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2 September 2015

Dear Assemblymembers:

I am writing to express **grave concerns regarding AB2x15**, the End of Life Options Act, and to express my opposition to this legislation. Among the many serious problems with this bill I will mention just a few, which concern me not only as a physician and medical ethicist, but also as a clinical psychiatrist with expertise in the problem of suicide.

Like the Oregon law, AB2x15 does not require physicians to refer for psychiatric consultation to rule-out the most common mental disorders or other causes that contribute to suicidal thinking and the wish to die. Many Californians already lack necessary access to mental health care services, and this bill places these and other vulnerable individuals at risk. The desire to end one's life, or the request for assisted suicide, is *nearly always a cry for help*. It is a distress signal, a kind of "canary in the coal mine," indicating that something in the patient's situation (medical, psychological, or social) is not adequately being attended to – an untreated clinical depression, fear or anxiety about the future or about one's medical condition, untreated or under-treated pain, family or relationship strain or conflict, and so on. Research demonstrates that 80 – 90% of suicides are associated with clinical depression or other treatable mental disorders, *including* for individuals at the end-of-life and individuals with a terminal condition. Yet alarmingly, only 5% of the individuals who have died by assisted suicide under Oregon's law were referred for psychiatric evaluation – and this number is decreasing every year (3% last year). Considering what we know about suicide risk factors, this constitutes medical negligence.

The risk that serious mental health issues will be overlooked in the application of this law is not merely theoretical: Consider the case of Michael Freeland, an Oregonian who had a 43-year history of depression and had made prior suicide attempts; and yet the physician who prescribed the deadly drug for him did not deem it necessary to refer for psychiatric evaluation or psychological counseling. While this is clearly negligent, there is nothing in the Oregon Law, or in AB2x15, to prevent this. The laws are in fact designed to protect physicians, not patients: according to this law, the physician is protected from all scrutiny and liability so long as he is acting "in good faith." This minimal "good faith" legal standard is found nowhere else in medical practice, where physicians are required to practice according to the higher "medical standard of care." The family of someone like Michael Freeland has no recourse as long as the physician claims he was simply acting in "good faith."

The social and public health consequences of this legislation are significant and should not be ignored. *Studies have repeatedly demonstrated a "social contagion" aspect to this behavior, which leads to copycat suicides*—this is known in social science as the "Werther Effect". Despite the inadequate system of monitoring and reporting in Oregon, the data we do have paints

a distressing picture. After suicide rates had declined in the 1990s, they rose dramatically in Oregon between 2000 and 2010, in the years following the legalization of assisted suicide in 1997. By 2010 suicide rates were 35% higher in Oregon than the national average. A rigorous study by David Albert Jones of Oxford University to be published next month controls for other factors that could account for this rise: this research demonstrates that the permissive assisted suicide laws have led to at least a 6% rise in overall suicide rates in Washington and Oregon. The law is a teacher, and these laws send the message that under difficult circumstances, some lives are not worth living. This is a message that will be heard not only by terminally ill individuals, but by all vulnerable persons who are tempted to take their own lives. Suicide is now a public health crisis: according to the CDC *suicide is currently the 2nd leading cause of death among college age students, and the 3rd leading cause of death among adolescents in the U.S.* We have strong evidence now that this bill would worsen this public health crisis.

A law allowing assisted suicide for some individuals creates two cohorts of patients, who no longer enjoy equal protection under the law or and no longer receive equal medical care. Assisted suicide is discriminatory, and the basis for discrimination is the patient's health status. Robin Williams walks into my office saying his life has become unbearable and so he wants to take his life; and I intervene to protect him and get him through the crisis. Then Brittany Maynard walks into my office saying her life has become (or will soon become) unbearable and so she wants to take her life; and not only do I not intervene to prevent her, but I actively engage in helping her to take her own life? These two incompatible approaches to suicide cannot co-exist side-by-side within medicine or mental health care—something will have to give.

Finally, it is worth noting that supporters of the bill constitute a homogenous elite: white, upper & middle class, well insured, well educated, able to navigate the complex healthcare system. These are precisely the folks least likely to be harmed by the bill. We don't see widespread support from the Latinos or African American community, from the uninsured or underinsured, from the economically or socially marginalized. What they want is access to good healthcare. They need MediCal to pay for excellent palliative care. They need hospitals in their communities not to close down. Why are we looking to Oregon, when have we ever looked to Oregon – a lilywhite state without the social and cultural diversity and complexity of California – for our public health policy?

AB2x15 is bad for medicine, places vulnerable patients at risk, and ignores the real healthcare issues for Californians. I strongly urge you to consider these public health issues and vote against this bill.

Sincerely,

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