

MEMORANDUM

TO: Members of the New York State Assembly and Senate Health Committees

FROM:  Margaret Dore, Esq., MBA.
Choice is an Illusion, a nonprofit corporation

RE: Vote "No" on Assisted Suicide and Euthanasia, Bills A. 5261-B, A. 2129-A, S. 5814 and S 3685.

DATE: January 9, 2016

INDEX

I. INTRODUCTION 1

II. FACTUAL AND LEGAL BACKGROUND 1

 A. Definitions: Physician-Assisted Suicide; Assisted Suicide; and Euthanasia 1

 B. Withholding or Withdrawing Treatment Is Not Assisted Suicide or Euthanasia 2

 C. The AMA Rejects Assisted Suicide and Euthanasia. 3

 D. Elder Abuse Is Already a Large and Uncontrolled Problem 3

 1. Elder Abuse is on the rise 3

 2. Victims do not report 4

 E. Assisters Can Have Their Own Agendas. 4

III. THE BILLS 5

 A. Bill "Requirements" Are Not Actually Required Due to Good Faith Immunity.. . . . 5

B.	Patients Are Not Required to Be "Dying"	6
C.	Patients May Have Years, Even Decades, to Live.	6
D.	Someone Else Is Allowed to Speak for the Patient.. . . .	7
E.	The Proposed Bills Allow Someone Else to Administer the Lethal Dose to the Patient	9
F.	If a Draft Bill From Assemblymember Paulin's Office Follows Washington State's Definition of "Self-Administer," Someone Else Will Be Allowed to Administer the Lethal Dose to the Patient.	10
G.	Allowing Someone Else to Administer the Lethal Doses to the Patient is Euthanasia	12
H.	No Oversight at the Death.	12
I.	Individual "Opt Outs" Are Not Allowed	13
J.	The Death Certificate is Required to List a Terminal Illness or Condition as the Cause of Death	14
IV.	THE WASHINGTON AND OREGON EXPERIENCE	15
A.	Any Study Claiming that Oregon's Law is Safe, is Invalid.. . . .	15
B.	Steerage to Suicide.	15
C.	In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost Is "Enormous."	16
D.	My Clients Suffered Trauma in Washington and Oregon.	17
V.	CONCLUSION	19

I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.¹ Our law is based on a similar law in Oregon. Both laws are similar to the proposed New York State bills, which seek to legalize physician-assisted suicide, assisted suicide and euthanasia as those terms are traditionally defined.²

The proposed bills are described as "aid in dying," but their reach is not limited to dying people. "Eligible" persons may have years, even decades, to live. The bills are a recipe for elder abuse. There are other problems.

I agree with proponents that assuring patient choice and control is paramount. The bills, however, are stacked against the patient. This is due to their actual language. Some of the words used do not have their normal meanings. I urge you to read the definitions and other provisions carefully. Don't be fooled; please reject this measure.

II. FACTUAL AND LEGAL BACKGROUND

A. Definitions: Physician-Assisted Suicide; Assisted Suicide; and Euthanasia.

The American Medical Association (AMA) defines physician-

¹ I am an elder law/appellate attorney licensed to practice law since 1986. I am also a former Law Clerk to the Washington State Supreme Court and the Washington State Court of Appeals, and a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. In addition, I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. For more information, see www.margaretdore.com and www.choiceillusion.org

² The four pending bills are: A. 2129-A, A. 5261-B, S. 3685 and S. 5814.

assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."³ The AMA gives this example:

[A] physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.⁴

"Assisted suicide" is a general term in which the assisting person is not necessarily a physician. "Euthanasia," by contrast, is the direct administration of a lethal agent with the intent to cause another person's death.⁵

B. Withholding or Withdrawing Treatment Is Not Assisted Suicide or Euthanasia.

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia when the purpose is to withhold or remove burdensome treatment -- as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. Consider this quote from an article in Washington state regarding a man removed from a ventilator:

[I]nstead of dying as expected, [he] slowly began to get better.⁶

³ The AMA Code of Medical Ethics, Opinion 2.211, Physician-Assisted Suicide. (Attached hereto at A-31).

⁴ Id.

⁵ Opinion 2.21, Euthanasia. (Attached hereto at A-32).

⁶ Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?," *The Seattle Weekly*, January 14, 2009. (Article attached hereto at A-

C. The AMA Rejects Assisted Suicide and Euthanasia.

The AMA rejects assisted suicide and euthanasia, stating they are:

[F]undamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.⁷

D. Elder Abuse Is Already a Large and Uncontrolled Problem.

1. Elder abuse is on the rise.

Nationwide, elder abuse is a crime growing in intensity with perpetrators often family members, but also strangers and new "best friends."⁸ In New York State, a prominent elder abuse victim was philanthropist-socialite, Brook Astor, swindled out of millions of dollars by her son.⁹ Amy Mix, of the AARP Legal Counsel of the Elderly, explains:

The elderly are at an at-risk group for a lot of reasons, including, but not limited to diminished capacity, isolation from family and other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers. . . .

33; quote attached at A-35).

⁷ See AMA Code of Medical Ethics, Opinions 2.211 and 2.21, supra at A-31 and A-32).

⁸ MetLife Mature Market Institute, "Broken Trust: Elders, Family and Finances, A Study on Elder Abuse Prevention," March 2009, at <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-broken-trust.pdf>

⁹ Kathryn Alfisi, "Breaking the Silence on Elder Abuse," *Washington Lawyer*, February 2015. (Article attached at A-36, quote at A-37).

[D]efendants are family members, lots are friends, often people who befriend a senior through church We had a senior victim who had given her life savings away to some scammer who told her that she'd won the lottery and would have to pay the taxes ahead of time. . . . The scammer found the victim using information from her husband's obituary.¹⁰

2. Victims do not report.

Elder abuse is prevalent in large part because victims do not report.¹¹ "One study estimated that only 1 in 14 cases of elder abuse ever comes to the attention of the authorities."¹² In another study, it was 1 out of 24 cases.¹³ Explanations include:

Many who suffer from abuse . . . don't want to report their own child as an abuser.¹⁴

E. Assisters Can Have Their Own Agendas.

People who assist a suicide or euthanasia can have their own agendas. In Oregon, there is the Thomas Middleton case, in which legal physician-assisted suicide was part of an elder abuse

¹⁰ Id.

¹¹ See e.g., National Center on Elder Abuse, Administration on Aging, <http://www.ncea.aoa.gov/Library/Data>, p.2

¹² Id.

¹³ Id.

¹⁴ "Adult Abuse," District of Columbia, Department of Human Services, as of July 23, 2015. (Attached hereto at A-38). See also <http://dhs.dc.gov/service/adult-abuse>

fraud.¹⁵ Consider also *People v. Stuart*: An adult child killed her parent under circumstances that "dovetailed" with the child's financial interests.¹⁶ The Court observed:

Financial considerations [are] an all too common motivation for killing someone.¹⁷

III. THE BILLS

A. Bill "Requirements" Are Not Actually Required Due to Good Faith Immunity.

The bills have an application process to obtain the lethal dose, which features patient protections described in mandatory terms, for example, that the attending physician, "shall" make the determination of "whether a patient has a terminal illness or condition, is capable, and has made the request voluntarily."¹⁸ These "mandatory" protections are not actually required due to good faith immunity for doctors and other participants in patient

¹⁵ See "Sawyer Arraigned on State Fraud Charges," KTVZ.com, 07/14/11, which states:

Middleton deeded his home to the trust and directed [Sawyer] to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than \$200,000, the documents show, and it was deposited into [accounts for Sawyer's benefit]. (Emphasis added)

Attached at A-39.

¹⁶ *People v. Stuart*, 67 Cal.Rptr.3d 129 (2007).

¹⁷ *Id.*, at 143.

¹⁸ A-5261B & S. 5814, § 2899(g)1(a). (Attached at A-10 & A-22). A-2129A and S. 3685 have similar language at § 2994-eee. (Attached at A-3 & A-15).

deaths.¹⁹ See below.

The bills do not define "good faith."²⁰ Common meanings include an honest intent to act, even when there is a lack of compliance with legal technicalities. Consider, for example, this legal dictionary definition:

[Good faith means an] honest intent to act without taking an unfair advantage over another person or to fulfill a promise to act, *even when some legal technicality is not fulfilled.* (Emphasis added).²¹

With good faith immunity, doctors and other participants in patient deaths are not required to follow a particular protective procedure. "Requirements" are not actually required due to good faith immunity.

B. Patients are Not Required to be "Dying."

The proposed bills seek to legalize "aid in dying." This phrase is misleading because the bills do not require dying patients, *i.e.*, if, for the purpose of argument, any bill requirement is actually required.²²

C. Patients May Have Years, Even Decade, to Live.

The proposed bills apply to "terminal" patients, meaning

¹⁹ The bills give doctors and other participants good faith immunity. See attached bills at A-6, A-11, A-18 and A-23.

²⁰ See all proposed bills, attached hereto at A-1 through A-25.

²¹ <http://dictionary.law.com/Default.aspx?selected=819> (Attached at A-40).

²² See proposed bills in their entirety, attached hereto at A-1 through A-25 (no requirement that patients be "dying").

those predicted to have less than six months to live.²³ Such persons can have years, even decades, to live due to misdiagnosis and the fact that predicting life expectancy is not an exact science.²⁴ Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18.²⁵ He was told that he would get progressively worse (be paralyzed) and die in three to five years.²⁶ Instead, the disease progression stopped on its own.²⁷ In a 2012 affidavit, at age 74, he states:

If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.²⁸

D. Someone Else Is Allowed to Speak for the Patient.

The proposed bills require patients to be "capable" or to have "capacity" to obtain the lethal dose.²⁹ These terms do not, however, have their normal meanings. These terms are specially

²³ See bills (defining "terminal" in terms of six months to live), at A-2, A-9, A-14 and A-21.

²⁴ See, for example, Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, April 17, 2014 (attached hereto at A-41 & A-42); and Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?," *The Seattle Weekly*, January 14, 2009. (Excerpts attached at A-33 to A-35)

²⁵ Affidavit of John Norton, ¶ 1 (Attached hereto, beginning at A-44).

²⁶ Id., ¶ 1.

²⁷ Id., ¶ 4 (Attached at A-45)

²⁸ Id., ¶ 5 (Attached at A-45)

defined to allow someone else to speak for the patient -- as long as the speaking person is "familiar with the patient's manner of communicating." A. 5861-B and S. 5814 state:

"Capable" means that a patient has the ability to understand, make and communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating (Emphasis added).³⁰

Similarly, A. 2129-A and S. 3685 state:

"Capacity" means that in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist the individual has the ability to make and communicate an informed decision to healthcare providers, including communication through a person familiar with the individual's manner of communicating (Emphasis added)³¹

Being familiar with a patient's "manner of communicating" is a very minimal standard. Consider a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but she, herself, does not understand Spanish. That, however, would be good enough for her to speak for the patient to obtain the lethal dose.

A patient's heir, wanting a quick inheritance, will have this same ability; a complete stranger will also have this ability. As long as individuals are familiar with the patient's

³⁰ A. 5261-B and S. 5814 § 2899-D(4). (Attached hereto at A-9 and A-21).

³¹ A. 2129-A and S. 3685 § 2994-aaa(4). (Attached hereto at A-2 and A-14).

"manner of communicating," their requests will be legally sufficient to obtain the lethal dose.

With other people allowed to speak for the patient during the lethal dose request process, simply because they are familiar with a patient's "manner of communicating," overreaching is invited. Patient choice and control is not guaranteed. Indeed, patients are at risk.

E. The Proposed Bills Allow Someone Else to Administer the Lethal Dose to the Patient.

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient.³² Common examples include parents who administer drugs to their children and adult children who administer drugs to their parents.³³ This is normal practice.³⁴

The proposed bills say that the patient "may" self-administer the lethal dose and describe the lethal dose as being "self-administered."³⁵ The bills do not say that administration of the lethal dose "must" be by self-administration.³⁶

³² Declaration of Dr. Kenneth Stevens, MD, 01/06/16, ¶ 9 (Declaration attached at A-47 to A-49, citation at A-49).

³³ Id.

³⁴ Id.

³⁵ See e.g., A. 2129-A at A-2 and A-5261-B at A-11.

³⁶ See all bills in their entirety, at A-1 through A-30.

With self-administration not mandatory under the bills, generally accepted medical practice allows someone else to administer the lethal dose to the patient.³⁷

With someone else allowed to administer the lethal dose, the patient's choice and control are once again not guaranteed.

F. If a Draft Bill From Assemblymember Paulin's Office Follows Washington State's Definition of "Self-Administer," Someone Else Will Be Allowed to Administer the Lethal Dose to the Patient.

A draft bill from Assemblymember Paulin's office states that a health care professional shall not administer the lethal dose, but may facilitate the patient in "self-administering" the lethal dose.³⁸ The draft bill states:

A health care professional shall not administer the medication [lethal dose] to the patient but, acting within the scope of his or her lawful practice, may facilitate the patient in self-administering the medication.³⁹

The draft bill does not define "self-administer."⁴⁰ In Washington State, self-administer is defined as the act of ingesting. Washington's law states:

³⁷ Cf. Dr. Stevens' declaration at A-49.

³⁸ A copy of the draft bill is attached hereto at A-26 to A-30. I obtained the copy from Assemblymember Paulin's staff on December 16 2015, at a continuing legal education event sponsored by the New York State Bar Association.

³⁹ Draft bill at A-28, lines 16-19. (Attached hereto at A-28).

⁴⁰ See draft bill in its entirety, attached at A-26 to A-30.

"Self-administer" means a qualified patient's act of ingesting medication to end his or her life . . . ⁴¹

Washington's law does not define "ingesting."⁴² Dictionary definitions include:

[T]o take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing."⁴³

With this definition, someone else putting the lethal dose in the patient's mouth qualifies as self-administration because the patient will thereby be "swallowing" the lethal dose, *i.e.*, "ingesting" it; someone else placing a medication patch on the patient's arm will qualify because the patient will thereby be "absorbing" the lethal dose, *i.e.*, "ingesting" it; someone else turning on lethal gas will qualify because the patient will thereby be "inhaling" the lethal dose, *i.e.*, "ingesting" it.

If the draft bill follows Washington State's definition of self-administer, someone else will be allowed to administer the lethal dose to the patient. Patient's choice and control will not be assured.

⁴¹ The Revised Code of Washington, § 70.245.010(12), states:

"Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner. (Attached at A-50).

⁴² See Revised Code of Washington, § 70.245.010 et seq., at <http://app.leg.wa.gov/RCW/default.aspx?cite=70.245>

⁴³ Webster's New World College Dictionary, ingest. <http://www.yourdictionary.com/ingest> (as of January 9, 2016).

G. Allowing Someone Else to Administer the Lethal Dose to the Patient is Euthanasia.

Allowing someone else to administer the lethal dose is euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 2.21, states:

Euthanasia is the administration of a lethal agent by another person to a patient
(Emphasis added).⁴⁴

The proposed bills and the draft bill (using Washington State's definition of self-administer), allows someone else to administer the lethal dose to a patient. This is euthanasia as that term is traditionally defined.

H. No Oversight at the Death.

If for the purpose of argument, the proposed bills and the draft bill only allow the patient to administer the lethal dose to himself or herself, the patient is still vulnerable to the actions of other people. This is because the bills and the draft bill do not require witnesses or even a doctor to be present when the lethal dose is administered.⁴⁵ There is a complete lack of oversight at the death.

This creates the opportunity for someone else to administer the lethal dose to the patient without his or her consent. If the patient struggled, who would know? And in case, I'm being

⁴⁴ Attached at A-32.

⁴⁵ See proposed bills and draft bill in their entirety, attached hereto at A-1 to A-30.

too subtle, the drugs used are water and alcohol soluble, such that they can be administered to a sleeping or restrained person.⁴⁶ Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, elaborates:

With assisted suicide laws in Washington and Oregon [and with New York bills], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. . . . [I]f a patient struggled, "who would know?" (Emphasis added).⁴⁷

I. Individual "Opt Outs" Are Not Allowed.

The bills and the draft bill do not allow patients to opt out of their provisions. Consider, for example, an elderly woman with a house and a bank account, concerned that her unemployed son will push her into assisted suicide or euthanasia. A possible protection is a will provision saying that anyone doing so is disinherited. Under the bills, such provisions are not valid. See, for example, A. 2129-A, which states:

A provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a

⁴⁶ The drugs used for assisted suicide in Oregon and Washington, Secobarbital and Pentobarbital (Nembutal), are water and alcohol soluble, such that they can be injected without consent, for example, to a sleeping or restrained person. See "Secobarbital Sodium Capsules, Drugs.Com, at <http://www.drugs.com/pro/seconal-sodium.html> and <http://www.drugs.com/pro/nembutal.html>. See also Oregon's government report, page 5, attached at A-51 (listing these drugs).

⁴⁷ Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," *The Advocate*, Official Publication of the Idaho State Bar, October 2010, page 14, available at [http://www.margaret-dore.com/info/October Letters.pdf](http://www.margaret-dore.com/info/October%20Letters.pdf)

person may make or rescind a request for aid-in-dying medication, is not valid. (Emphasis added).

Attached hereto at A-5, lines 13 to 16.⁴⁸

So if you are a person who gets talked into things, and you don't want to get talked into suicide (or facilitating your own homicide), you are not allowed to make legal arrangements to try and prevent it. So much for your personal choice and control.

J. The Death Certificate is Required to List the a Terminal Illness or Condition as the Cause of Death.

The proposed bills require the death certificate to list the patient's underlying terminal illness or condition as the cause of death.⁴⁹ In Washington State, a similar requirement has been interpreted by the Washington State Department of Health to require the death certificate to not even hint that the true cause of death was assisted suicide or euthanasia. See Washington State's Death Certificate Instructions for Medical Examiners, Coroners and Prosecuting Attorneys.⁵⁰

The significance is a lack of transparency and a legal inability to prosecute criminal behavior, for example, in the case of an outright murder for the money. In other words, with

⁴⁸ All four bills have this type of provision. See A-5, A-12, A-17, A-24 and A-29. The draft bill has additional language involving self-administration. See A-30, lines 11 to 20.

⁴⁹ See bills at A-4, A-12, A-16 and A-24.

⁵⁰ Attached hereto at A-52.

the cause of death pre-determined to be a terminal illness or condition, there can be no prosecution for murder as a matter of law. Perpetrators will have little or no legal deterrent to curtail overreaching behavior.

IV. THE WASHINGTON AND OREGON EXPERIENCE

A. Any Study Claiming that Oregon's Law is Safe, is Invalid.

In 2011, the lack of oversight over administration of the lethal dose in Oregon prompted Montana State Senator Jeff Essmann to make this observation: Oregon studies claiming that assisted suicide is safe are invalid. He stated:

[All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].

So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.⁵¹

B. Steerage to Suicide.

It is well documented that Oregon's Medicaid program steers

⁵¹ Hearing Transcript for the Montana Senate Judiciary Committee on SB 167, February 10, 2011, at http://www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf

E:\ASE 2016 +\New York\Memo.wpd

people to suicide via coverage incentives.⁵² Private providers and insurance companies have this same ability.⁵³ Do you want this to happen to you or your family?

C. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost Is "Enormous."

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. This statistical correlation is consistent with a suicide contagion in which legalizing and normalizing physician-assisted suicide encouraged other suicides. Please consider the following:

Oregon's assisted suicide act went into effect "in late 1997."⁵⁴

⁵² See Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (A-53); KATU TV Web Staff, "Letter noting assisted suicide raises questions," July 30, 2008 (A-56); and Affidavit of Kenneth Stevens, MD (A-58 to A-66).

⁵³ Consider this letter from Oregon:

[D]uring the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher. . . .

We got a different doctor, and [my husband] lived another five years or so. But after that nightmare in the doctor's office and encounters with a "death with dignity" inclined nurse, I was afraid to leave my husband alone again with doctors and nurses, for fear they'd morph from care providers to enemies, with no one around to stop them.

<http://www.choiceillusion.org/2013/12/i-was-afraid-to-leave-my-husband-alone.html>

⁵⁴ Oregon's assisted suicide report for 2014, first line, at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

By 2000, Oregon's conventional suicide rate was "increasing significantly."⁵⁵

By 2007, Oregon's conventional suicide rate was 35% above the national average.⁵⁶

By 2010, Oregon's conventional suicide rate was 41% above the national average.⁵⁷

According to the Oregon Health Authority, there is a significant financial cost associated with these other suicides. One reason is that people who attempt suicide (and fail) can injure themselves or become disabled by the attempt. The Oregon Health Authority states:

[T]he estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.⁵⁸

If New York, with its much larger population, legalizes assisted suicide and has the same experience as Oregon, the financial cost could be much larger.

D. My Clients Suffered Trauma in Washington and Oregon.

In 2012, a study was published addressing trauma suffered by

⁵⁵ See Oregon Health Authority News Release, 09/09/10, at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf> ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-72)

⁵⁶ *Id.*

⁵⁷ Oregon Health Authority Report, *Suicides in Oregon, Trends and Risk Factors* (2012 Report), at A-77.

⁵⁸ See report at A-78.

persons who witnessed a legal assisted suicide in Switzerland.⁵⁹ The study found that one out of five family members or friends present at an assisted suicide were traumatized. These people:

[E]xperienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.⁶⁰

In Oregon and Washington State, I had two cases where my clients suffered similar trauma. In the first case, one side of the family wanted the father to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it is not clear that administration of the lethal dose was voluntary. A man who was present told my client that the client's father had refused to take the lethal dose when it was delivered, stating: "You're not killing me. I'm going to bed," but then took the lethal dose the next night when he was already intoxicated on alcohol. My client, although he was not present, was traumatized over the incident, and also by

⁵⁹ "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; *European Psychiatry* 27 (2012) 542-546, available at <http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf> (First page attached at A-43).

⁶⁰ Id.

the sudden loss of his father.

V. CONCLUSION

The proposed bills and the draft bill are stacked against the patient. "Mandatory" protections are not actually required due to good faith immunity. Someone else, including a stranger, is allowed to speak for a patient during the lethal dose request process. On a more obvious note, there is a complete lack of oversight at the death. If the patient struggled, who would know?

Even if you are for the concept of assisted suicide and euthanasia, the proposed bills and the draft bill are wrong for New York. I urge you to reject these measures.

Respectfully Submitted,



Margaret Dore, Esq., MBA
Law Offices of Margaret K. Dore, P.S.
Choice is an Illusion, a nonprofit corporation
www.margaretdore.com
www.choiceillusion.org
1001 4th Avenue, Suite 4400r
Seattle, WA 98154
206 389 1754 main reception
206 389 1562 direct line
206 697 1217 cell