicidal ideations by treating their pain, depression, and/or other medical problems. Linda Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act," 342 NEW ENG. J. MED. 557, 557 (2000). Given the prevalence of suicide hotlines and counselors that could save the lives of almost half of those contemplating suicide, it is irresponsible and contrary to the State's interest in life not to require such counseling.

* *Inadequate Protection Against Coercion or Undue Influence*: A 4321 purportedly requires that the patient's request for lethal medications be voluntary; however, it fails to provide adequate protection against coercion or undue influence. The bill does not define "coercion" or "undue influence." Instead, it appears to accept (1) nominal and unsupported assertions by a patient that his or her request is voluntary and that he or she is not being coerced, and (2) minimal evaluation by the physician that the patient is acting "voluntarily" and "not being coerced."

* *Witnesses to Written Request Can Have Conflicts of Interest*: The bill requires that the patient's written request for physician-assisted suicide be witnessed by two persons. One of the witnesses can be a relative, heir, or someone with a claim to the patient's estate. There is no requirement that the second witness (who is not a relative or heir) be completely independent. This could easily result in abuses. For example, the second witness could be a friend of a person who stands to benefit financially from the patient's death.

* *Attending Physician May Refer Patient to Another Provider for Actual Prescription*: Any suggestion that a patient requesting lethal medication under

A 4321 is receiving personalized and complete care from his or her "attending physician" is specious. Proposed Section 2899-f(2) provides that "[u]pon receiving confirmation from a consulting physician, … the attending physician who determines that the patient has a terminal illness or condition, has capacity and has made a voluntary request for medication, … may personally, *or by referral to another physician*, prescribe or order appropriate medication."

* *No Oversight of Lethal Drug Administration*: The bill does not require that the attending or prescribing physician be present when the lethal medication is ingested to ensure the patient's voluntary decision/action or to deal with possible complications. In fact, there is no requirement that any witness attest to the patient's physical or mental capacity when the drugs are ingested or to confirm that the patient's decision was voluntary.

* A 4321 Perpetuates Dangerous Falsehoods: Attempting to maintain the fiction that physician-assisted suicide is legitimate medical treatment, A 4321 asserts that action taken in accordance with the bill does not "constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, euthanasia, mercy killing, or homicide … under the law."

* A 4321 Fails to Protect the Freedom of Conscience of Healthcare Providers:

A 4321 provides only limited conscience protections for individual healthcare providers and private healthcare facilities. Public healthcare facilities, such as a county health clinic or hospital, are not expressly protected. Under proposed Section 2899-m(2)(b), private healthcare facilities that object to assisted suicide must, "if a patient … requests," promptly transfer the patient "to another health care facility that is reasonably accessible under the circumstances and willing to permit the prescribing, dispensing, ordering and self-administering" of lethal medication. Such mandated transfers would violate the freedom of conscience of many private healthcare facilities including Catholic and other religiously affiliated hospitals, who believe that any action that facilitates or furthers assisted suicide is a grave violation of their sincerely held religious beliefs.