VERMONT ASSISTED-SUICIDE PROPOSAL (S. 144)

S. 144, the Vermont "Patient Choice and Control at the End of Life" Act, is an assisted-suicide proposal patterned on Oregon's law permitting assisted suicide. It was introduced on April 17, 2009, by Senators Lyons, Snelling, Ashe, Ayer, Bartlett, Choate, Flanagan, MacDonald, McCormick, Miller, Racine, Shumlin and White.

If passed, S. 144 will transform the crime of assisted suicide into a medical treatment in Vermont. It would give doctors the power to prescribe lethal drug overdoses for their patients' to commit suicide.

ANALYSIS

- **S. 144 gives the illusion of "choice." Yet, it will actually constrict patient choice.**

  Under S. 144, a physician must fully "inform" the patient of "all feasible end-of-life services, including comfort care, hospice care, and pain control." [§ 5280 (7) (E) and § 5282 (3) (E)] However being "informed" of all options does not mean that the patient will have access to all such services.

  Eleven percent of Vermont residents currently have no health insurance. Furthermore, even those who have health care coverage may find that their insurance carrier will not cover all services, but that it will cover assisted suicide.

- **S. 144 would allow governmental and private health insurance to approve prescriptions for suicide to cut costs.**

  Assisted suicide could become a means of health care cost containment. In Oregon, the Oregon Health Plan (OHP) has notified some patients that medications prescribed to extend their lives would not be covered, but that the OHP would pay for assisted-suicide. Drugs for assisted suicide are very inexpensive – far less costly than medications to extend patients' lives and make them more comfortable.

  Referring to payment for assisted suicide, the Oregon Department of Human Services explains, "Individual insurers determine whether the procedure is covered under their policies, just as they do any other medical procedure."

  When assisted suicide is a legally-accepted, inexpensive medical treatment, the force of economic gravity can lead to increased pressure on patients to request, and doctors to prescribe, assisted suicide.

- **S. 144 would give physicians the power to suggest assisted suicide to their patients.**

  Its supporters claim that, if S.144 passes, physicians would not be able to suggest assisted suicide to their patients. That claim is false.

  In fact, nothing in S. 144 prohibits HMOs, insurance companies, health providers, or others from *suggesting* assisted suicide to a patient or *encouraging* a patient to request a lethal prescription.

- **S. 144 would permit doctors to help mentally ill or depressed patients commit suicide.**

  Although S.144 requires that all patients receive "counseling" before receiving an assisted-suicide prescription, the "counseling" is minimal, at best. It consists of only one consultation between the patient and a psychiatrist, a psychologist or a clinical social worker. That consultation is *only* to determine if the patient "has capacity" and does not have "impaired judgment." [§ 5280 (4)]

  Even if the counselor determines that the patient has a mental disorder or disease, that patient would still be able to get help to commit suicide, as long as the counselor determines that the patient's judgment is not impaired.

- **S. 144 does not require that family members be notified when a doctor prescribes assisted-suicide drugs for a loved one.**

  Family notification is *not required*, only recommended. [§5282 (6) and § 5286] The patient's immediate family man not even be notified until after the patient is dead.

- **S. 144 has no safeguards for the patient at the time the drug overdose is taken.**

  S. 144 covers patient-related activities only until the time the prescription for suicide is written. The lethal drugs could be stored over time, with no concern for public safety or patient protection. There are no provisions to insure that the patient is competent at the time the overdose is taken or that the patient knowingly and/or willingly takes the lethal drugs.

  Due to this lack of protection at the time of their deaths, S. 144 would put patients at enormous risk. Someone who would benefit from the patient's death, for example, could coerce or trick the patient into taking the fatal drugs, and no one would know that the patient's death was not voluntary.

- **S. 144 sets the stage for elder abuse and premature transfer of assets.**

  Since victims of domestic abuse, including elder abuse, are extremely vulnerable to persuasion from their abusers, it takes little imagination to understand how S. 144 could be manipulated to lead an at-risk patient into requesting assisted suicide or taking the lethal drugs after they are prescribed.

  Although witnesses to the patient's request for assisted suicide must affirm that the patient "appeared to understand the nature of the document and to be free from duress or undue influence" [§ 5281 (2) (c) and § 5296 Affirmation of Witnesses (1)(c)], the witnesses may be total strangers who don't really know the patient. Victims of elder abuse and domestic abuse are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to "choose" assisted suicide.

  S. 144 contains no penalties for coercing a patient into requesting assisted suicide.

- **S. 144 would allow drugs for suicide to be delivered to the patient by a third party.**

  Nothing in S. 144 requires the patient to obtain the drugs in person. A pharmacist can give the lethal drugs to a friend or acquaintance for delivery to the patient. [§ 5282 (12)]

- **S. 144 would allow doctors to prescribe assisted-suicide drugs to patients who could live for many years.**

  Under S. 144, doctors can prescribe assisted suicide to patients who have a "terminal condition," which is defined as "an incurable and irreversible disease which would, within reasonable medical certainty, result in death within six months." [§ 5280 (11)]

  However, that definition does not require that the patient is expected to die within six months, even with medical treatment. Therefore, it is possible that a patient could be considered "terminal" for the purpose of qualifying for assisted suicide even if, with medical treatment, the patient could live much longer.

  For example, diabetes is both incurable and irreversible. An insulin dependent diabetic patient who stops taking insulin will, within reasonable medical certainty, die within six months. Thus, diabetic patients could, under S. 144, be eligible for assisted suicide.

- **S. 144 would force facilities to permit prescriptions for assisted suicide to be written on their premises.**

  Under the "Health Care Facility Exception," a facility "may prohibit an attending physician from writing a prescription" for assisted suicide for a patient "who is a resident in its facility *and intends to use the medication on the facility's premises*."
  [§ 5294 (emphasis added)]

  Therefore, facilities may not prohibit an attending physician from writing a prescription for assisted suicide *on* premises if the physician believes the patient will actually take the lethal overdose *off* premises.

- **S. 144 would permit patients to request assisted suicide within days after "moving" to Vermont.**

  S. 144 states that only residents of Vermont would be eligible for assisted suicide.
  [§ 5280 (8)] A Vermont voter's registration may be used to prove residency.
  [§ 5282 (2) (B)]

  One can register to vote in Vermont immediately after having a Vermont address. There is no required time that must elapse before one becomes a resident. According to the VT Secretary of State's office, "This means that it is the voter's intent and action that determines residency, not how many nights a year the voter sleeps in town."

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Additional information about the practice of assisted-suicide in Oregon, which is the model for Vermont's assisted-suicide proposal, is available at:
http://www.internationaltaskforce.org/sptlt2.htm

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