Protection of Conscience Project
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Maine, assisted suicide, and freedom of conscience

Accommodation of objecting physicians convoluted and unsatisfactory

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Introduction

Maine's *Death with Dignity Act*[1] was signed by the state governor on 12 June, 2019,[2] to take effect on 18 September. By the last week in August, physicians in the state were deeply divided and significant institutional health care providers were expected to opt out.[3]

In reviewing the *Act*, the Project focus is on sections relevant to the protection of those who refuse to provide or facilitate suicide for reasons of conscience. These are convoluted and unsatisfactory. In brief, the *Act*

- imposes obligations on physicians that may be unacceptable to those who unwilling to facilitate assisted suicide,
- provides insufficient protection for objecting physicians not employed or by or under contract with an objecting institution,
- limits the ability of objecting health care facilities to maintain institutional integrity.

Overview

Maine's *Death with Dignity Act* permits physician assisted suicide for any resident of Maine who is 18 years of age or over, who can make and communicate informed decisions, who has been diagnosed with a terminal illness and who is likely to die within six months. Physicians assist by providing a prescription for lethal medication. The patient must make a written and oral request for the medication, and a second oral request 15 days later. Two physicians must agree that the patient is decisionally competent and meets the medical criteria. Additional consultation is required if there is concern about psychological or psychiatric conditions that may impair a patient's judgement.

Only physicians can prescribe the lethal medication for qualified patients. A physician who writes such a prescription must deliver it directly to a pharmacist, who will dispense it to the physician, the patient or the patient's agent. Physicians need not be present when the patient takes the medication.

See the text of the *Act*[1] for more details about the eligibility criteria and process.

This outline indicates that the law will directly affect physicians, pharmacists and health care facilities, though it will also have an impact on nurses and other health care workers involved with the care and treatment of terminally ill adult patients.

Section 2: definitions

The broad definition of "health care provider" is welcome. It includes anyone permitted to provide "health services." Since "health services" is undefined, "health care provider" must encompass at least physicians, nurses, pharmacists and all allied occupations. Equally important, the term explicitly includes health care facilities.

A critical element of the law is the definition of attending physician: "the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease." The definition includes every physician primarily reponsible for the treatment of a terminally ill patient, regardless of their views about assisted suicide.

Section 3: patients' right to information

Section 3 implies that health care providers must provide patients with information on "all treatment options reasonably available" for their care. This roughly reflects the standard expected for informed consent with respect to any medical treatment. Within the context of this statute, however, the provision must relate specifically to assisted suicide. This may lead to conflict for two reasons.

First, physicians who oppose assisted suicide typically do not consider it to be reasonable or a medical treatment, so they may be unwilling to volunteer information about assisted suicide in their discussion of treatment options with potentially eligible patients. Assisted suicide advocates take the opposite position, and given the law, the state medical regulator may do so as well.

Second, physicians willing to discuss assisted suicide as an option (and even to provide or refer for it) may be unwilling to do so unless a patient first asks about it or clearly expresses an interest in it. The law is not clear on this point.

Section 6: Attending physician responsibilities

By virtue of the definition of "attending physician," Section 6 imposes on every physician primarily responsible for treating a terminally ill patient the obligation to do everything preparatory to the actual prescription of lethal medication, including assessments and referrals for the required second consultation and documentation required by Section 14 (i.e., Sections 6(A) to (I) and (K).

Physicians opposed to assisted suicide who believe that doing these things would make them complicit in suicide would probably be unwilling to comply. However, they are not exempted by Section 6 from fulfilling the responsibilities it imposes.

Section 21: "voluntary participation"

The heading of Section 21 suggests that participation of individual and institutional health care providers (IHCPs) must be voluntary, and this might be thought to remedy the problem raised for objecting physicians by Section 6. It does not.

Section 21 exempts objecting individuals and IHCPs only from "providing" lethal medication and "carry[ing] out [a] qualified patient's request" - nothing else. Physicians are not relieved of the other responsibilities imposed by Section 6: to do everything preparatory to the actual prescription of lethal medication.

It appears that objecting physicians can avoid this only if they are employed by or under contract with an objecting IHCP that forbids their participation in assisted suicide (see Section 22, below). In that case, they can secure an exemption from Section 6 by relying upon the definition of "participation" that applies only to IHCP-employee-contractor relations.

If an objecting physician is unwilling to provide lethal medication, the patient is free to find a willing colleague, in which case the objecting providers must cooperate in the transfer of medical records needed to act upon the patient's request. That much is consistent with the practice in most other jurisdictions, and the arrangement is not usually problematic. However, a provision to the same effect in New Jersey's assisted suicide law has been challenged by an objecting physician as a violation of his religious freedom.[4]

The *Act* is silent on the particularly contentious issue of referral. Section 6 does not include an obligation to refer for assisted suicide, but referral is not excluded by Section 21.

Section 22: objecting institutions

Hospices and denominational hospitals and health care facilities may be unwilling to provide or allow assisted suicide, or to allow any encouragement or facilitation of assisted suicide on their premises. Such policies typically reflect concern about the welfare of their patients and rejection of the practice as incompatible with the philosophy or moral norms informing the operation of the institution. IHCPs usually enforce the policies by requiring employees and those working on their premises to conform to institutional guidelines or directives, backed by the threat of discipline or restriction of access to the premises.

Section 22 of the Act addresses this kind of situation, but limits the ability of objecting IHCPs to maintain their institutional integrity. Recall that Section 21 exempts them only from actually providing lethal medication or carrying out an assisted suicide request. It does not specifically authorize them to prohibit assisted suicide on their premises, though other state or federal laws may do so.

Can prohibit employee participation on premises or within the scope of employment

Under Section 22(A), objecting IHCPs can prohibit physicians employed by or under contract with them from participating in assisted suicide

- on premises the objecting IHCPs own, manage or directly control, or
- anywhere, within the scope of their duties as an employee or contractor,

provided the affected employees or contractors are first given written notice of the prohibition [Section 22(B)].

"Participating" includes all of the preparatory evaluations and consultations required of attending or

consulting physicians, not just the prescription of lethal medication. As noted above, this is the only means by which objecting physicians can avoid the obligation imposed by Section 6 to do everything short of the actual prescription and delivery of lethal medication.

Cannot prevent employees from participating elsewhere or outside scope of employment

Objecting IHCPs cannot prohibit employees or contractors from participating in assisted suicide elsewhere, presumably when they are acting outside the scope of their employment or contract [Section 22(D)2]. This seems consistent with what one would expect at least in the case of non-denominational facilities or of employees who do not share institutional religious convictions.

Cannot prevent referral

Referral does not count as participation, so objecting IHCPs cannot stop employees acting even *on* their premises *and within* the scope of their employment from referring patients to colleagues who will provide assisted suicide [Section 22(G)2].

Cannot prevent participation on premises by employees acting outside scope of employment

Moreover, it would seem that objecting IHCPs cannot prohibit employees or contractors from participating in assisted suicide *even on their premises* as long as they are acting outside the scope of their employment or contract [Section 22(D)1].[5] So, for example, it appears that a physician employed only part-time by an objecting IHCP would, under this provision, be able to prescribe and deliver lethal medication on the objecting IHCP's premises when acting for a different employer.

IHCPs may be unable to prohibit or prevent assisted suicide on premises

Finally, Section 22 is concerned exclusively with IHCP-employee-contractor relationships. Nothing in the *Act* authorizes an objecting IHCP to prevent physicians who are not employees or contractors from doing assisted suicide assessments, writing lethal prescriptions and even delivering lethal medications to patients on their premises. If they deliver the medication to a patient in the facility, it is difficult to see how self-administration on the premises can be prevented.

Conclusion

The provisions of *Maine's Death with Dignity Act* relevant to the accommodation of freedom of conscience and religion are so convoluted and unsatisfactory that one wonders if Maine legislators actually intended to enact what they have written.

In any case, that is what they have enacted. It is thus not surprising that, only a month before the *Act* was due to come into effect, health care organizations and authorities had still not developed policies and standards to implement it.[3]

Notes:

1. Laws of Maine, 129th Legislature (2019) c 271, An Act to Enact the Maine Death with Dignity Act [Internet] Available from: <http://legislature.maine.gov/legis/bills/bills_129th/chapters/PUBLIC271.asp (Cited 2019 Sep 20).

2. Miller K. New Maine law will allow terminally ill patients to end their lives with medication. Portland Press Herald. 2019 Jun 12. Available from: <https://www.pressherald.com/2019/06/12/mills-signs-medication-assisted-suicide-bill/> (Cited 2019 Sep 18).

3. Thistle S. As 'death with dignity' law nears, Maine doctors hesitate. Portland Press Herald. 2019 Aug 25. Available from: <https://www.centralmaine.com/2019/08/25/as-death-with-dignity-law-nears-maine-doctors-hesitate/> (Cited 2019 Sep 18).

4. Schwartz B. Bergenfield Doctor's Lawsuit Halts NJ Physician-Assisted Suicide Act [Internet]. Jewish Link. 2019 Aug 21. Available from: <https://www.jewishlinknj.com/community-news/bergen/32984-bergenfield-doctor-s-lawsuit-halts-nj-physician-assisted-suicide-act>. (Cited 2019 Sep 19).

5. Section 22(D)1: "Participating . . . while on premises that are not owned or under the management or direct control of the prohibiting health care provider *or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider*" [Emphasis added).