Reasons to Oppose Virginia HB 858

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I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation. We advocate for the terminally ill, who often have compromised capacity to choose, making them vulnerable to abuse. I have expertise in pediatric anesthesiology, critical care, and medical ethics. On behalf of our Virginia members and as a physician residing in Washington State (WA), where physician-assisted suicide was legalized in 2009, we urge you to oppose HB 858 which is the most radical, dangerous policy of its kind in the nation.

Summary: Medically-assisted suicide laws inevitably violate (rather than uphold) patient autonomy, create (based on subjective, error-prone criteria) a class of marginalized patients from whom the standard of medical care is withheld, allow lethal drugs to unnecessarily substitute for good palliative care and pain control, disproportionately prey on those with mental health problems and disabilities, and destroy the foundation of medical ethics, creating distrust among patients and the health care profession. Oversight is inadequate to enforce the law or detect abuse, and the bill contains multiple conscience violations. This bill is a set-up for elder abuse.

- This bill does not give patients any new rights. Rather, it gives new rights and powers to health care practitioners, not patients, by creating subjective, error-prone criteria[1] by which they place people who wish to hasten their death, often for psychological distress over new-onset disabilities, into two classes: a protected group (getting standard mental health services) or a marginalized group (getting suicide help). Legal power to devalue some patients entrenches discrimination in health care. This is especially concerning when the people in charge of this determination may have incentives to reduce health care costs, and lethal drugs are cheaper than palliative care.
- No full second opinion required. Every other bill or state law requires two full evaluations, and at least one by a physician, to determine eligibility for lethal drugs. However, this bill requires only one practitioner to perform a full evaluation of the patient, and it can be a non-physician who has no special expertise in end-of-life matters. A second opinion is required only if the patient is not in hospice (to confirm terminal illness—but not capacity or voluntary decision-making) and to possibly confirm capacity, only if the attending practitioner is uncertain.
- Most physician assistants (PAs) do not have the training to conduct the evaluations and decisions required in this bill. Yet this bill allows PAs to make independent, complex, deadly decisions without special training--in contrast to current law that prohibits independent work (18VAC85-50-40 and 54.1-2952) and requires special training to perform vastly simpler laser hair removal (18VAC85-50-191).
- The complexity of mental, physical, social, and other factors affecting terminally ill patients' decision-making process has led many psychiatrists to opine that specialized forensic psychiatrists may be needed to determine a terminally ill patient's decision-making capacity.[2] This bill designates that only psychologists and social workers, practitioners with less training and qualifications than psychiatrists, evaluate capacity (lines 55-57). It excludes psychiatrists, including those with forensic training who would be most qualified to make a capacity assessment, from making this determination.
- Lethal drugs are never necessary for pain or symptom management. Patients rarely seek lethal drugs for inadequate pain control, but usually for psychological distress over new onset disabilities associated with terminal illness. Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care.

- Evaluation of patient mental capacity is too narrowly defined in cognitive terms only, lacking the broad assessment of disability and social, psychological, mental health, and other factors that may compromise vulnerable terminally ill patients' capacity to choose.
- Capacity fluctuates and declines as terminal illness progresses. Requiring capacity evaluation at the time of prescription but not when a patient decides to take the lethal drugs means that the person could lack capacity when ingestion occurs. Given no consent form validation of witness identity or voluntary patient signature, and no capacity evaluation or a neutral party when patients ingest lethal drugs—laws and this bill are a perfect set-up for undetected elder abuse and allow greedy heirs to hasten death.
- This bill discriminates against those with mental health problems, as they have a high incidence of desiring to hasten death, and the measures for evaluating capacity are inadequate. Mental health problems are difficult to diagnose, especially with the complexity of terminal illness. Studies have found that of terminally ill patients who have a desire to hasten death, 40 to nearly 60 percent have depression.[3,4], which is difficult to diagnose and underdiagnosed and undertreated in the terminally ill.[5] Yet less than 5% of those who receive lethal drugs are referred for mental health counseling in states where lethal drug prescriptions are legal. One study found that depressed patients in Oregon (OR) are receiving lethal drug prescriptions, and all who received them died within two months of their interview.[6]
- The provision to eliminate the waiting period demonstrates reckless disregard for patients. The determination that death is near is difficult and imprecise for experts, and patients typically have loss of both mental capabilities and swallowing function as death nears. Therefore, the option to eliminate the waiting period for lethal drugs for patients expected to die within 15 days is unnecessary, unethical, and medically contraindicated. Only one practitioner (who could be a nonphysician) with no special expertise is required to make this complex determination.
- Conscience violations are greater than in other bills/policies.
    - The bill requires health care practitioners to refer to other participating providers and perhaps provide information about a practice they do not consider medical care—both of which make the practitioner complicit in the process.
    - Objecting health care entities may not prohibit employees from conducting parts of this practice on their premises.
    - People, including doctors or family members, could potentially be guilty of a felony for "undue influence"—perhaps strongly trying to talk a patient out of obtaining lethal drugs. Could this be why the bill designates increased funds for state correctional facilities—to accommodate people jailed for trying to stop assisted suicide?
- Oversight is woefully inadequate in current laws in other states, and this bill has less oversight. The OR Health Division states doctors' reports could be "a cock-and-bull story"; they can't enforce the law or detect abuse.[7] In WA, hundreds of doctors' forms and patients' consents are missing. Yet nothing has been done to discipline physicians or enact better quality control measures. In OR, patients have been given lethal drugs for diagnoses of anorexia, hernia, arthritis, "medical care complications,"[8] and other non-terminal conditions. The so-called "safeguards" in OR have not prevented documented instances of coercion,[9] inappropriate selection,[10] botched attempts,[11] and active euthanasia.[12] No investigation or sanctions have been instituted, nor does the law (or this bill) empower any quality control.
- This bill violates the medical ethics standards and will create distrust among physicians and between physicians and their patients. Patients can be demoralized when physicians offer them lethal drugs, because it indicates that the physician does not value the patient's life. Doctors distrust colleagues, when their patients have died from inappropriate lethal prescriptions, over their objections.
    - Dr. Charles Bentz, an Oregon internist, referred a long-time patient with documented depression to an oncologist for cancer treatment. Dr. Bentz refused the oncologist's request to be a "second opinion" for physician-assisted suicide because the patient was depressed. However, two weeks later his patient was dead from lethal drugs. Dr. Bentz was appalled that a once-trusted colleague failed to recognize and treat depression, failed to listen to the patient's long-time physician, and preyed on a vulnerable patient.[13] Suicidal ideation should be seen as a cry for help, regardless of the patient's life expectancy.

References:

1. For example, prognoses of life expectancy are guesses. Some will live beyond what is expected even with low survival rates such as 5% in 5 years. Inaccurate prognoses are documented in states that have legalized physician-assisted suicide, with some patients living years beyond the 6-month prediction. For example, in 2012 in WA, 17% of patients lived 25 weeks or more, with a maximum time of 150 weeks—about 3 years. How many of the patients who took lethal drugs might have lived longer is unknown. Washington State Department of Health. 2013 Death with Dignity Act Report. 2014. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf?uid=63faaaafe406d
2. Ganzini L, Leong GB. Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists. *American Journal of Psychiatry* 2000; **157**(4): 595-600.
3. Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. *Journal of the American Medical Association* 2000; **284**(22): 2907-11.
4. Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995; **152**(8): 1185-91.
5. Kolva E, Rosenfeld B, Saracino R. Assessing the Decision-Making Capacity of Terminally Ill Patients with Cancer. *Am J Geriatr Psychiatry* 2018; **26**(5): 523-31.
6. Ganzini L, Goy ER, Dobscha SK. Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. *BMJ* 2008; **337**: a1682.
7. Oregon Health Division. A Year of Dignified Death. Portland, OR: Oregon Health Division, 1999.
8. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf
9. Kate Cheney was denied a lethal prescription twice because of dementia and concern that Kate's daughter was the driving force behind her request. Kate's daughter took her doctor shopping until lethal drugs were prescribed. Kate died by lethal ingestion. Barnett, Erin Hoover. "Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die." The Oregonian. January 9, 2019.
10. Michael Freeland was given a prescription for lethal drugs without a mental health evaluation despite a history of depression. He was later hospitalized for suicidal behavior; before discharge, his guns were removed from his home, but not his lethal drugs. Doctors with an assisted suicide organization renewed his 6-month prognosis to make his lethal drugs “legal.” He lived two years beyond his original prognosis, and never took the lethal drugs. He reconciled with his estranged daughter prior to death, an opportunity he would have missed had he taken lethal drugs. Hamilton, N. Gregory and Catherine Hamilton. Competing paradigms of responding to assisted-suicide requests in Oregon: Case report. American Psychiatric Association Annual Meeting. New York, New York, 2004
11. Ingestion of lethal drugs have complications including vomiting, aspiration, severe mouth burning, seizures, and not dying. David Prueitt, for example, woke up 65 hours after ingesting lethal drugs, and died of natural causes 13 days later. Seattle Times staff. "Oregon man woke up after assisted-suicide attempt." Seattle Times. March 4, 2005, https://www.seattletimes.com/nation-world/oregon-man-woke-up-after-assisted-suicide-attempt/.
12. Patrick Matheny and Barbara Houck both had neurological conditions who had problems with self-administering lethal drugs. Mr. Matheny was "helped" by his brother-in-law because of his trouble swallowing, and Mrs. Houck had to be spoon-fed. Kenneth Stevens testimony: https://www.pccef.org/articles/art40HouseOfLords.htm
13. Testimony from Charles J. Bentz, MD, FACP, to the WA Senate Health & Long Term Care Committee on 4/5/21 in opposition to ESHB 1141, a bill that dropped safeguards for physician-assisted suicide.