Analysis: 2015 SB 128 California "End of Life Option Act" (as amended 6/16/15)

This 2015 bill is the 8th attempt by doctor-prescribed suicide activists in California to transform a prescription for a lethal dose of drugs into a "medical treatment." It is patterned after Oregon's "Death with Dignity Act."

Under the amended[1] "End of Life Option Act" (SB 128):

A doctor would be able to prescribe a massive overdose of drugs for a person to take to end his or her life.

The bill refers to an "aid-in-dying drug"[2] that would be taken to bring about an individual's death. Many individuals erroneously assume that this means a patient would take "a pill" for that purpose.

> According to the latest official report from Oregon, 99 % of prescriptions under that state's "death with dignity" law were for either of two barbiturates (sedatives): secobarbital or pentobarbital.[3]

The usual therapeutic dosage for each is 100-200 mg. The usual lethal dose prescribed for doctor-assisted suicide is up to 100 times greater - 9,000 to 10,000 mg.[4]

Government bureaucrats and profit-driven health insurance programs could cut costs by denying payment for treatment that patients need and want, while approving payment for less costly assisted suicide deaths.

> This has already been documented in Oregon – the state with the law upon which the California proposal is based. The Oregon Health Plan (OHP) has notified some patients that medications prescribed to extend their lives or improve their comfort level would not be covered, but that the OHP would pay for a lethal drug prescription.[5]
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> 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."[6]

The bill, as amended, would not permit insurance companies to include denial of treatment and information about the availability of payment for assisted suicide in the same communication.[7] However, the insurance provider could let the patient know that the cost for the lethal drug overdose is covered if the patient or the attending physician asks what options would be covered.

California's Capital Public Radio recently reported that health care – particularly for poor patients – has become increasingly difficult to provide.[8]

If the California bill is approved, will health insurance programs and government health programs do the right thing – or the cheap thing?

Family members, health care providers and others could advise, suggest, or encourage vulnerable individuals to request doctor-prescribed suicide.

The bill would penalize anyone for "knowingly coercing or exerting undue influence"[9] on an individual to request the lethal prescription. Additionally, it requires that the physician discuss the patient's request "outside of the presence of any other persons" to determine whether the patient "is feeling coerced or unduly influenced by another person."[10] However, "coercion" and "undue influence" have a very narrow legal meaning and do not include suggesting, advising, or encouraging a patient to request doctor-prescribed suicide.[11]

Since victims of domestic abuse, including elder abuse, are extremely vulnerable to persuasion from their abusers, it takes little imagination to understand how the bill could put abused individuals at risk of being persuaded to request doctor-prescribed suicide. Victims of such abuse are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to request assisted suicide.[12]

"Doctor shopping" could take place until a health care professional can be found to declare that the patient is qualified for the lethal prescription.

If an attending physician believes a patient does not have the ability to make an informed decision or that the patient is being pressured to request the prescription for assisted suicide, nothing in the bill prohibits a health provider, family member or another person from arranging for the patient to be evaluated by other health care professionals until one is found who would declare the patient capable of choosing assisted suicide.

> This has taken place in Oregon where it has been noted that "a psychological disorder — senility, for example — does not necessarily disqualify a person."[13]
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> A woman died of assisted suicide under Oregon's "Death with Dignity Act," even though she was suffering from early dementia. Her own physician had declined to provide a lethal prescription for her. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly pushing for it and 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."
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> Finally, she was assessed by a managed care ethicist who determined that she qualified for assisted suicide, and the lethal dose was prescribed.[14]

An individual could request doctor-prescribed suicide based on fear of being a burden to others.

Under the bill, the written request is to indicate whether the individual informed or decided not to inform his or her family of the request for assisted suicide.[15] But such family notification by the person is not required. If an individual fears becoming a burden and if loved ones are unaware of that concern, they are unable to reassure the person of their care and love.

In the last official Oregon report, fear of becoming a burden on others was given as a reason for requesting lethal drugs by more than 57 % of those who died using that state's assisted-suicide law.[16]

The oral requests could be made by phone and the written request could be sent by mail or electronic means.

The bill requires that a person make two oral requests and a written request, before receiving the prescription for the lethal drugs. It states that the attending physician shall, directly and not through a designee, receive all three requests.[17]

However it does not require that those requests be made in the presence of the physician. The patient could, in fact, phone in the oral requests and mail the written request directly to the physician.

Someone who would benefit financially from the person's death could serve as a witness to the patient's written request.

The bill requires that there be two witnesses to the individual's written request for doctor-prescribed suicide. The witnesses must attest that the individual "has the capacity to make medical decisions," is "acting voluntarily" and is "not being coerced to sign the request."[18] Only one of those witnesses shall not be a relative or someone entitled to any portion of the person's estate upon death.[19]

This provides little protection since it permits one witness to be a relative or someone who *is* entitled to the patient's estate. The second witness could be a "best friend" of the first witness, and no one would know.

Drugs for suicide could be mailed to a patient.

Nothing in the bill requires the patient to obtain the drugs in person. The bill permits the lethal drugs to be delivered by "personal delivery, or, with a signature required on delivery by United Parcel Service, United States Postal Service, Federal Express, or by messenger service."[20]

However, even with a required signature, services such as Federal Express, UPS and the USPS only require the signature of the person accepting the delivery, not the person to whom the package is addressed. There are no protections to prevent unintended individuals from signing for the package of drugs.

In addition, the bill permits the assisted-suicide drugs to be dispensed to "a person expressly designated by the qualified individual."[21] That designated person could be an abusive family member or heir who persuaded the patient to request the prescription and who was one of the two witnesses to the patient's written request for doctor-prescribed suicide.

There are no protections for the person once the assisted-suicide prescription is filled and delivered.

Like the Oregon law, the bill only addresses activities taking place up until the individual receives the lethal drugs. There are no provisions to assure that the person is competent at the time the overdose is taken or that he or she knowingly and willingly takes the drugs.

Due to this lack of protection at the time of their deaths, the bill would put patients at enormous risk. For example, someone who would benefit from the individual's death could trick or even force the person into taking the fatal drugs, and no one would know.

Why are there no safeguards at the most important part of the process – at the time the patient takes the drugs that will cause death?

There is an illusion of choice. Yet the bill, if passed, would constrict patient choice.

"Choice" is an appealing word, but inequity in health care is a harsh reality.

Under the bill, before writing a prescription for death, a doctor must discuss "the feasible alternatives or additional treatment opportunities, including but not limited to, comfort care, hospice care, palliative care, and pain control."[22] However, discussing all options does not mean that the patient will have the ability to access those options.

Patients may find that their insurance will not cover the "feasible alternatives" their doctors informed them about but, instead, will pay for doctor-prescribed suicide.

If doctor-prescribed suicide becomes just another "end of life option," and a cheap option at that, the standard of care and provision of health care changes. There will be less and less focus on extending life and eliminating pain, and more and more focus on the "efficient and inexpensive treatment option" of death.

If doctor-prescribed suicide is legalized in California, it could become the only "medical treatment" to which many people have equal access. The last to receive health care could be the first to receive doctor-prescribed suicide.

Physicians would be able to write assisted-suicide prescriptions for mentally ill or depressed patients.

If the attending or consulting physician believes that the patient has a mental disorder, the physician must refer the patient for a "mental health specialist assessment" which may consist of only one consultation.[23] The purpose of the assessment is to determine if that "individual has the mental capacity to make medical decisions, act voluntarily and make an informed decision." Even if the person has a mental disorder, the lethal prescription can still be provided as long as the mental health specialist believes the patient does not have "impaired judgment".[24]

This provision is the same as that contained in Oregon's law where, in 2014, only 3 of the 155 patients who received lethal prescriptions were referred for a psychological evaluation.[25] A study about Oregon's law found that it "may not adequately protect all mentally ill patients".[26]

Individuals who could live for many years would be eligible for assisted suicide.

Under the bill, doctors would be permitted to prescribe assisted suicide to patients who have a "terminal disease" which is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months."[27]

However, that definition does not require that the individual is expected to die within six months, *even with medical treatment*, nor does it require that the condition be *uncontrollable.* Therefore, it is possible that a person could be considered "terminal" for the purpose of qualifying for assisted suicide even though, with medical treatment, he or she could live much longer.[28]

For example, diabetes can be both incurable and irreversible but it is controllable. An insulin-dependent diabetic who stops taking insulin will, within reasonable medical judgment, die within six months. Thus, under the bill, diabetics could be eligible for doctor-prescribed suicide even though they could live virtually normal lives with insulin.

> There is documentation that this has occurred under Oregon's assisted-suicide law. In the latest official report from Oregon, diabetes is noted as the underlying terminal condition that made the patient eligible for a lethal prescription.[29]

A representative of an assisted-suicide advocacy organization could witness a vulnerable patient's written request.

In Oregon, members of the assisted-suicide advocacy group that spearheaded the state's law have acknowledged that they play a key role in the vast majority of deaths under the state's assisted-suicide law.[30] The same advocacy organization is a major promoter of SB 128.

There is no way to know if reporting by physicians and pharmacists is accurate and there are no provisions for investigating or enforcing the law's requirements.

The State Public Health Officer may review records of prescribing physicians and must make an annual statistical report related to activities of physicians and pharmacists under the California "End of Life Options Act".[31] All data contained in the annual reports would be provided by the prescribing physicians and the pharmacists who dispensed the lethal drugs. However, the bill contains nothing that gives enforcement or investigative authority to the State Public Health Officer so there is no way to ensure the accuracy of information in the annual report.

> This is similar to the Oregon law, where the first official Oregon State summary of the law's utilization stated that information in the report may not have been accurate or complete. "[F]or that matter, the entire account could have been a cock-and-bull story. We assume, however, that physicians were their careful and accurate selves."[32]
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> A medical epidemiologist with the Oregon Health Division and co-author of the state's first official report said neither the law approved by voters nor the legislature had given any enforcement powers to the Health Division. She noted that the division had to rely on the word of doctors who are not required to be at the patient's bedside when the lethal drugs are

taken. For that reason, the doctors who provide information for the annual reports may not have knowledge about any complications.[33]

The overall suicide rate in California could dramatically increase.

Already more people in California die annually from suicide than from motor vehicle accidents,[34] and suicides vastly outnumber homicides[35] in the state.

Starting two years after its doctor-prescribed suicide law went into effect, Oregon's suicide rate skyrocketed, making it 41% higher than the nation's average.[36]

If California adopts SB 128, will the overall suicide rate in California also increase?

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Note: Supporters of SB 128 point to Oregon to claim that there are no problems with the law and that safeguards are meticulously followed and monitored. Yet, in closed-door sessions, they acknowledge that this is not true. For documented information about this contradiction, see "The Oregon Experience."[37]

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[1] SB 128 was amended in the Senate on April 14, 2015, twice on June 1, 2015 and again on June 16, 2015.
[2] Section 443.1 (b).
[3] http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf, p. 5 and p. 6, n. 8.
[4] Jennifer Fass and Andrea Fass, "Physician-assisted Suicide: Ongoing Challenges for Pharmacists, " *Am. J. Health Syst Pharm.* 2011:68(9): 846-849. Available at: http://www.medscape.com/viewarticle/742070_print (last accessed 5/5/15). For more information on drugs used for doctor-prescribed suicide, see: http://www.patientsrightscouncil.org/site/wp-content/uploads/2015/05/Drugs_used_-for_doctor-prescribed_suicide.pdf.
[5] KATU Television, "Letter noting assisted suicide raises questions" (interview about one such case and the response of the Oregon Health Plan). Available at: http://www.katu.com/news/26119539.html (last accessed 1/29/15).
[6] Oregon Dept. of Human Services, "FAQs about the Death with Dignity Act." Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf (last accessed 6/3/15).
[7] Section 443.13 (c).
[8] Pauline Bartolone, "Doctors Medical Center Closure Shows Struggle of Hospitals that Serve the Poor," April 20, 2015. Available at: http://www.capradio.org/articles/2015/04/20/doctors-medical-center-closure-shows-struggle-of-hospitals-that-serve-the-poor (last accessed 4/29/15).
[9] Section 443.17 (b).
[10] Section 443.5 (a) (4).
[11] For example: "coercion" generally means imposing one's will on another by means of force or threats and "undue influence" includes such activities as controlling the necessities of life such as medication, access to information, interaction with others or access to sleep.
[12] For example, statistics indicate, "Only four percent of reported elder abuse cases come from the elder person; 96 percent of the reports come from somewhere else." Gazette.net (Maryland), "A safe place for abused seniors," February 9, 2015. Available at http://www.gazette.net/article/20150209/NEWS/150209456/1007&source=RSS&template=gazette (last accessed 4/29/15).
[13] "Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die," *Oregonian*, February 4, 2015. Available at: http://www.oregonlive.com/health/index.ssf/2015/02/physician-assisted_suicide_a_f.html (last accessed 4/20/15).
[14] Ibid.
[15] Section 443.11 (a).

[16] Official report for 2014 deaths under Oregon's Death with Dignity Act, pg. 5. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf (last accessed 4/6/15).
[17] Section 443.3 (a).
[18] Section 443.3 (b) (3).
[19] Section 443.3 (c) (1).
[20] Section 443.5 (c).
[21] Ibid.
[22] Section 443.5 (a) (2) (E).
[23] Section 443.1 (k).
[24] Section 443.8 (b) & (c).
[25] Official report for 2014 deaths under Oregon's Death with Dignity Act, p. 5. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf (last accessed 4/6/15).
[26] Linda Ganzini, Elizabeth R. Goy, Steven K. Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," *British Medical Journal*, Oct. 25, 2008, pp. 973-978.
[27] Section 443.1 (q).
[28] According to data regarding predicted life expectancy, a prognosis of six months is typically given as a median for patients with a similar diagnosis and can be completely inaccurate when applied to a particular patient. "[I]f a patient is told she has a year median survival, it means that half of similar patients will be alive at the end of a year and half will have died. It's possible that the person's cancer will advance quickly and she will live less than the median. Or, if she is in good health and has access to the latest in treatments, she might outlive the median, sometimes by many years." Amanda Aronczyk, "Cancer Patients and Doctors Struggle to Predict Survival," NPR, February 10, 2015. Available at: http://www.npr.org/blogs/health/2015/02/10/384011538/cancer-patients-and-doctors-struggle-to-predict-survival (last accessed 4/30/15).
[29] Official report for 2014 deaths under Oregon's Death with Dignity Act, p. 6, fn. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf (last accessed 4/6/15).
[30] Officers of Compassion in Dying/Compassion & Choices of Oregon were the chief proponents of Oregon's assisted-suicide law. They have proclaimed themselves stewards of the law. According to one spokesperson for the organization, in 2009, it was involved in 97% of deaths under the law. For documentation see: "The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization." Available at: http://www.patientsrightscouncil.org/site/oregon-assisted-suicide-deaths (last accessed 4/29/15).
[31] Section 443.19.
[32] Center for Disease Prevention & Epidemiology – Oregon Health Division, "A Year of Dignified Death," March 16, 1999, Vol. 47, No. 6, p. 2. Available at: http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/1999/ohd4806.pdf (last accessed 4/29/15).
[33] Joe Rojas-Burke, "Suicide critics say lack of problem in Oregon is odd," *Oregonian*, February 24, 2000.
[34] In 2010, there were 3,913 suicide deaths and 2,922 deaths from motor vehicle accidents in California. National Vital Statistics Reports Volume 61, Number 4, "Deaths: Final Data for 2010", May 8, 2013, p. 88. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf (last accessed 01/29/2015).
[35] In 2010, there were 3,913 suicide deaths and 1,954 homicide deaths in California. National Vital Statistics Reports Volume 61, Number 4, "Deaths: Final Data for 2010", May 8, 2013, pp. 88, 89. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf (last accessed 01/29/2015).
[36] Oregon's suicide rate increased by 49.3 percent, making it 41 percent higher than the national rate. Available at: http://www.oregonlive.com/health/index.ssf/2013/05/report_oregons_suicide_rate_hi.html (last accessed 01/31/15).
[37] "The Oregon Experience." Available at: http://www.patientsrightscouncil.org/site/the-oregon-experience (last accessed 1/30/15).

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