Dear Sisters and Brothers in Christ:

As Catholics we believe in the sanctity of every human life, from the moment of conception to the moment of natural death. While we may not often consider end-of-life issues, now is the time to pay closer attention. Several states have already legalized physician-assisted suicide, and efforts are ongoing in New York State as well.

At the recommendation of our Diocesan Public Policy Committee Bishop Matano has chosen this as our diocesan advocacy issue for 2020. Parishes will be collecting signatures in opposition to the legalization of physician-assisted suicide during Public Policy Weekend, February 7th and 8th,.

In the meantime, there are important things to remember. First, it's important to know what physician assisted suicide (PAS) does NOT mean, so let's start with some clarification on **Catholic teaching on end-of-life medical treatment.**

In their document *Now and at the Hour of Our Death*, our Catholic Bishops from New York State wrote:

***Out of deep respect for the gift of life, we must always accept, and others must provide, ordinary medical means of preserving life. Ordinary means are those that offer us a reasonable hope of benefit and would not entail excessive burden on us, our family or the community. Ordinary means of medical treatment are morally obligatory. Withholding ordinary care with the intention of causing death is considered passive euthanasia and is always gravely contrary to God's will.***

***But Catholics are not morally bound to prolong the dying process by using every medical treatment available. Allowing natural death to occur is not the same as killing. Some treatments may be considered "extraordinary" (as opposed to ordinary) and are not morally obligatory because the burdens and consequences are out of proportion to the beneficial results anticipated for a particular patient. These are considered morally optional treatments. (page 3, see full text at www.nyscatholicconference.org)***

PAS is not the same as allowing natural death to occur. Choosing not to undergo another round of chemotherapy at the end stage of cancer is not PAS. Administering narcotic pain medicine to a dying person with the intention of reducing her pain is not PAS. PAS means a physician facilitating a person's death by providing the means and/or the information to enable that person to end her life.

PAS legislation is morally objectionable in many ways, a few of which are:

• it endangers vulnerable elderly and disabled patients who may be coerced into taking their own lives;

• it provides no counseling for patients with clinical depression whose mental illness may be driving them to this action;
• it flies in the face of society's suicide prevention efforts. Please start to learn about and pray about this issue so you can be an effective advocate for life.

Please start to learn about and pray about this issue so you can be an effective advocate for life.

You can be a voice for the vulnerable TODAY. In the words Bishop Matano, "*When we subjectively determine when life begins and ends, when it is viable or not, or when it is too burdensome to endure, we begin a path toward self-destruction. Life is no longer precious, but just another commodity in the business of living. Relativism becomes the absolute, and even the value of life itself is questioned.*" Today you can support the vulnerable in our community who are best served by improving our palliative care system, not the legalization of physician assisted suicide. Put your faith into action, give them your voice, and take the time to sign the petition.

**Interested in learning more about proposed legislation in NYS?** Below are aspects of the legislation outlined by the New York State Catholic Conference. For more information go to https://www.nyscatholic.org/.

*Each section can be separated and inserted into your bulletin.*

## Fatal Flaws in Assisted Suicide Legislation

Proponents of the so-called "Medical Aid-in-Dying Act" (A.2694/S.3947) 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" 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," § 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))
- 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 § 2988-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.
- The bill requires two witnesses to a patient’s written request for assisted suicide. But one of the witnesses can be a person entitled to a portion of the patient’s estate, or a person associated with the health care facility where the patient is receiving treatment. § 2899-e(3)
- 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.
- 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 7 and 8, below).

**6. Patients are stripped of existing legal protections.**

- The bill states that "A patient who requests medication under this article shall not, because of that request, be considered to be a person who is suicidal, and self-administering medication under this article shall not be deemed to be suicide, for any purpose." § 2899-n(1)(a). This would strip patients of important legal protections.
- Under current law, persons who are at risk of harming themselves are given extensive protection under Mental Hygiene Law Article 9. That statute permits the involuntary commitment of any person who may be in danger of harming him or herself, so that they can be evaluated and treated by mental health practitioners. There are also extensive due process provisions in that law to ensure that the person's rights are being protected.
- Other vulnerable patients may be protected by the appointment of a guardian or conservator pursuant to Mental Hygiene Law Article 81. There are also substantial due process requirements that are designed to ensure the safety of the patient.

- This excludes the possibility of invoking significant legal protections from vulnerable patients, and creates an invidious double standard -- terminally ill patients are denied rights and due processes that are available to all others.

**7. 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**"). This fits any reasonable definition of "suicide". § 2899-d(8)
- 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 have actually 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.

**8. 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 (*see* §§ 2899-l(2) and 2899- r(2)) and prevents any meaningful oversight by law enforcement officials.
- 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. See § 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. § 2899-q(1). As a result, if this bill were enacted, there is no possibility for independent evaluation of how the law is being implemented.
- 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.

**9. 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.

**10. 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". § 2899-m(2)(a) (emphasis added).
- 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.