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SUICIDE PREVENTION INITIATIVES

TO: Honorable Members, New York State Legislature

FROM: Herbert Hendin, M.D., CEO and Medical Director, Suicide Prevention Initiative, New York City

SUBJECT: Physician-assisted suicide legislation, 2015-2016 Session

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I have done extensive research on assisted suicide in the Netherlands and, together with Dr. Kathleen Foley, a leading expert on end-of-life care, have done comparable research on physician-assisted suicide (PAS) in Oregon. The proposed New York State bill ((Senate bill 5814/Assembly bill 5261-B) is modelled after the Oregon law. The U.S. Supreme Court cited my studies in Oregon and the Netherlands in its 1997 decision in *Vacco vs. Quill*, finding that there is no right in the Constitution to physician-assisted suicide.

Given the choice between dying slowly in pain and dying quickly, most people would be tempted to choose dying quickly. Advocates for the legalization of PAS present these as the only choices and offer their agenda as the answer. But evidence suggests that good palliative medicine can help people face death with dignity; assisted suicide falls short of that goal.

Oregon was the first state to legalize PAS. Its "Death with Dignity Act" has become the model for bills introduced in numerous other states. At first glance the Act seems to require reasonable safeguards for patients near the end of life: presenting patients with the option of palliative care; limiting the procedure to those who are terminally ill; ensuring that patients are competent to make end-of-life decisions for themselves; obtaining a second opinion on the case; and ensuring the voluntariness of the request. The evidence, however, indicates that these guidelines are not followed, with harmful consequences for the patients.

In 2008, Dr. Foley and I completed a study of published Oregon cases and available video evidence that was published in the *Michigan Law Review* (Volume 106, June 2008). Our study documented a failure to ensure that palliative care alternatives were made available to patients, and the inadequacy of the safeguards ostensibly designed to ensure a patient's psychiatric health and voluntariness of the decision. Among our findings:

- Doctors presented the option of palliative care in a manner that inevitably led patients to reject it.
- After patients had made the request for PAS and received the needed pills, their obvious ambivalence about going ahead was ignored. They were encouraged to act on the grounds that they should do so before they were no longer capable of acting.
- Family members who felt burdened by caring for older patients conveyed that feeling to the patient. In some cases they were primarily responsible for influencing the patient to request assisted suicide and for persuading the doctor to support that request.

A concern with protecting physicians rather than patients pervades the Oregon experience. Physicians assisting in a suicide are exempt from the ordinary standards of care, skill and diligence required of physicians in other medical circumstances. Instead the physician is immunized from civil and criminal liability for actions taken in “good faith” in assisting a suicide even when the physician acts negligently.

Most physicians have not been trained in palliative care, and most states have a long way to go in providing full access to such care. New York, in particular, ranks 48<sup>th</sup> in the nation in hospice utilization. Physicians who had supported assisted suicide and receive training in end-of-life care tend to change their minds. What patients need is not a right to assisted suicide but the right to adequate end-of-life care.

I strongly urge you, as New York State lawmakers, to reject the legalization of doctor-assisted suicide and focus instead on accessible quality end-of-life care.

Sincerely,



Herbert Hendin, M.D.  
CEO and Medical Director