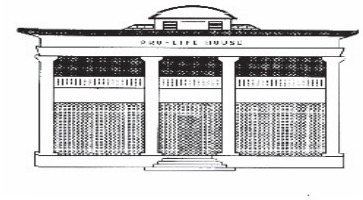

Greetings

" For behold, when the voice of your greeting came to my ears, the babe in my womb leaped for joy." **Luke 1 45**

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Flirting with Death

by Richard M. Doerflinger

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Did New Jersey's Assembly approve an assisted suicide bill without understanding it? The bill is bad public policy, shot through with dangerous loopholes and contradictions that threaten to push many vulnerable citizens of New Jersey toward death.

The former Hemlock Society, now called "Compassion & Choices" (C&C), thinks it scored a major coup with the publicized death of young brain cancer patient Brittany Maynard. The organization has distributed videos in which Maynard expresses her desire to die by barbiturate overdose before her illness worsens, and her frustration over having to move to Oregon to obtain a doctor's help in doing so. C&C plans to use videos featuring Maynard, recorded before her November 1, 2014, suicide, to exploit public sympathy for her plight and promote its legalization proposals in a dozen states.

The first state to act on these proposals is New Jersey, whose state Assembly rushed to approve an assisted suicide bill, A. 2270, on November 13 of last year. At this writing, the bill is poised for Senate debate later this month; Governor Christie has said he opposes it.

One can hope the Senate will view this proposal more carefully than the Assembly did in its fit of sympathy for Maynard. Whether doctor-assisted suicide for terminally ill patients should be legal is a question that tends to divide Americans right down the middle. Certainly the prospect of authorizing assistance in the suicides of one class of citizens, while retaining full legal protection for the lives of everyone else considering suicide, should trouble anyone committed to equal protection under law. But A. 2270 is bad public policy by any reasonable standard. Like its predecessors in Oregon and Washington, it is shot through with dangerous loopholes and contradictions that threaten to push many vulnerable citizens of New Jersey toward death.

Assembly members may be assuming that A. 2270 would provide the option of a "humane and dignified death" for people fitting the profile projected by Maynard. In this scenario, a lucid person of sound mind, facing an imminent death of intractable pain and suffering, consults with her loving family and makes a voluntary and uncoerced decision to obtain a physician's help in taking her own life. Whether that profile fits Maynard's own case is anyone's guess—we have seen only the "reality television" show that C&C wanted us to see. But it unquestionably has little to do with the real-world impact of A. 2270. To understand why, we must read the bill carefully.

Support of a loving family

Brittany Maynard, as a 29-year-old woman who was healthy and active until she contracted cancer, was probably accustomed to thinking and acting for herself and having her wishes respected by those around her. But fewer than 1 percent of the people who have died under the Oregon law (six out of 752), and *none* of the 71 who died last year, were under 35. The median age has consistently been 71. Last year, half the patients cited being a "burden" on others as a reason for taking the lethal dose.

New Jersey is debating this proposal in a society where elder abuse is said by some health officials to be a "silent epidemic." An estimated 90 percent of this abuse and neglect is practiced by family members—especially by those who may stand to inherit. Elderly patients can internalize the attitudes of those around them, concluding that they are indeed a useless "burden." As a result, they may languish and die or even kill themselves outright. This trend is denounced by experts in gerontology as a lethal consequence of ageism in our society. To ignore this social context is to commit legislative malpractice.

In one notorious case in Oregon, an elderly woman named Kate Cheney was qualified for assisted suicide although she had serious memory lapses. The doctors who were initially consulted refused to approve her suicide, judging her incapable of making her own medical decisions. So her grown daughter—described in one medical report as "somewhat coercive" in her insistence that her mother needed lethal drugs—found some who would ignore her mother's dementia and sign the form (see Hendin and Foley at 1626-7). How commonly this kind of thing happens is impossible to say, in light of such laws' provisions for covering up the facts of individual cases.

The New Jersey bill requires two witnesses to the patient's written request for lethal drugs. *One* of the witnesses cannot be a relative, a person entitled to part of the patient's estate under a will or by operation of law, *and* an owner,

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operator, or employee of the health-care facility where the patient resides or is being treated. The other witness can fall into any or all of these categories of people who may have a vested financial interest in the patient's death. (The "and" here is strange, seeming to imply that both witnesses can be some of these things, but neither witness can be all three at once. The Oregon law says "or," which is not as absurd, but still allows one witness to have a financial motive and the other to be his or her paid accomplice.) If the patient resides in a long-term-care facility, one witness *must* be designated by the facility, which certainly may have an interest in ridding itself of an especially difficult or expensive patient.

At least the patient ultimately must speak for himself or herself, right? Well, sort of. The patient is deemed "capable" if he or she can communicate health-care decisions to a provider, "including communication through persons familiar with the patient's manner of communicating," such as those relatives who may stand to inherit (Sec. 3). "Oh yes, doctor, when he blinks his eyes that way, he's asking to die."

But aren't there also truly loving families who do care about their elderly members and would want to make sure they are not being railroaded into death? Yes, of course, and those families need not even be notified that any of this is going on. Family notification is optional, so a depressed suicidal patient—with the "tunnel vision" typical of suicidal depression—can choose not to tell a family that might contradict or question this decision. Such a patient may be surrounded solely by doctors, witnesses, health facility owners, and C&C "advisors" who want that death as much as, or more than, the patient does.

The state itself could also have fiscal and other motives. By passing the bill, the government has selected a class of citizens it thinks are more in need of suicide assistance than suicide prevention. How enthusiastic will it be about paying for continued care for those holdouts who refuse this aid? Last year, over half the patients who committed assisted suicide in Oregon relied on the government for their health coverage or had no coverage at all. Over three-quarters of those dying under Washington's assisted suicide law were partly or completely dependent on Medicare or Medicaid. Some cancer patients in Oregon have received letters from the state's health plan saying that the government will not pay for their doctor's recommended treatment to extend their lives, but will be happy to pay for assisted suicide.

Imminent Death?

2270 says it does not qualify a patient for a lethal drug overdose "solely because of the person's age or disability" (Sec. 3), and then proceeds to do just that. A patient is "terminally ill" if he or she is "in the terminal stage of an irreversibly fatal illness, disease, or condition." But life itself is an irreversibly fatal condition, and old age is its terminal stage. The only attempt at a meaningful definition here is that the patient must also have "a prognosis, based upon reasonable medical certainty, of a life expectancy of six months or less."

The phrase "reasonable medical certainty" sounds strict, until we realize four things. First, A. 2270 explicitly says the "terminal" diagnosis is *not* to be based solely on "a diagnosis of any specific illness, disease, or condition." The doctor says you're going to die, but he may not know what you have. Some patients taking their lives under the similar Oregon law actually have "unknown" officially listed as their terminal illness. Second, such prognoses are known to be notoriously unreliable in the best of circumstances. Every year, tens of thousands of people whose six-month life expectancy qualified them for hospice care outlive that prediction. And some people who "qualified" for assisted suicide in Oregon, but didn't end up taking the drugs, have lived much longer than six months.

Third, a statement in an earlier version of the bill that the patient must be expected to die in six months "*with or without* the provision of life-sustaining treatment" was deleted in the final version. The phrase itself is ambiguous—it might be construed to mean "even with life-sustaining treatment"—but its absence ensures that each doctor will decide what "terminal" means. If you have a chronic condition from which you would die soon *without* treatment, you may be terminal. Persons with Type I diabetes are terminal without insulin. Many people with disabilities are terminal, once you deny supportive care. Everyone who can't feed him- or herself is terminal without assistance in getting food and water, which these days is defined as treatment. If you wonder why manydisability rights groups are appalled at proposals like New Jersey's, look no further.

Finally, the reference to "reasonable medical certainty"—along with everything else in A. 2270 that may initially look like an objective standard—is undermined by the bill's standard of care. It says at one point that the new law should not be construed to "lower the applicable standard of care to be provided by a health care professional" (Sec. 15). Yet it then proceeds to do exactly that, by stating that anyone who "substantially complies in good faith" with the Act's requirements "shall be deemed to be in compliance" with it. "Good faith" is the loosest of legal standards, much weaker than the negligence standard physicians are generally held to. Instead of meeting the objective standards for what doctors *should* know, a doctor need only say that he sincerely didn't know that he failed to live up to them. "I really thought he was pretty sick." The Act adds that nothing done in such "good faith" compliance may constitute "patient abuse or neglect" (Sec. 17). That is, even if a certain behavior would be considered abuse or neglect in every other legal and medical context, it may not be treated as such.

So, in a matter of literal life and death, standards are much lower than anywhere else in law or medicine. You're like-

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ly to be seen as terminal (hence a candidate for assisted suicide) if the doctor feels that you are, or thinks that you could become so without treatment. If you take the lethal drugs in a few weeks based on that prediction, there is, of course, no chance to prove him wrong.

Of Sound Mind?

Supposedly to ensure a voluntary decision by someone who is of sound mind, a patient is considered not "capable" of requesting lethal drugs if he or she has "a psychiatric or psychological disorder or depression that causes impaired judgment" (Sec. 8). But that assessment is made by the doctor who will write the lethal prescription, along with the consulting physician he hand-picks to confirm his judgment. If they decide you are "capable," you are not referred for any evaluation by a psychologist or psychiatrist. In Oregon last year, over 97 percent of the patients given lethal drugs (69 out of 71) received no such referral—despite numerous studies showing that suicidal wishes among the terminally ill, like similar wishes among the able-bodied, are most often due to clinical depression. Depression is an especially acute problem among older men, and can lead to suicide when combined with factors ranging from physical illness to drug and alcohol problems and financial distress.

The doctors who declare patients qualified for assisted suicide are not randomly selected. C&C has boasted of its direct involvement in the vast majority of such cases in Oregon, as it has its own list of doctors who are willing and able to get patients around any pesky "safeguards." If the patient's own physician, or the next physician, discovers a disorder such as depression, the patient can simply shop around to find one who won't care (or just call C&C in the first place). Only that last physician, the one who wants to assist a suicide, files a report with the state. Even the presence of clinical depression is not itself disqualifying—it must be a depression or disorder "that causes impaired judgment." So the doctors can agree that suicidal depression is "a completely normal response" to serious illness (as any physician selected by C&C is likely to do), and find that the patient's judgment is not impaired (see Hendin and Foley at 1624).

Even if physicians are trying to be responsible, studies also show that most physicians are very unreliable at diagnosing depression. And psychological assessments are, of course, covered by the aforementioned standard .

First, by C&C's own account, the time when the so-called "safeguards" apply is*not* actually the time when patients decide to kill themselves. By obtaining the drugs, they are only keeping their options open *in case* they may someday decide to take their lives. As the executive director of the group's New York chapter says, echoing a theme C&C has stated many times: "Having this option gives great comfort to those who are dying, and many never take the drugs."

So what safeguards against abuse exist to prevent impaired judgment, coercion, or undue influence from others with their own selfish motives at the time the decision to take life is actually made? The answer is: Zip. Zilch. Nada. Nothing.

There is no assessment for depression or competence, no interview to check for subtle or overt coercion, no witnessing requirement. In Oregon last year, the prescribing physician was known to be present at only 11 percent of the deaths, and no health-care provider was present in 81 percent of cases. A. 2270 says the patient is to "self-administer" the drugs (sec. 2), but then defines "self-administer" to mean "ingest" (sec. 3). In other words, the patient is the one who swallows or "takes in" the lethal dose, not necessarily the one who puts it in his or her mouth. A. 2270 sends vulnerable patients home with a lethal overdose of drugs and instructions on how to use them to kill, where those drugs will be controlled by the most powerful person in that household. How likely is it that this most powerful person will be the frail elderly patient?

Second, this bill is constructed to ensure that abuses are never discovered. Reporting of such a death (with identifying information removed) can only be conducted by the physician who approved the suicide. No one else is authorized to offer an alternative version of events. The physician—the person who, in every other circumstance, would be seen in New Jersey law as the perpetrator of a crime—can simply report having followed all the guidelines. As state officials in Oregon have observed, "the entire account" could be "a cock-and-bull story" for all the government knows. In fact, the death may not be recorded as a suicide. The physician can record the underlying illness as the official cause of death—in Washington state's law, such lying is actually required (Dore at 395). And with no required family notification, it is unlikely that anyone will order an autopsy or even know there is anything to be suspicious about. A. 2270 is an invitation to homicide, abetted by official cover-up.

C&C will no doubt announce to the world (as it has in Oregon and Washington) that the safeguards are working just fine, since there have been no reports of abuse. The reality is that even with this closed system for hiding the facts, some very disturbing cases have indeed come to light in Oregon. Some patients have been saved only because they were fortunate enough to consult a physician committed to addressing their real problems instead of helping them kill themselves. One patient who has gone public, Jeanette Hall, says she voted for the Oregon law, and wanted to use it when diagnosed with terminal cancer. But because a physician persuaded her to accept treatment, now she says it is "great to be alive" over thirteen years later, and she opposes laws like New Jersey's.

The Broader Context

The serious risks and abuses invited by this proposal are no accident or drafting error. These elements have been included in the proposals pushed by Hemlock/C&C for two decades, beginning with the Oregon law. Clearly, they reflect the low standard of protection that C&C believes these patients warrant. They also reflect the views and actions of Hemlock's founder, Derek Humphry. He came to public notoriety by writing a book about his involvement in aiding the suicide of his first wife, Jean. Later he apparently told his second wife, Ann Wickett Humphry, that the pills hadn't worked for Jean, and he ended up smothering her to death—an action Wickett herself took when she and Derek had agreed to assist the suicides of both her parents. When Ann contracted cancer, she later wrote, Humphry abandoned and humiliated her, ultimately driving her to her own suicide. The illusory "safeguards" of the Oregon and Washington laws and their New Jersey clone are porous enough to allow or invite all of this horrifying behavior.