District of Columbia "Death with Dignity Act of 2016"
Analysis of the law now in effect

This Act transformed a prescription for a lethal dose of drugs (referred to in the Act as "covered medication" [1]*) into an acceptable medical treatment in the District of Columbia. It is patterned after Oregon's law permitting doctor-prescribed suicide.*

Under the "Death with Dignity Act of 2016":

Government bureaucrats and profit-driven health insurance programs can 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 District of Columbia law 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.[2]

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."[3]

In the District of Columbia, will health insurance programs and government health programs do the right thing – or the cheap thing?

Individuals who could live for many years are eligible for doctor-prescribed suicide.

To be eligible for a suicide prescription, a patient must be diagnosed with a terminal disease, defined as a condition that is incurable and irreversible and will, within reasonable medical judgment, result in death within 6 months.[4]

There are many conditions (diabetes, certain types of leukemia, disabilities requiring ventilator support, etc.) that, without medical treatment, would result in death within six months. However, with medical treatment, individuals with those conditions could live for many years. Yet those individuals are eligible for doctor-prescribed suicide under the Death with Dignity Act.

> There is documentation that this has occurred under Oregon's assisted-suicide law. In an official report from Oregon, diabetes is noted as the underlying terminal condition that made the patient eligible for a lethal prescription.[5]

Why is the definition of "terminal disease" so broad?

There is an illusion of choice. Yet the Act constricts patient choice.

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

Under the Act, before writing a prescription for death, a doctor must inform the patient of "the feasible alternatives to taking the covered medication, including comfort care, hospice care and pain control."[6] However, discussing such alternatives 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.

When 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 is less and less focus on extending life and eliminating pain, and more and more focus on the efficient and inexpensive "treatment option" of death.

Doctor-prescribed suicide becomes the only "medical treatment" to which many people have equal access. The last to receive health care can be the first to receive doctor-prescribed suicide.

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

Just as with Oregon's law, the Act requires that a person make two oral requests and a written request to the attending physician before receiving the prescription for the deadly overdose of drugs.[7]

Nothing in the Act requires that any of those requests be made in the presence of the physician. The patient can, in fact, phone in the oral requests and send the written request by mail or by electronic means.

Severely depressed or mentally ill patients can receive doctor-prescribed suicide, without having any form of counseling.

Even if the patient is severely depressed or has a psychiatric or psychological disorder, a physician is not required to refer the patient for counseling unless the attending or consulting physician believes that the patient has "impaired judgment."[8] As long as the doctor believes the patient can make and communicate decisions,[9] no counseling is required.

This provision is similar to that contained in Oregon's law where, in 2015, only 5 of the 132 patients who received lethal prescriptions were referred for a psychological evaluation.[10] A study about Oregon's law found that it "may not adequately protect all mentally ill patients."[11]

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

Even if the patient is referred for counseling and is found to have “impaired judgment,” the Act does not prohibit a health care provider, a family member or another person from arranging for the patient to be evaluated by other counselors 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]
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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.” Finally, she was assessed by a managed care ethicist who determined that she was qualified for assisted suicide, and the lethal dose was prescribed.[13]

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

The Act requires that witnesses to the patient's written request attest that the person signing the request is capable, acting voluntarily, and not being unduly influenced to sign the request.[14] However, "undue influence" has a very narrow legal meaning[15] and does not include 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 the Act places 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.[16]

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

The Act 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.[17]

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.

A person who would benefit financially from the person's death can pick up and deliver the lethal prescription to that person.

The lethal drugs can be dispensed to "an expressly identified agent designated by the qualified patient."[18] A potential heir could encourage the patient to authorize him or her to pick up the drugs for delivery to the patient's residence.

Individuals can request doctor-prescribed suicide based on fear of being a burden to others.

In an official Oregon report, fear of becoming a burden on others was given as a reason for requesting lethal drugs by 42% of those who died using that state's assisted-suicide law.[19]

Patients have no protection once the assisted-suicide prescription is filled.

Like the Oregon law, the Act only addresses activities taking place up until the prescription is filled. There are no provisions to assure that the patient is competent at the time the lethal drug overdose is taken or that he or she knowingly and willingly took the drugs.

Due to this lack of protection, the Act puts 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 stage of the process – at the time the patient takes the drugs that will cause death?

The prescription, once filled, could be transported to another state where the patient can take it.

Nothing in the Act (or in the doctor-prescribed suicide laws in Oregon, Washington, Vermont, California and Colorado) requires that the prescribed lethal drugs be taken in the jurisdiction where the prescription was written and filled.

If such deaths occur outside of the District of Columbia, there would be no record of them. For example, according to an official Oregon report, the death status is unknown for 43 patients who received the prescription for doctor-prescribed suicide.[20]

The death certificate will not reflect the actual cause and manner of death.

The Act states that actions taken in accordance with the Death with Dignity Act do not constitute suicide or assisted suicide.[21] Therefore, the true cause of death (barbiturate overdose) and the true manner of death (suicide) cannot be listed on the death certificate.[22] The Act enables the prescribing doctor (who does not need to be present at the time of death) to sign the death certificate.[23]

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Note: Supporters of the Act point to Oregon in their claim that there are no problems with the law and that safeguards contained in the law are meticulously followed and monitored. Yet, in closed-door sessions, those supporters acknowledge that this is not true. For documented information about this contradiction, see "The Oregon Experience."[24]

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[1] District of Columbia "Death with Dignity Act of 2016." Available at: http://lims.dccouncil.us/download/33261/B21-0038-SignedAct.pdf. Sec. 2, (5).
[2] Sue Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 8, 2008. Available at http://abcnews.go.com/Health/story?id=5517492&page=1 (last accessed January 6, 2017).
[3] 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. See pg. 4 (last accessed January 6, 2017).
[4] Sec. 2 (16).
[5] Official report for 2015 deaths under Oregon's Death with Dignity Act, p. 7, fn. 2. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf, (last accessed January 6, 2017).
[6] Sec. 4 (a) (2) (E).
[7] Sec. 3 (a).
[8] Sec. 5 (a).
[9] Sec. 2 (2) definition of "capable" and Sec. 2 (15) (a) definition of "qualified patient."
[10] Official report for 2015 deaths under Oregon's Death with Dignity Act, p. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf, (last accessed January 6, 2017).
[11] 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.
[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 January 6, 2017).
[13] Ibid.
[14] Sec. 3, (c) Declaration of witnesses.
[15] For example, "undue influence" includes such activities as controlling the necessities of life such as medication, access to information, interaction with others or access to sleep.
[16] 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.
[17] Sec. 3 (b) (3) (A) and (B).
[18] Sec. 6 (c) (C).

[19] Official report for 2015 deaths under Oregon's Death with Dignity Act, p. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf, (last accessed January 6, 2017).
[20] Official report for 2015 deaths under Oregon's Death with Dignity Act, p. 3. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf, (last accessed January 6, 2017).
[21] Sec. 16 (b).
[22] Sec. 6 (h).
[23] Sec. 6 (g).
[24] "The Oregon Experience." Available at: http://www.patientsrightscouncil.org/site/the-oregon-experience (last accessed January 6, 2017).
For additional information about state proposals to legalize doctor-prescribed suicide, see the Patients Rights Council web site: http://www.patientsrightscouncil.org/site.

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