An Analysis of New York State's Medical Aid in Dying Act (A. 2383A S. 3151)

Michael Dauber

ABSTRACT

Medical Aid in Dying Act (A. 2383A S. 3151) was recently filed with the New York State legislature[1]. The bill is designed to legalize a form of voluntary euthanasia for patients with terminal illnesses who wish to end their lives rather than experience unbearable suffering and decline. The bill is modelled after a similar act that legalized physician-assisted suicide in Oregon in 1997, the Death With Dignity Act.[2,3] This article will provide a brief sketch of the legislative climate surrounding the bill, the content of the bill itself, and an analysis of the views of proponents and critics.

Keywords: medical aid in dying act, New York, end of life, legislature, physician-assisted suicide

INTRODUCTION

Medical Aid in Dying Act (A. 2383A S. 3151) was recently filed with the New York State legislature[4]. The bill is designed to legalize a form of voluntary euthanasia for patients with terminal illnesses who wish to end their lives rather than experience unbearable suffering and decline. The bill is modelled after a similar act that legalized physician-assisted suicide in Oregon in 1997, the Death With Dignity Act.[5,6] This article will provide a brief sketch of the legislative climate surrounding the bill, the content of the bill itself, and an analysis of the views of proponents and critics.

II. DISCUSSION

A. History and Legislative Climate

While physician assisted suicide remains a controversial issue in both theory and practice, there has been a steady trend toward legalization over the past twenty years, starting most famously with Oregon, which became the first state to legalize physician-assisted suicide in 1997. Since then, Montana, Washington State, Vermont, Colorado, and Washington D.C., and California have joined Oregon in legalization, with each passing legislation except for Montana, in which the practice was legalized judicially in Baxter v. Montana.[7] Over the years, many medical organizations have also shifted their stances on physician-assisted suicide [5], as have bioethicists, individual physicians, and the general public.

This year's Medical Aid in Dying Act follows a ruling in a Court of Appeals case last year, Myers V. Schneiderman (2017) [6], in which The New York State Court of Appeals ruled that New York law does in fact make physician-assisted suicide illegal despite the fact that the practice is not explicitly forbidden by name. The case follows a long history of precedent against a legal right to physician assisted suicide, most popularly referred to in the Supreme Court cases Washington v. Glucksberg (1997) [7] and Vacco v. Quill (1997) [8]. The two cases have the effect of acknowledging that physician assisted suicide is a moral right of self-determination. However, this right is never acknowledged as a legal right or entitlement because there is a compelling state interest against the practice that can be explained by the concern for the erosion of trust in the medical profession. The state also has an overriding interest in protecting the value and continuation of life.

The cases also accept that there is a fundamental ethical difference between the withdrawal or withholding of life-sustaining treatment and physician assisted suicide. This distinction has been at the crux of the debate for decades. Peter Singer delineated a fine distinction between the different kinds of euthanasia in Practical Ethics in 1979 [9], writing that there are ethical differences between voluntary, non-voluntary, and involuntary euthanasia. Voluntary euthanasia occurs when the patient actively wishes to have his or her life terminated; involuntary euthanasia, which is illegal everywhere, occurs when a patient objects to having his or her life terminated, but an individual terminates the patient's life anyway; and non-voluntary euthanasia occurs when an individual is incapable of consenting to have his or her life terminated, but their life is terminated anyway. All physician-assisted suicide laws and cases concerning the legalization of the practice specifically concern voluntary euthanasia. The same year, James Rachels wrote his seminal essay Active and Passive Euthanasia [10], in which he argued that there is no ethical difference between active and passive actions if the intended goal is the same; there ought not to be an ethical or legal difference between withdrawing life-support and other medical interventions, a practice generally considered ethical, and actively administering medications that will end the patient's life. He goes a step further, suggesting that it is immoral to prohibit active (voluntary) euthanasia, because doing so forces patients to undergo further pain and suffering. The courts have traditionally only acknowledged what Rachels would call passive euthanasia (i.e. letting a terminal patient die in accordance with his or her wishes or the consent of a surrogate, by withdrawing life-sustaining treatments or declining to initiate further interventions), and so physician-assisted suicide legislation is designed to legalize active euthanasia.

Because precedent is so set against judicial acknowledgment, especially in the Supreme Court, the main push for legalization comes from state legislatures. While many states are currently considering enacting their own bills and some surveys suggest that a significant majority of individuals favor legalization [11-13], it is by no means certain that the Medical Aid in Dying Act will be legalized in New York. An earlier version of the bill was filed last year but was not adopted, and some individuals familiar with the situation suggest that it is unlikely to pass this year either.

B. A Note on Terms

Before delving into the main analysis of the bill itself, it is important to take note of the terms used in the bill and in this article. One of the key points of contention in the debate revolves around terminology: proponents of physician-assisted suicide and some medical organizations often prefer the term "medical aid in dying," rather than any language involving the term "suicide" to capture two unique aspects of the practice. First, medical aid in dying appears to be phenomenologically different than stereotypical cases of suicide: patients who chose medical aid in dying do so in order to avoid the prospect of severe physical and psychological suffering that may come with terminal diagnoses and disease progression. This practice is substantially different from otherwise healthy individuals who wish to die from a sense of hopelessness, meaninglessness, or depression. It reflects a fundamentally different experience of one's relationship to oneself, one's physician and family, and the world as a whole, and occurs as a staged, regulated, reflective choice in response to the fact that one's physical maladies cannot be fully treated or cured. For the purposes of this article, the concept of a possible "end-stage" of mental illness is ignored, as current medical policies do not acknowledge mental illness as terminal in the same manner as physiological/metabolic disorders. This distinction is acknowledged by the American Society of Suicidology, which issued a statement in October 2017 affirming that the phenomena are conceptually and ethically distinct [14]. Second, "medical aid in dying" serves to better capture the fact that patients with terminal illness will die regardless of medical intervention. With medical aid in dying, patients receive aid in controlling the manner, timing, and quality of their deaths, regaining some measure of control over their fates.

On the other hand, opponents criticize the use of the term as a way to euphemize in an attempt persuade medical practitioners, politicians, and the general public that the practice isn't really morally wrong. Typical of debates in bioethics and philosophy, no side is truly correct: the semantic issue largely boils down to one's individual intuitions. While I personally see the distinction between the actions of individuals with depression or other psychiatric distress who would otherwise be metabolically capable of long-term survival and the actions of the terminally ill, suicide itself refers in raw terms to the act of terminating one's life. The wider issue is that the term "suicide" has rightfully come to have a negative moral connotation, such that its use frequently causes an automatic moral prejudice on the part of the listener. So, while I personally see no issue with using the term "suicide" to describe medical aid in dying, it is understandable why many individuals wish to use less morally-charged terms. The point is not to sneak an immoral action into law and to render participants in the debate ignorant; rather, proponents of the terms "medical aid in dying" are trying both to accurately describe the phenomenon and to use terms that do not automatically carry negative connotations.

C. The Bill

Based on the act that legalized physician-assisted suicide in Oregon, the medical aid in dying act allows mentally competent patients with terminal illness to request medications that will end their lives. Physicians will be legally permitted to prescribe and dispense medications that the patient may voluntarily consume. In order to obtain a prescription a patient must be at least 18 years old and have a terminal illness (as defined by the law). Two physicians must confirm both the diagnosis and that the patient meets the legal requirements to make a request (the attending physician on the case and an additional consulting physician). Patients will be required to make both oral and written requests. The written request must be witnessed by "at least two adults who, in the presence of the patient, attest that to the best of his or her knowledge and belief the patient has capacity, is acting voluntarily, and is not being coerced to sign the request" [15]. At least one witness cannot be related to the patient, entitled to receive any of his or her estate or any other benefit upon the individual's death, an employee of the institution in which the patient is being treated, or a member of the medical team responsible for determining the patient's capacity. Patients with uncertain capacity for decision-making must be referred to a separate mental health professional for evaluation. Perhaps most crucially, patients can revoke their request for medical aid in dying at any point during the process, and patients must self-administer the drugs, distinguishing the proposal from laws that would directly involve the physician in the act.

Physicians are responsible for confirming the patient's diagnosis and prognosis, and that the patient is over the age of 18. Additionally, physicians must determine that the patient is mentally competent and has the capacity to choose medical aid in dying. The duties of the physician include verifying that the request is free of coercion or undue influence, referring the patient to outside mental health professionals when necessary, documenting each step in the process specified under the law (including the relevant paperwork, listed in the text of the law along with sample forms), and prescribing the medications and informing the patient of the associated risks, expected effects, and possible complications (i.e. that the drugs might not work as intended).

The bill also importantly specifies that doctors, nurses, mental health professionals, the institution in which the patient is being treated, and other members of the care team are not criminally, professionally, or civilly liable for the patient's death. The patient's death will not be legally considered suicide, which protects rights of inheritance upon the patient's death, which might otherwise be compromised if the patient were deemed to have committed suicide. Finally, the Act also includes a "conscientious objector" clause that states that no health care professionals are legally required to participate in medical aid in dying in any capacity.

III. ANALISYS

As mentioned above, the bill is largely based on legislation that legalized medical aid in dying in Oregon in 1997. As such, any positive or negative commentary on this bill could largely be directed towards that bill as well. However, it is important to carefully go over what this specific bill does well and what it might be able to do better.

On the positive end, the Medical Aid in Dying Act provides a measured, thorough process for ensuring that patients have capacity for decision-making and that they truly wish to pursue medical aid in dying. It builds on legislation that has worked well in Oregon for twenty years; Oregon has not seen any cases of alleged abuse of medical aid in dying, nor have fears that the number of suicides per year would skyrocket or that elderly or poor individuals would be systematically pressured to choose medical aid in dying come to fruition. Assume for the purposes of this analysis that medical aid in dying cases are actually considered suicides (the Oregon State government does not [16]). While the total number of suicides has indeed risen in states in which physician assisted suicide is legal [17], the overall rate of deaths from physician-assisted suicide has remained relatively low (37.2 for every 10,000 deaths in Oregon in 2016[18]), suggesting that fears of systematic, disastrous consequences are unwarranted, especially given the numerous safety checks in place. While it is true that accurate statistics on potential abuses or pressures are inherently difficult to obtain, the fact that no verified, systematic evidence has appeared is encouraging, and New York advocates are wise to follow the model set by the Oregon law.

That being said, there are two areas in which the bill might be improved, both of which concern additional safeguards to prevent abuses. The first issue lies in witness documentation of the patient's capacity and desire for medical aid in dying. In an effort to prevent coercion, undue influence, and other conflicts of interest, the bill requires that at least one witness cannot be an individual who stands to benefit from the patient's choice in any way. However, the bill also allows one such individual to be present. It is still possible that the presence of one such individual could present an undue influence.

Admittedly, this scenario is highly unlikely, given the number of interactions that the care team will have with patients requesting medical aid in dying. If a patient truly did not wish to pursue medical aid in dying, he or she would almost certainly have an opportunity to approach his or her physician or another health care professional alone and ask for help. However, no such isolated interactions are required under the law, at least not explicitly. While many might not think such interactions are necessary and could be undesirable from the perspective of some patients, isolated interactions are sometimes required to gauge the patient's true wishes. Clinical ethicists frequently note that patients will sometimes ask for one thing in the presence of family members and another when discussing their situation without family presence. Although not an end of life case, I had one such case myself. A patient was being asked which of his children he would like to be discharged home to. When one of his daughters was present (let's call her Emily), he expressed a desire to live with her; when we asked her to step out, he asked us not to send him home with her, as she abused him.

Again, while such cases are admittedly rare, it would widely be considered good practice for a clinician to talk to the patient at least once without family present in medical aid in dying cases. However, the law proposed would not explicitly require such an interaction or documentation that such a conversation occurred. It is likely that clinicians will hold these conversations anyway, but an often-repeated legal maxim is "get it in writing": the Medical Aid in Dying Act could only be strengthened by including an explicit reference to the need for such conversations.

A second safeguard that could be added to the bill comes from a case cited by medical aid in dying critic Margaret Dore. At a recent event held at Hofstra University, she described a case in which a patient's son may have slipped him the medications in a "special drink" after the two had been drinking for a while [19]. The allegation is that the patient's son had wanted the patient to die, and that the patient was having second thoughts upon receiving news of a better prognosis.

Now, the facts of the case are anything but confirmed, partly by definition: unless one was present that night, it would be impossible to truly know what happened. Additionally, Dore's opponent at the event David Leven noted that the case was never brought to trial, and as such the fact remains that there have not been any cases that have ever shown that medical aid in dying medications have been administered without patient consent. Still, one might worry that cases like the one she described are theoretically possible under the current medical aid in dying policies legalized around the country, given the fact that patients are given the medications as a take-home prescription.

There are two possible solutions to this problem. First, policy-makers might reconsider the idea of giving the patient the medications as an open-ended take-home prescription, and instead dispense the drugs only by request of the patient when they are ready to consume them. Patients would not be able to store the drugs at home without a predetermined date of use, but would be given the drugs on the day they plan to use them, either by selecting a date in advance or by calling their doctor for the drugs once they are ready to consume them. This would reduce the likelihood of abuse against the patient or of accidental consumption or abuse by a third party, and serve as a final check that the patient wishes to choose medical aid in dying. Alternatively, legislators could require either the presence of a health care professional or a brief visit by a health care professional on the day the patient wishes to consume the medications. While the extra visit would not entirely eliminate the risk of abuse, the additional check would allow clinicians to verify the patient's state of mind on the date of consumption. It would also provide a check that may be a clear point of investigation if abuse is suspected: skipping the check could raise red flags for regulators. Of the two additional regulations, involving a healthcare professional would be preferable, as logistical issues with pharmacies might prevent a patient from obtaining the medications themselves in a timely manner. Health care professionals are usually available, or could reasonably be made available to support such a policy if it were enacted.

One might reasonably object to my suggestions by pointing to the fact that no evidence of abuses has been gathered or verified, or that my suggestions present an undue, unwelcome burden on both patients and their families. It is also possible that patients may innocently forget to wait for a health care provider check-in before consuming the medications, raising suspicion on family members despite the absence of wrongdoing. I certainly see the strength of both criticisms. However, given the stakes involved in physician-assisted suicide legislation and that such policies provide legal sanction for clinicians and individuals to end lives, it does not seem unreasonable to take additional precautions to ensure that medications are administered ethically.

CONCLUSION

The Medical Aid in Dying Act will be reviewed by the New York State Legislature some time this year. The bill, based on the Oregon Death with Dignity Act, is in line with other major legislation to legalize and regulate physician-assisted suicide and presents widely recognized policies. While the bill does appear to meet the best practices of states in which physician-assisted suicide is legal, there are a few areas in which additional regulations could be added as further safeguards for ethical implementation and regulation.

REFERENCES

---

[1] Medical Aid in Dying Act (A. 2383A S. 3151). New York State Assembly. Accessed 25 March 2018. Accessible here: http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Actions=Y&Floor%26nbspVotes=Y&Memo=Y&Text=Y. The page contains the full text of the proposed bill.

[2] Chin, Arthur E., Katrina Hedberg, Grant K. Higginson, and David W. Fleming. "Legalized physician-assisted suicide in Oregon—the first year's experience." New England Journal of Medicine 340, no. 7 (1999): 577-583.

[3] "Death With Dignity Act" (1997). Oregon Health Authority. Accessed 25 March 2018. Accessible here: http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx

[4] Medical Aid in Dying Act (A. 2383A S. 3151). New York State Assembly. Accessed 25 March 2018. Accessible here: http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Actions=Y&Floor%26nbspVotes=Y&Memo=Y&Text=Y. The page contains the full text of the proposed bill.

[5] Chin, Arthur E., Katrina Hedberg, Grant K. Higginson, and David W. Fleming. "Legalized physician-assisted suicide in Oregon—the first year's experience." New England Journal of Medicine 340, no. 7 (1999): 577-583.

[6] "Death With Dignity Act" (1997). Oregon Health Authority. Accessed 25 March 2018. Accessible here: http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx

[7] Baxter v. Montana, 2009 W.L. 5155363 (2009).