

Lawmakers rush to reintroduce End of Life Options Act, but haste makes bad policy



By: Laura Petrillo, MD (@lpetrillz) August 21, 2015

The End of Life Options Act, which would legalize physician-assisted suicide, was stalled in the California legislature earlier this summer and seemingly shelved until next year. But in a surprise move, lawmakers introduced a new bill with the same purpose **on Tuesday**, during a special session on healthcare financing called by Governor Brown. The new bill would bypass the Assembly committee where SB128, the former bill, was stalled for lack of support.

The issue that lawmakers are trying to rush through the legislative process is not a trivial

one— the bill would give physicians the power to prescribe medication with lethal intent to terminally ill patients, a fundamental shift in the role of medicine to date. This is an issue that deserves deep contemplation, expert and community input, and thorough vetting to ensure the safety of everyone who might be affected. Instead, the lawmakers found a way to charge ahead in a special session and bypass the members of the Assembly who had hesitation about the bill.

Geripal community, whatever your philosophical views on assisted suicide, **take a moment to think about how the most vulnerable members of our society might be at risk if assisted suicide were legal in your state, and if you have concerns, speak up now.** Many states have bills that have been introduced in the past year to ride the Brittany Maynard momentum, though none has successfully become a law, yet.

Here are the groups of people at greatest risk, should assisted suicide become legal under laws modeled after the Oregon Death with Dignity Act:

Older adults. Under the California SB128, the burden of ensuring that patients are acting autonomously, have capacity to make decisions, and are free from coercion, falls to the physician who receives the patient’s initial written and oral requests. At the moment, the bill states that requests must come from individuals, not their surrogate decision makers or advance directives, though there is a troubling clause that individuals can communicate “through a person familiar with the individual’s manner of communicating,” which could mean anything. There is no discussion of what to do in the case of cognitive impairment or dementia, which may present subtly in conversation or on exam, and there are no requirements for assessment of the patient’s mental status or oversight at any point after the medication is prescribed, leaving patients open to coercion from family or caregivers as their disease progresses. For a fascinating story that illustrates how dementia muddies the timing of a fully autonomous exit, check out [Sandy Bem’s story](#).

Lonely adults. In the Netherlands, where assisted suicide and euthanasia have been socially acceptable for longer than in the U.S., the condition of terminal illness, defined in SB128 as a doctor's estimate of prognosis six months or less, is not the only reason that people can choose to end their lives. [In a study](#) that came out last week from a Netherlands euthanasia clinic, 6.8% of patients whose requests for euthanasia were granted had the only "medical" condition of being "tired of living," and the type of suffering named by 49% of recipients was loneliness. The slippery slope argument is often dismissed, but prominent ethicists Barron Lerner and Arthur [Caplan](#) warned that "the European data are particularly relevant for the United States." Indeed, in Oregon, [an amendment was proposed to the Death with Dignity law](#) earlier this year to extend the prognosis criteria from 6 to 12 months, underscoring the permeability of the hard line for what constitutes a terminal illness.

Disadvantaged socioeconomic groups. Despite the increased access to healthcare from the Affordable Care Act, patients and their families are still financially burdened by their medical care, and the proportional effect of this is greatest on the poorest members of society. [Data from Oregon](#) and Washington indicate that 40% of people who use assisted suicide express concern about being a burden on family, and 3% of people cite the financial implications of treatment as a reason for seeking assisted suicide. The response to this stress should not be to hand over lethal medication, but to redouble our efforts to increase access to good quality care for dying patients (and for everyone, all throughout life). The fact that the new assisted suicide bill was introduced in a healthcare financing session brings to mind the terrible implication that assisted suicide could save money for the entire healthcare system, though that was unlikely the intent of the lawmakers.

Patients with psychiatric illness. As with decision-making capacity, the burden of evaluating patients for mental illness falls to the original provider who receives the request, and the language in the bill is casual: "If there are indications of a mental disorder, the consulting physician shall refer the individual for a mental health specialist

assessment.” Unfortunately, in Oregon, despite the finding of a [2008 study](#) by Ganzini et al in BMJ that 26% of Oregonians who requested assisted suicide met criteria for depression, only 3 out of 105 people who died by assisted suicide in [Oregon in 2014](#) were referred for a psychiatric evaluation. Besides the depressed individuals, the legalization of assisted suicide puts the greater community of people suffering from mental illness at risk, by condoning the idea that suicide is acceptable when people have decided life is not worth living for them. Suicide contagion is a real phenomenon, and there has been [a concerning rise in the rate of all suicides](#) in Oregon since legalization of assisted suicide. For a dramatic view of how legalization of assisted suicide can change a society’s attitude toward protection of people with mental illness, I recommend this [story about euthanasia in Belgium](#).

Proponents of “Death with Dignity” and SB128 believe that assisted suicide is for a select group of people who want to make an independent, personal choice to control the circumstances of their death, which would otherwise be a gruesome process with inevitable suffering. For a public already anxious about death, and unfamiliar with its final stages, this can be compelling. But this is an unrealistic portrayal of death— the vast majority of patients can actually achieve the level of control and relief from suffering that they hope for through existing hospice and palliative care services. Proponents still insist that even with adequate access to palliative and hospice care (which not every patient yet has), there is a role for assisted suicide for some patients. That may be— but we owe it to our patients to think about at what cost. Evidence from Europe and even Oregon demonstrate that introducing the option of assisted suicide opens a Pandora’s box of far-reaching consequences, with the greatest implications for our most vulnerable members of society.

We have an obligation as healthcare providers to keep our patients safe, and we can’t afford to rush the decision about whether assisted suicide is sound public policy. Please use your voice. To take action in California, write to your Assembly member ([find yours here](#)) and [Governor Brown](#).