

Assisted Suicide: The Rhetoric v. The Reality

by Rita L. Marker, Esq

On October 5, 2015, Governor Jerry Brown signed ABx2-15, the California "End of Life Option Act."¹

In his signing statement, Brown noted that it was not an ordinary bill because it dealt with life and death. He stated that he had considered many of the varied, contradictory and nuanced positions from those who favored as well as those who opposed the bill. But, he concluded:

*In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.*²

That Governor Brown was sincere is beyond doubt. Similarly, the intentions of others who promoted the "End of Life Option Act" were sincere, as are those in other states who support similar proposals (called by such names as "Death with Dignity" or "Aid in Dying").

Yet their perspective and their sincerity come at great cost to individuals who do not have access to similar resources as do supporters of such proposals.

For example, Governor Brown stated that it would be a comfort to be able consider the options afforded by the bill. Indeed, the California law does require that, before prescribing the lethal dose of drugs (referred to as an "aid-in-dying drug"), the physician must inform the patient of the "feasible alternatives or additional treatment options including, but not limited to, comfort care, hospice care, palliative care, and pain control."³ However, this presumes that the patient would have the financial ability to obtain those feasible alternatives or options.

Governor Brown would certainly be able to make an informed decision after considering them. But what about the patient who would prefer one of those options but doesn't have the financial ability to get it? Considering an option and obtaining that option are two very different things.

Take, for example the case of Stephanie Packer, a young California mother who was diagnosed with a terminal form of scleroderma. Her doctor prescribed treatment that would be less toxic than other drugs and her insurance company indicated that it would cover the cost.

But, then, California's "End of Life Option Act" went into effect and the insurance company notified Packer that its approval had been withdrawn. They would not pay for the "feasible

Rita Marker is an attorney admitted to practice in California and Washington, D.C. as well as before the United States Supreme Court. She has been the executive director of the Patients Rights Council since it began in 1987. She is the author of the critically acclaimed book, Deadly Compassion. (Wm. Morrow & Co., 1993; Harper/Collins, 1994; Avon Books, 1995). Ms. Marker was among the first to be profiled in the American Medical Association's American Medical News during its series on "people making news in an era of dramatic change in medicine."

Ms. Marker is a contributor to Contemporary Perspectives on Rational Suicide (Taylor & Francis, 1999) and the author of articles that have appeared in numerous publications including: Akron Beacon Journal, American Thinker, Chicago Sun-Times, Detroit News, Duquesne Law Review, Journal of Pharmacy Technology, Maryland Journal of Contemporary Legal Issues, Michigan Hospitals, The New York Times, Saint John's Journal of Legal Commentary, Senior Patient, State Government News and USA Today.

Ms. Marker is a former adjunct professor of Political Science & Ethics at the University of Steubenville, Ohio. She has made presentations and debated in Hong Kong, Ireland, Italy, France, Belgium, England, Australia, Canada, Colombia, Switzerland, Slovenia and the United States including: American Bar Association, Case Western Law School, Commonwealth Club of San Francisco, Florida State University, Italian Society of Bioethics, Kentucky Legislature, League of United Latin American Citizens, Marquette University, Michigan Governor's Conference on Aging, Michigan Legislature and the NAACP.

option" of treatment that Packer wanted and needed. Packer then asked if assisted suicide would be covered under her plan.

The response was, "Yes, we do provide that to our patients, and you would only have to pay \$1.20 for the medication."⁴

Packer's experience was not unique. Similar cases have been reported in other states where doctor-prescribed suicide is considered a medical treatment.⁵ And there is no way to know how many other cases have gone unreported.

The reality is that low income individuals face great difficulties when they attempt to receive necessary health care. Those who are disenfranchised and underprivileged confront barriers to basic care and the reality of obtaining any and all "feasible options" is out of reach.

Yet proponents of doctor-prescribed suicide virtually always depict it as a choice to be made by a patient who has a loving family and a caring doctor who, after lengthy discussions with the patient, would write a prescription for lethal drugs to be used as a last resort.

"Choice" is an appealing word. But inequity in health care is a harsh reality. Examination of the contents of bills which have passed and those which are under consideration is vital.

Just Another "Medical Treatment" – And a Cost Effective One

The California experience presents a study of the confluence of cost containment and political gyrations. Until September 2015, the state had been one of 35 where more than 175 assisted-suicide bills had been introduced and rejected.⁶ And, in July 2015, it appeared that the California proposal was also dead, having failed to pass the Assembly Health Committee. It seemed that the two-year bill could not be heard again until January 2016 – but its sponsors had another plan.

Because the state's Medicaid program (Medi-Cal) was facing a billion-dollar shortfall, Governor Brown called a special session specifically to pass legislation to fund the Medi-Cal program. The bill's sponsors jumped on the

opportunity to introduce it again, even though it was not on the subject for which the special session was called. This provided a perfect opportunity for the sponsor to circumvent many of the regular session requirements. Even more important was the fact that the special session Assembly Health Committee would be smaller and the members hand-picked, allowing the removal of legislators who had opposed the measure weeks earlier during the regular session. With the stumbling block of the earlier configured Assembly Health Committee out of the way, the bill passed the new committee and went to the full Assembly where it passed. It then went to the Senate whose leadership, which included the bill's sponsors, waived any committee hearing and sent the bill straight to the floor. It passed in a final vote on September 11, 2015 and was signed into law less than three weeks later.

Passage of that law, as well as of previous similar measures in Oregon,⁷ Washington,⁸ and Vermont⁹ resulted in a seismic shift. Assisted suicide, if accomplished by means of a doctor's prescription for a deadly overdose of drugs, was transformed from a crime into a "medical treatment."

This led to an inescapable result: Doctor-prescribed suicide became the least expensive "treatment" for a terminal condition.

Indeed, shortly before the California law went into effect, the state put plans into motion to assist in covering the cost of life-ending drugs. The funding, in the amount of \$2.3 million, had been tucked into the state budget.¹⁰ Oregon also uses state funding to pay for doctor-prescribed suicide. In addition to state funding, private insurance companies cover the cost of the lethal prescription.

The Oregon Public Health Department explains, "The Act does not specify who must pay for the services. Individual insurers determine whether the procedure is covered under their policies (just as they do with any other medical procedure)."¹¹

There is little question that authorization for treatment and care generally depends upon cost effectiveness. The cost of drugs for doctor-prescribed suicide is miniscule compared to the cost

of providing treatment to make a patient more comfortable and to extend life. This fact was recently articulated by the Indiana State Medical Association (ISMA) when its members confirmed the organization's opposition to assisted suicide. "Will the government and insurance companies do the right thing – pay for treatment costing thousands of dollars—or the cheap thing – pay for lethal drugs costing hundreds of dollars?" the ISMA stated in a press release.¹²

In addition to the very real concerns about denial of needed and wanted treatment and care, other aspects of the debate over assisted-suicide need careful scrutiny.

Rhetoric v. Reality

The standard description of "death with dignity," "end of life options," "aid in dying" and similar laws states that the purpose of such a law is to provide terminally ill patients with the right to die without suffering intractable pain in their final days or weeks. Proponents emphasize that such measures contain numerous safeguards against abuse. They point to Oregon (the state on which virtually all bills are patterned) to show that there have been no problems or abuses in the years since its "Death with Dignity" law went into effect. Additionally, those promoting such laws adamantly declare that deaths occurring under such laws are not suicide since the person is dying already and is merely determining the way in which they will die.

Contrasting this rhetoric with the reality is crucial.

Diagnosis & Prognosis

Rhetoric:

The patient must be terminally ill, with a life expectancy of six months or less, and that prognosis must be affirmed by two physicians.

Reality:

The two physicians need not be specialists, nor do they need to have any long time relationship with the patient.

The two physicians (attending physician and consulting physician) may have no expertise or even no experience in diagnosing or treating terminal illness. As long as a physician is admitted to practice medicine, he or she can be the attending physician.

In California, soon after the "End of Life Option Act" passed, Dr. Lonny Shavelson, a Bay Area physician opened a right-to-die practice. Shavelson's medical expertise had been primarily as an emergency room physician prior to his leaving medical practice to become a photo-journalist. His new business is called "Bay Area End of Life Options" where he charges \$200 for an initial patient evaluation and, for patients he considers qualified, the clinic will charge an additional \$1,800 for expenses related to follow up visits, forms, etc.¹³

According to annual reports from Oregon, some patients had less than a one-week relationship with the prescribing physician.¹⁴ The physician does not need any particular expertise in treating the illness with which the patient is diagnosed. For example, a patient diagnosed with ovarian cancer could be diagnosed by a proctologist and that diagnosis could be affirmed by a dermatologist. Additionally, the life expectancy of six months or less does not state that it is *with or without* medical treatment.

There are conditions that are incurable and irreversible and would cause death within six months without treatment but, with treatment, the patient could live indefinitely. Among these are insulin-dependent diabetes and certain types of leukemia. Official Oregon reports indicate that diabetes is one of the underlying conditions that has qualified the patient for the death with dignity prescription.¹⁵

Safeguards –Requests

Rhetoric:

The patient must make 2 oral requests and 1 written request. The written request must be witnessed by 2 individuals.

Reality:

While it is true that those requests must be made, only one of the witnesses to the written request must be a disinterested party. According to the California written request form's Declaration of Witnesses, "Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death."¹⁶

However, this means that an heir can be one witness and that heir's "best friend" may be the other witness.

Coercion or undue influence prohibited

Rhetoric:

All of the current laws permitting doctor-prescribed suicide provide that a person who coerces or exerts undue influence on a patient to request life-ending drugs is guilty of a felony.¹⁷

Reality:

Both coercion and undue influence have narrow legal meanings. They do not prohibit someone from suggesting, advising, or encouraging a patient to request doctor-prescribed suicide.

Since victims of domestic abuse, including elder abuse, are extremely vulnerable to persuasion from their abusers, it takes little imagination to understand how this could put abused individuals at risk of being persuaded to request the lethal prescription.

Mental Evaluation

Rhetoric:

Patients must receive counseling prior to receiving the death with dignity prescription.

Reality:

None of the current laws or any of the proposals to permit physician-assisted suicide require that every patient receive counseling or an evaluation by a mental health professional.

Typical of references to such an evaluation is that which is found in Oregon's law. It states:

*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, either physician shall refer the patient for counseling.*¹⁸

Note that this does not require referral for counseling for all patients or even for all who have a mental disorder or depression.

Counseling (which may include only one visit with a mental health professional) is only required if the physician believes that disorder is causing impaired judgment such that the patient does not know what he or she is requesting.

Included in the law's medical record documentation requirements is: "A report of the outcome and determinations made during counseling, *if performed*."¹⁹

In the latest official report of deaths under the Oregon Death with Dignity Act, fewer than 4% of patients were referred for counseling prior to receiving the prescription for the life-ending drugs.²⁰ A study about Oregon's law found that it "may not adequately protect all mentally ill patients."²¹

Prevention of Dying in Prolonged and Excruciating Pain

Rhetoric:

When a bill is being proposed, supporters portray it in much the same way as did Governor Brown in his signing statement – as a means of preventing dying in prolonged and excruciating pain.

Reality:

The latest research shows that those who request the prescription are not primarily concerned about pain. Instead, once such measures pass, even its supporters shift emphasis to the fact that pain or concern about future pain is rarely the catalyst for such requests. As the director of Bay Area End of Life Options acknowledges, "It's almost never about pain. It's more about dignity and control."²²

According to official annual reports from Washington and Oregon, pain (which includes not only pain but also fear of pain) was ranked as a reason for the request by far less than half of the patients who died from doctor-prescribed suicide.²³ Instead, the main reasons for the requests were loss of independence, poor quality of life, the inability to care for themselves, and fear of being a burden. Emphasis is placed on a revulsion of being cared for by others – essentially that being dependent on others would be a fate worse than death.²⁴

This affirms disability rights leaders' warnings about the threat of assisted suicide. As Marilyn Golden, Senior Policy Analyst at the Disability Rights Education & Defense Fund (DREDF) stated, "We have known all this for some time. But it's nice to see it laid out so nicely. On the other hand, it's horrifying to see the conclusion with its parade of what's considered worse than death, without consideration for how people's goalposts tend to change, and why."²⁵

After the Prescription Is Filled

Rhetoric:

A patient may request the prescription to have on hand "just in case." This gives patients peace of mind, knowing that they can die in the way, and at the moment, of their own choosing.

Reality:

The laws and proposals related to doctor-prescribed suicide only address activities that take place up until the prescription is filled. According to the legal guidance regarding the Oregon law, "The Act merely regulates the conduct of all parties *up to the point of the drug prescription.*"²⁶

There are no provisions to ensure that the patient is competent at the time the drug overdose is taken or that the patient knowingly and willingly takes the drugs.

Due to this lack of protection, patients are at enormous risk. For example, someone who would benefit from the patient's death could trick or even force the patient into taking the lethal drugs. No one would know that the patient's death was not voluntary.

No Reported Abuses

Advocates of doctor-assisted suicide point to official reports from Oregon, claiming that the data in those reports proves that the law is working well and is free of problems or abuse. However, that claim is subject to skepticism. The reports are based on prescribing doctors self-reporting their cases to the state. And there are no penalties for not reporting.

Those responsible for issuing official annual reports have acknowledged from the very beginning of the Oregon law's implementation that official reports may not be accurate or complete. According to the Oregon Health Division, "The entire account [given by reporting doctors] may be a cock and bull story. We assume, however, that physicians were their usual careful and accurate selves."²⁷

Not Dead Yet, a national disability rights organization, has documented the fact that claims of no abuse under the Oregon law are demonstrably false.²⁸

Not Suicide?

Supporters of doctor-prescribed suicide adamantly oppose using the word "suicide" to refer to deaths occurring under laws permitting the practice. In fact, Washington State requires physicians to falsify death certificates for assisted suicide deaths. The state's "Instructions for Physicians and other Medical Certifiers" are explicit:

If you know that the decedent used the Death with Dignity Act, you must comply with the the strict requirements of the law when when completing the death record:

- 1. The underlying terminal disease must be listed as the cause of death.*
- 2. The manner of death must be marked as "Natural."*
- 3. The cause of death section may not contain Any language that indicates that the Death with Dignity Act was used.*

*The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act.*²⁹

Thus, unless the death certificate falsifies the real cause of death, it will not be accepted and the physician will be required to submit a new death certificate that hides the facts.

Does such a requirement change the fact that death from a deadly overdose of drugs prescribed by a physician for the purpose of causing the patient's death is actually a suicide?

Use of verbal engineering does not change reality. Calling a mountain lion a poodle does not make it a harmless lap dog. Nor does calling death by a deadly overdose of drugs change the fact that it is not a natural death.

There's no question that proposals to permit doctor-prescribed suicide in every state will continue. Isn't it important that we all understand what such proposals really permit?

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¹ "End of Life Option Act." Available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15. (Last accessed October 25, 2016.)

² Governor Edmund G. Brown, Jr., Signing Message, October 5, 2015. Available at: https://www.gov.ca.gov/docs/ABX2_15_Signing_Message.pdf. (Last accessed October 25, 2016.)

³ Cal. Health & Safety Code § 443.5 (a) (2) (E).

⁴ Bradford Richardson, "Assisted-suicide law prompts insurance company to deny coverage to terminally ill California woman," *Washington Times*, October 20, 2016. Available at: <http://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den>. (Last accessed October 20, 2016.)

See also: Allie Sanchez, "Insurer offers to pay for assisted suicide but not chemotherapy," *Insurance Business America*, October 21, 2016. Available at: <http://www.ibamag.com/us/news/breaking-news/insurer-offers-to-pay-for-assisted-suicide-but-not-chemotherapy-39441.aspx>. (Last accessed October 22, 2016.)

⁵ Sue Donaldson James, "Death Drugs Cause Uproar in Oregon," *ABC News*, August 6, 2008. Available at: <http://abcnews.go.com/Health/story?id=5517492&page=1>. (Last accessed, October 22, 2016.)

See also: Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," *Fox News*,

July 28, 2008. Available at: <http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care.html>. (Last accessed, October 24, 2016.)

⁶ For a listing of "Attempts to Legalize Euthanasia/Assisted Suicide" since 1994 in the United States, see: <http://www.patientsrights council.org/site/failed-attempts-usa>.

⁷ Oregon Death with Dignity Act, ORS §§ 127.800 – 127.995. The law passed by voter initiative in 1993 but, due to court challenges, did not go into effect until October 1997.

⁸ Washington Death with Dignity Act, RCW §§ 70.245.010 – 70.245.903. The law passed by voter initiative in 2008 and went into effect in March 2009.

⁹ Vermont Choice at End of Life Act, 18 V.S.A. Chapter 113 §§ 5281 – 5293. Vermont legislators approved the law in 2013 and it went into effect immediately.

¹⁰ Kimberly Leonard, "Californians Can Choose to Die – With the Help of Taxpayers," *U.S. News & World Report*, March 21, 2016. Available at: <http://www.usnews.com/news/articles/2016-03-21/in-california-government-to-pick-up-the-tab-for-death-with-dignity>. (Last accessed October 20, 2016.)

¹¹ "Frequently Asked Questions about the Death with Dignity Act," Response to question, "Will insurance cover the cost of participation in the Act?" *Oregon Health Authority, Public Health*. Available at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx#insurance>. (Last accessed October 20, 2016.)

¹² Sara Fentem, "Indiana Medical Association Votes Against Physician Assisted Death," *Indiana Public Media*, October 3, 2016. Available at: <http://indianapublicmedia.org/news/indiana-medical-association-votes-physician-assisted-death-106464>. (Last accessed October 20, 2016.)

¹³ Tracy Seipel, "Bay Area physician opens right-to-die practice," *San Jose Mercury News*, June 7, 2016. Available at: http://www.mercurynews.com/health/ci_29985455/bay-area-physician-opens-right-die-practice. (Last accessed October 28, 2016.)

¹⁴ Oregon Public Health Division, "Oregon Death with Dignity Act: 2015 Data Summary," February 4, 2016, P. 7. Available at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>. (Last accessed October 20, 2016.)

¹⁵ Oregon Public Health Division, "Oregon Death with Dignity Act: 2015 Data Summary," February 4, 2016, P. 6 and p. 7, n. 2. Available at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>. (Last accessed October 20, 2016.)

¹⁶ Cal. Health & Safety Code § 443.11.

¹⁷ See, for example, Washington Death with Dignity Act, RCW 70.245.200 (2). Available at:

<http://app.leg.wa.gov/RCW/default.aspx?cite=70.245.200>. (Last accessed October 20, 2016.)

¹⁸ Oregon Death with Dignity Act, ORS §127.825 s. 3.03 (5). Definition of "Counseling." (Emphasis added.)

¹⁹ Oregon Death with Dignity Act, ORS §127.855 s. 3.09 (5). Medical Records Documentation Requirements. (Emphasis added.)

²⁰ Oregon Public Health Division, "Oregon Death with Dignity Act: 2015 Data Summary," February 4, 2016, P. 6.

²¹ 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*, October 25, 2008, PP. 973-978.

²² Liz Szabo, "'Death with dignity' laws and the desire to control how one's life ends," *Washington Post*, October 24, 2016. Available at:

https://www.washingtonpost.com/national/health-science/death-with-dignity-laws-and-the-desire-to-control-how-ones-life-ends/2016/10/24/6882d1e6-9629-11e6-bc79-af1cd3d2984b_story.html and

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²³ Oregon Public Health Division, "Oregon Death with Dignity Act: 2015 Data Summary," February 4, 2016, p. 6, End of Life Concerns. Available at: [http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf)

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²⁴ Liz Szabo, "'Death with dignity' laws and the desire to control how one's life ends," *Washington Post*, October 24, 2016. Available at:

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²⁵ For more information about the Disability Rights Education & Defense Fund, see: <https://dredf.org>.

²⁶ Barbara Coombs Lee, Eli D. Stutsman, Kelly T. Hagen, "Physician Assisted Suicide," *Oregon Health Law Manual*,

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²⁷ Oregon Health Division, *CD Summary*, vol. 48, no. 6 (March 16, 1999) p. 2, Study Limitations. (Emphasis added.) Available at:

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²⁸ Not Dead Yet, "Oregon State Assisted Suicide Reports Substantiate Critics' Concerns," October 4, 2016. Available at: <http://notdeadyet.org/2016/10/oregon-state-assisted-suicide-reports-substantiate-critics-concerns.html>. (Last accessed November 8, 2016.)

²⁹ "Instructions for Physicians and Other Medical Certifiers for Death Certificates: Compliance with the Death with Dignity Act," Available at:

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