

2015 Massachusetts Analysis House No. 1991

Patterned on Oregon's doctor-prescribed suicide law, this bill differs, in part, with that law and creates additional loopholes that place vulnerable patients at risk.

Under House No. 1991:

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 palliative care."¹ 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 Massachusetts, 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.

An agent appointed pursuant to a health care proxy may be able to request the assisted-suicide prescription on behalf of the principal (patient).

Massachusetts law explicitly provides that a health care agent "shall have the authority to make any and all health care decisions on the principal's behalf that the principal could make" subject only to any express limitations in the health care proxy.²

A third party could request assisted suicide on behalf of a patient without any oversight to determine the accuracy of the request.

Under the bill, patients are considered capable of requesting assisted suicide not only by communicating the decision on their own but also by "communication through persons familiar with the patient's manner of communicating if those persons are available."³

This could include not only translating various languages but also facilitated communication⁴ which could lead to a patient's wishes being misunderstood, misinterpreted, or disregarded. There is no requirement that the accuracy of such communication assistance be verified.

Who will know if the person communicating on behalf of the patient is doing so accurately? What, if any, professional expertise will be required of those communicating on behalf of the patient?

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

The bill would penalize anyone who "coerces or exerts undue influence" on an individual to request the lethal prescription.⁵ 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.⁶

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.⁷

Someone who would benefit financially from the person's death could serve as a witness and claim that the individual is competent, acting voluntarily and not being coerced to sign the request for assisted suicide.

The bill requires that there be two witnesses to the individual's written request for doctor-prescribed suicide. Only one of those witnesses shall not be a relative or someone entitled to any portion of the person's estate upon death.⁸

However, 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 the best friend of the first witness and no one would know.

The lethal prescription could be written on the same day as the diagnosis, based upon a written request.

The bill does not require any waiting period between the time the patient is diagnosed with a terminal condition and the time the lethal dose is prescribed.

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

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?

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 "Aid in Dying"⁹ as a medical practice of a physician prescribing lawful medication to bring about a humane and dignified 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.¹⁰

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!¹¹

"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 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."¹²

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."

Finally, she was assessed by a managed care ethicist who determined that she qualified for assisted suicide, and the lethal dose was prescribed.¹³

There are Draconian disclosure requirements for health care providers who are unwilling to participate in providing doctor-prescribed suicide.

The disclosure requirements include, "at a minimum": the mechanism the provider will use to make a referral to a willing provider, the complaint processes available to persons affected by the objecting provider and the fact that the unwilling provider must bear the cost of transferring a patient to a willing provider. Also, providers who are not willing to participate must describe internal and external complaint procedures to any person upon request as well as to a patient or the patient's decision maker upon admission or at the time of initial receipt of health care.¹⁴

Such requirements could result in excessive costs for providers who are not willing to provide the lethal prescription. For example, even if a patient has been informed that a particular facility will not provide doctor-prescribed suicide, the patient could choose to be admitted to the facility even though he or she is planning to request the prescription. The patient could then request the

prescription, potentially placing the facility in the position of bearing expenses that could include ambulance transport to a facility many miles away.

However, the bill does not require any disclosure requirement from those who are willing to provide doctor-prescribed suicide. Why not?

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 Massachusetts 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.¹⁵

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."¹⁶

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

Death certificates would not reflect the true manner of death.

Death certificates reflect both the cause and manner of death.

The bill states that the cause of death be listed as "self-administered due to a terminal diagnosis of (the underlying disease) as the cause of death."¹⁷ It makes no reference to the manner of death.

The manner of death is suicide. However, the bill specifically states that "state regulations, documents and reports shall not refer to the practice of aid in dying under this chapter as 'suicide' or 'assisted suicide.'"¹⁸

Thus, death certificates for those dying of doctor-prescribed suicide would be falsified.

In addition:

The bill contains contradictions regarding the necessity of a consulting physician's confirmation of the diagnosis and prognosis.

It states that the attending physician is to "refer the patient to a consulting physician to medically confirm the diagnosis and prognosis and for a determination that the patient is competent and is acting voluntarily."¹⁹

Yet, in the requirements for medical record documentation, the bill refers to a waiver of the consulting physician's diagnosis, stating "unless waived as provided in section 8," the consulting physician's information must be included in documents submitted by the attending physician.²⁰

However, section 8 makes no reference to a consulting physician nor is there any reference to a waiver in section 8 or in any other section of the proposal.

The bill contains contradictions regarding counseling.

It states that the attending physician is to "refer the patient for counseling pursuant to section 8."²¹ Furthermore, it states that the "attending physician shall refer..." for counseling and the "counselor must submit" a written report.²²

Yet, in the requirements for medical record documentation, it requires "a report of the outcome and determinations made during counseling, if performed."²³ This indicates that counseling is not required and that the prescription can be written for the patient even if no counseling is performed.

The bill does not include any provision for monitoring whether doctor-prescribed suicide is being carried out in compliance with the law.

The bill indicates that prescribing physicians are to document or file detailed information in individual patient medical records.²⁴ However, data which is to be reported to the Department of Public Health is to include only basic numbers (the number of requests, the number of prescriptions written, the number of requests rescinded and the number of patients that took the prescription).²⁵

The bill implies special protections for actions taken by "patient advocates"²⁶ but does not define what is meant by or who qualifies as a patient advocate.

Would a representative of a doctor-assisted suicide advocacy group be considered a patient advocate who could support the patient's request for doctor-prescribed suicide as well as facilitate taking the prescription?

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Note: Supporters of House No. 1991 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."²⁷

¹ H 1991, Lines 164-165 [Section 6 (1) (b) (v)].

² Mass. Gen. Laws. Ann. ch. 201D, §5.

³ H 1991, Lines 16-17 [Section 1].

⁴ Facilitated communication in which a person, called a "facilitator," supports the hand or arm of a person who is impaired, using a device such as a keyboard to help the individual communicate.

⁵ H 1991, Lines 311-315 [Section 17].

⁶ 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.

⁷ 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).

⁸ H 1991, Lines 100-103 [Section 3 (3)].

⁹ H 1991, Lines 9-11 [Section 1].

¹⁰ Oregon Public Health Division: Death with Dignity Act - 2014

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>, p. 5 and p. 6, n. 8 (last accessed 7/27/15)..

¹¹ 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.

¹² "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).

¹³ Ibid.

¹⁴ H 1991, Lines 284-305 [Section 16 (4)].

¹⁵ 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).

¹⁶ 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).

¹⁷ H 1991, Lines 191-193 [Section 6 (2)].

¹⁸ H 1991, Lines 269-270 [Section 15 (5)].

¹⁹ H 1991, Lines 166-167 [Section 6 (1) (c)].

²⁰ H 1991, Lines 235-239 [Section 12 (5) and (6)] (emphasis added). This error appears to be a case of cutting and pasting from a previous bill [2013-2014 HB 1998, Section 7 and Section 12 (5) and (6)].

²¹ H 1991, Line 168 [Section 6 (1) (d)].

²² H 1991, Lines 205-208 [Section 8].

²³ H 1991, Line 240 [Section 12 (7)] (emphasis added) .

²⁴ H 1991, Lines 227-246 [Section 12].

²⁵ H 1991, Lines 250-254 [Section 14].

²⁶ H 1991, Lines 264-268 [Section 15 (4)].

²⁷ "The Oregon Experience." Available at: <http://www.patientsrightscouncil.org/site/the-oregon-experience> (last accessed 6/30/15).

Patients Rights Council
P.O. Box 760
Steubenville, OH 43952
740-282-3810 or 800-958-5678
<http://www.patientsrightscouncil.org>
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