

New Hampshire's Assisted-Suicide Proposal Analysis of Amended H. B. 304

Currently, assisted suicide is a crime in New Hampshire. It is a class B felony, punishable for up to seven years in prison, if a person aids another to commit suicide and that aid results in suicide or in an attempt to commit suicide. [N.H. Rev. Stat. § 630:4]

H.B. 304, called the "Death with Dignity Act," is modeled on Oregon's assisted-suicide law. It would transform the crime of assisted suicide into a medical treatment. The original proposal, as amended, is analyzed below.

NEW HAMPSHIRE'S ASSISTED-SUICIDE BILL:

- **Gives government health programs, managed care programs and others the opportunity to cut health care costs by encouraging vulnerable patients to request assisted suicide.**

Tragically, elder abuse is a common occurrence in today's society. Elderly patients could easily be pressured by family members or unscrupulous health care providers into requesting assisted suicide. Although the bill specifically states that it prohibits coercing or using undue influence on a patient to request the deadly drugs [137-L:15, II], nothing in the bill prohibits managed care providers, insurance companies or others from suggesting assisted suicide to a patient or from encouraging a patient to request a lethal prescription.

During debate on a similar proposal in California, Sen. Joe Dunn (D-Santa Ana) cast the deciding "No" vote because the "power of money" would influence HMO's, health insurers and the state to save money while cutting back on patient care.¹

In Oregon, some patients have been told by their health insurance provider that a costly drug prescribed by a doctor to treat the patient's illness would not be covered but inexpensive lethal drugs for assisted suicide would be.²

- **Lets greedy heirs, exhausted caregivers, or uncaring health care providers select witnesses for a patient's written assisted-suicide request.**

A patient's written request for assisted suicide must be witnessed by two people who may not be a relative or a person who would inherit the patient's property or an owner, operator or employee of the health care facility where the patient is being treated. [137-L:4, II] But individuals in those categories could select their own personal friends or acquaintances to serve as witnesses.

This sets the stage for elder abuse and premature transfer of assets. It allows those who will benefit from the patient's death to play a key role in facilitating an assisted-suicide prescription.

- **Permits doctors to prescribe assisted-suicide drugs to patients who are not New Hampshire residents.**

A person need not be a state resident to be assisted in committing suicide. One need only be someone who is "regularly treated" in a New Hampshire health care facility. [137-L:2, XII] A person could travel to New Hampshire several times seeking treatment for any ailment (such as a skin condition) and be considered "regularly treated" in a New Hampshire facility. Then, if that individual has any condition that would meet the criteria of "terminal," he or she could qualify for assisted suicide in the state.

- **Lets doctors help depressed or mentally ill patients commit suicide without providing any type of counseling or psychological evaluation.**

A referral for counseling is only necessary "if, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder, or depression *causing impaired judgment.*" [137-L:7; emphasis added] So, while a person may be depressed or mentally ill, a referral for counseling is necessary only if the physician believes the patient's judgment is impaired. (i.e., The patient is unable to make decisions regarding personal, interpersonal, financial and/or medical affairs.) Many people who are depressed or mentally ill are certainly capable of making such decisions.

According to Oregon's tenth annual assisted-suicide report, not one patient was referred for a psychological or psychiatric evaluation before receiving a lethal drug prescription.³ Yet, a recent Oregon Health & Science University study found that one in four Oregonians who request assisted suicide are likely to be clinically depressed, and the assisted-suicide law may fail to protect these patients.⁴

- **Lets a doctor help a patient commit suicide even after the patient is found to have impaired judgment.**

Counseling that is required if the physician believes the patient's judgment is impaired consists of only one consultation between the patient and a psychiatrist or psychologist. [137-L:2, V] Even if a patient is found to have impaired judgment, the assisted-suicide bill does not prohibit a health care provider, family member or other person from arranging for the patient to be evaluated by other counselors until one is found who will declare the patient capable of choosing assisted suicide.

In Oregon, it has been noted that "a psychological disorder – senility, for example – does not necessarily disqualify a person" from receiving assisted suicide. There, a woman who was suffering from early dementia died of assisted suicide even though her own physician declined to provide the lethal prescription. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly seeking it, and because her daughter seemed to be coaching her to do so. She was then taken to a psychologist who determined that she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, a managed care ethicist, who was overseeing her case, determined that she was qualified for assisted suicide, and the drugs were prescribed.⁵

- **Lets a doctor write an assisted-suicide prescription for a patient without seeing the patient in person after diagnosis of a terminal condition is made.**

The bill requires patients to make three requests for assisted suicide – two oral requests which do not need to be witnessed and one written witnessed request. [137-L:9] However, none of those requests must be made in person. The two oral requests could be made by telephone and the written request could be sent by mail or fax.

- **Allows drugs for suicide to be sent to the patient by mail or courier.**

Nothing in the bill requires that the drugs be provided in person to the patient. In one known Oregon assisted-suicide death, the patient received his lethal overdose by Federal Express.⁶

- **Forces hospitals, nursing homes and other care facilities to allow doctors to prescribe lethal drugs or otherwise participate in patients' assisted-suicide deaths on the premises.**

The bill states that providers shall not be under any duty to participate in assisted suicide. [137-L:14, IV] However, under the bill, no health care provider may subject a person to *any* penalty, including loss of privileges at the facility, for participating in assisted suicide. [137-L:14, II]

- **Contains no safeguards for the patient at the time the drug overdose is taken.**

The attending physician is to counsel the patient about the importance of having someone else present when the drugs are taken and of not taking the drugs in a public place. [137-L:5, VI] However, there are no protective measures to insure that the patient knowingly and/or willingly takes the overdose.

A greedy heir who arranged for his friends to witness his elderly aunt's death request could mix the drugs into her food without her knowledge. The proposal has no provisions to guard against such abuse.

According to Dr. Katrina Hedberg, lead author of most of Oregon's official reports, the state's job "is to make sure that all the steps happened up to the point the prescription was written" and the "law itself only provides for writing the prescription, not for what happens afterwards."⁷

- **Has no provisions to investigate inaccurate, incomplete and misleading reports or to investigate abuse surrounding assisted-suicide deaths.**

Although assisted-suicide advocates claim that Oregon's official reports about the practice of assisted suicide prove that there have been no problems or abuses, those claims are, at best, misleading. According to data provided by Compassion & Choices – the assisted-suicide advocacy group that is the chief promoter of "Death with Dignity" bills – the organization has participated in three quarters of Oregon's assisted-suicide deaths.⁸

According to Oregon's largest newspaper, "Essentially, a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know."⁹

As with Oregon's assisted-suicide law, the New Hampshire bill requires that assisted suicide cases be reported [137-L:12] but, as in Oregon's law, there are no penalties for non-reporting or for inaccurate or incomplete reporting.

From the time that Oregon's law went into effect, state officials have acknowledged that "it is difficult, if not impossible to detect accurately" whether reports are complete.¹⁰ State officials have acknowledged that they "assume, however, that physicians were their usual careful and accurate selves" when filing reports about their involvement in assisted suicide.¹¹

Oregon's Dr. Hedberg explained that investigation into potential assisted-suicide irregularities cannot take place since "not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves." ¹²

¹ Greg Lucas, "Committee votes down assisted-suicide bill," *San Francisco Chronicle*, June 27, 2006.

² *KATU TV*; "Letter noting assisted suicide raises questions," Portland, OR; July 31, 2008.

³ DHS, "Tenth Annual Report on Oregon's Death with Dignity Act," March 18, 2008, Table I.

⁴ Linda Ganzini, Elizabeth Goy, Steven Dobscha, "Prevalence of depression and anxiety in patients requesting physician' aid in dying: cross sectional survey," *British Medical Journal*, Oct. 8, 2007, pp. 973-975.

⁵ Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Jan. 17, 1999.

⁶ Erin Hoover, "Dilemma of assisted suicide: When?" *Oregonian*, Jan. 17, 1999.

⁷ Testimony of Dr. Katrina Hedberg before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*. Apr. 4, 2005, p. 259, question 566.

⁸ "Compassion & Choices of Oregon Summary of Deceased Patients, 1/1/98 through 9/25/08" distributed by George Eighmey, Executive Director of C & C of Oregon, Vancouver, WA Public Library Forum on I-1000, Sept. 25, 2008.

⁹ Editorial Board, "Washington state's assisted-suicide measure: Don't go there," *Oregonian*, Sept. 20, 2008.

¹⁰ *New Eng. J. Med*, Feb. 18, 1999, p. 583.

¹¹ OHD, CD Summary, vol. 48, no. 6, March 16, 1999.

¹² Testimony of Dr. Katrina Hedberg before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*. Apr. 4, 2005, p. 266, question 615.

3/16/09

*International Task Force
on Euthanasia and Assisted Suicide*

P.O. Box 760, Steubenville, OH 43952
740-282-3810 or 800-958-5678
www.internationaltaskforce.org

Copyright © 2009 International Task Force