Disability Rights Education & Defense Fund DREDF

# QUESTIONS

## >For Medical Professionals Implementing the California EOL Option Act<

**HIGHLY RECOMMENDED READING**

*Physician-Assisted Suicide in Oregon:* A Medical Perspective, Drs. Herbert Hendin & Kathleen Foley, Michigan Law Review, June 2008.

http://dredf.org/wp-content/uploads/2012/08/Hendin-Foley-Michigan-Law-Review.pdf, or go to http://dredf.org/public-policy/assisted-suicide/ and scroll down to C.1.

1. HYPOTHETICAL: An individual with a significant speech impairment, who has received a terminal diagnosis, is very difficult for medical personnel to understand. His or her family member or caregiver, professing to interpret what s/he is saying, represents the individual as requesting lethal drugs under the California assisted suicide law.

   You have a concern about the accuracy of the interpreting. The law addresses interpreters using a different language, but not the situation of a speech-impaired person who is using English. Nor are there certified interpreters for this situation. How is undue influence or coercion to be judged in such a situation?

   You further observe that the individual has a feeding tube into which foreign substances could be placed by someone else.

   You are also concerned that such an individual's quality of life may be inaccurately assumed to be low, due to these disabilities.

   How can you ensure, to the greatest extent possible, that abuse or coercion is prevented?

2. HYPOTHETICAL: An individual with a terminal diagnosis and various disabilities requests lethal drugs. S/he is living in an institutionalized setting. You wonder if s/he would feel the same way if not confined in an institutional setting. You are not sure if the full range of palliative care has been provided. What do you do?

3. How can erroneous assumptions that people with disabilities necessarily experience a reduced quality of life be excluded from evaluations made by medical professionals in implementing the California assisted suicide law?

4. Can it be ensured, to the greatest extent possible, that depression and other psychiatric disabilities will be properly treated in the context of the California End of Life Option Act? How?

5. What can be done to improve medical practice, given the research conclusion[1] that many doctors' drive to prolong life is easily overcome by lack of insurance coverage or the inadequacy of such coverage?

6. What can be done in California hospitals and health plans to improve upon the low incidence in requests for psychiatric consultations by doctors who issue lethal prescriptions in Oregon, with only 3% referred in 2014?[2] Several related pieces of information have a bearing on this question. According to the new California Act, the "mental health specialist assessment" means "one or more sessions … [to determine] that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder."[3] To clarify this, a person who has depression may still be eligible for assisted suicide if a physician or, upon the optional referral, a psychiatrist or psychologist, says the depression does not cause impaired judgment. Yet studies show that most physicians aren't able to diagnose depression.[4] It is anyone's guess how Oregon medical professionals assess whether depression does cause impaired judgment, and whether the desire for a lethal prescription is the product of rational or impaired judgment.[5] There is no objective evidence to justify the conclusion that the suicidal impulses of ill and disabled people are any less the product of impaired judgment than those of physically healthy people. Specialists in the field of elder suicide prevention believe that suicidal feelings in seniors who face illness and disability can be successfully addressed.[6]

7. What can be done in California hospitals and health plans to address the absence in the law for any requirement that a disinterested witness be present at the time the lethal dose is administered? What can prevent an heir or abusive caregiver administering the lethal drugs without the individual's consent? This problem must be considered in the context that Federal authorities estimate that one in ten elders are abused, most often by family and caregivers.[7]

8. How can assisted suicide in California be overseen and implemented in a way that does not contribute to suicide contagion, as data suggest may have happened in Oregon?[8] It is noteworthy that the State of Connecticut's Suicide Prevention Plan 2020[9] addresses the possible connection between assisted suicide and pressures on people with disabilities to commit suicide.[10]

9. What can be done to overcome the fact that at least some doctors are willing to deny life-sustaining health care and overrule an individual's expressed decision to receive care under futility policies[11] based on subjective standards that amount to quality of life judgments?

10. What is the role of informing the family or other close associates of a patient requesting to use the California End of Life Option Act?

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**ENDNOTES**

[1] Sorlie, et al., Mortality in the uninsured compared with that in persons with public and private health insurance, *Arch Intern Med.* 1994;154(21):2409-2416. doi:10.1001/archinte.1994.00420210037005, http://archinte.jamanetwork.com/article.aspx?articleid=619594.

[2] Oregon Death With Dignity Act Report 2014, page 5: https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf.

[3] State of California, End of Life Option Act, 2015.

[4] Study: Doctors Don't Always Spot Depression: www.time.com/time/health/article/0,8599,1913312,00.htm.

[5] Martyn, Susan R. and Bourguignon, Henry J., Physician's Decisions About Patient Capacity: The Trojan Horse of Physician-Assisted Suicide (2000). Psychology, Public Policy and Law, Vol. 6, 2000. Available at SSRN: http://ssrn.com/abstract=1158077.

[6] See, e.g. Center for Elderly Suicide Prevention, http://www.ioaging.org/services/all-inclusive-health-care/psychological-services/center-for-elderly-suicide-prevention/; Older Americans Behavioral Health, Issue Brief 4: Preventing Suicide in Older Adults, www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Issue%20Brief%204%20Preventing%20Suicide.pdf.

[7] U.S. Official: Elder Abuse is 'Broad and Widespread,' Healthline News, Jan. 27, 2014, www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714.

[8] Absence of Response to Oregon's Adult Suicide Problem, Report from Physicians for Compassionate Care Education Foundation, www.pccef.org, June 2, 2015, www.pccef.org/pressreleases/documents/AbsenceofresponsetoOregonssuicideproblem6115pressrelease7v_000.pdf. Also see A Deadly Model: Suicide Contagion, https://dredf.org/wp-content/uploads/2012/08/A-Deadly-Model-Suicide-Contagion.pdf.

[9] Stephen Mendelsohn: CT Suicide Prevention Plan 2020 Includes Concerns About Disability & Assisted Suicide, www.notdeadyet.org/2015/11/stephen-mendelsohn-ct-suicide-prevention-plan-2020-includes-concerns-about-disability-assisted-suicide.html.

[10] Also see "SB 128 Would Trigger More Suicides—Letter From Ellen, who has struggled with suicidal issues for many years, to California senators," http://dredf.org/public-policy/assisted-suicide/sb-128-would-trigger-more-suicides/.

[11] Medical Futility in End-of-Life Care, *Journal of the American Medical Assn.*, Vol. 281, No. 10, page 937, March 10, 1999, www.thaddeuspope.com/images/CEJA_AMA_-_JAMA_-_1999.pdf.