PATIENTS RIGHTS ACTION FUND

Review of Arizona's H.B. 2254 "Medical Aid in Dying" (2021)

***Overview*:**

Neither the Arizona constitution nor the U.S. Constitution contains a right to assisted suicide or what House Bill 2254 deceptively terms "medical aid in dying." Indeed, Arizona law criminalizes assisted suicide. A.R.S. § 13-1103(A)(3).

The U.S. Supreme Court has affirmed that a prohibition on assisted suicide advances multiple state interests. Importantly, it protects "vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes," reinforces the "policy that the lives of terminally ill . . . people must be no less valued than the lives of the young and healthy," and mitigates the risk that some might resort to physician aid in dying "to spare their families the substantial financial burden of end-of-life health-care costs." *Washington v. Glucksberg*, 521 U.S. 702, 731–32 (1997).

For cases involving requests to physicians to prescribe lethal medications, legal prohibitions on assisted suicide also protect the integrity and ethics of the medical profession because assisted suicide is fundamentally incompatible with the physician's role as healer. Suicide, including assisted suicide, is not a typical reaction to an acute problem or life circumstance, and many individuals who contemplate suicide, including the terminally ill, suffer from clinical depression or other treatable emotional or mental issues, which frequently go undiagnosed and untreated by physicians. *See, e.g.*, New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 77-82 (May 1994). For this reason and many others, the medical profession as a whole opposes assisted suicide because it is contrary to the medical profession's role as healer and undermines the provider-patient relationship. *Glucksberg*, 521 U.S. at 731.

House Bill 2254 undermines the State's "most significant interest" in protecting and preserving human life, including the lives of the vulnerable, sick, and disabled. *Rasmussen by Mitchell v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987). Instead, the bill erroneously accepts a "sliding-scale approach" that claims certain "qualities of life" are not worthy of equal legal protection. *Glucksberg*, 521 U.S. at 729.

Maintaining Arizona's existing prohibition on assisted suicide, including physician-assisted suicide, is the only way to protect vulnerable citizens.

***Specific Concerns with Arizona's "Medical Aid in Dying" Act*:**

The title of House Bill (HB) 2254 disingenuously implies that it offers options to terminally ill patients in confronting their illnesses; however, the only option explicitly offered is suicide. The "Medical Aid in Dying" Act (hereinafter, "the Act") purports to provide a legal mechanism under which certain patients are able to request assistance from an attending physician in committing suicide, specifically access to lethal medications that patients will "self-administer." There are many significant problems with the bill that endanger the vulnerable, sick, and disabled.

* Dangerous Policy Decision to Decriminalize Physician-Assisted Suicide: Recognizing that a state's "most significant interest" is its "interest in preserving life," *Rasmussen by Mitchell*, 741 P.2d at 683, Arizona law currently criminalizes assisted suicide. A.R.S. § 13-1103(A)(3). The Act specifically decriminalizes physician-assisted suicide, deceptively reclassifying it as accepted medical treatment or "medical aid in dying."

* The Act Perpetuates Dangerous Falsehoods: Attempting to maintain the fiction that physician-assisted suicide is legitimate medical treatment, the Act asserts that "[a]ctions taken in accordance with this [Act] do not, for any purpose, constitute suicide, assisted suicide, mercy killing, elder abuse or homicide under the law" and requires that the cause of death be falsely listed as the patient's underlying terminal illness (as opposed to accurately reflecting the patient's suicide).

* The Act May Violate the Conscience Rights of Some Healthcare Providers, Associations, and Pharmacists: While the Act affirms the right of healthcare providers to decline to write prescriptions for lethal medication, it requires them to provide, upon request, information about the law to patients, refer patients to another physician, and transfer patients to other healthcare providers. Similarly, while a healthcare facility may maintain a policy against providing assisted suicide, it nevertheless must "coordinate" the transfer of a patient requesting physician assisted suicide. Such actions may violate the consciences of healthcare providers and should not be mandated.

Additionally, the Act provides that professional organizations and associations may not take adverse action against their members for participating in physician-assisted suicide. Some organizations and associations may have religious or moral objections to assisted suicide and may not wish to associate institutionally with healthcare providers who participate in the practice. Thus, the Act implicates compelled speech and association problems.

* Weak Enforcement of Arizona Residency Requirement: Under the Act, only adult residents of Arizona may request physician-assisted suicide. While the Act on

its face seems intent on ensuring Arizona does not become a tourist destination for assisted suicide, an obvious loophole exists.

The Arizona residency requirement is found in multiple provisions of the Act, including the definition of "qualified patient," description of who may request a prescription, and a residency requirement section itself. Under § 36-3313, residency may be established if the patient possesses an Arizona driver license, an Arizona nonoperating identification license, is registered to vote in Arizona, owns or leases property in Arizona, files an Arizona state tax return for the most recent taxable year, or "provides other means of demonstrating residency acceptable to the attending physician." Thus, attending physicians have ultimate authority to determine if the residency requirement is satisfied. This broad, "catch-all" provision could allow out-of-state residents to find a willing physician and then "means of demonstrating residency" this physician will accept.

* Act May Allow Attending Physician to "Shop" for a Consulting Physician Who Will Give a Concurring Opinion: The Act requires that both the attending physician and a consulting physician determine that the patient is suffering from a terminal illness in order to be considered "qualified" for assisted suicide. The consulting physician must examine the patient and his or her relevant medical records, confirming "in writing the attending physician's diagnosis that the patient is suffering from a terminal illness." Similarly, the consulting physician must "verify" that the patient is capable, acting voluntarily, and has made an informed decision. The consulting physician's diagnosis, prognosis, and verification must be documented in the patient's medical records.

But the Act fails to mention what happens if a consulting physician does *not* verify that the patient is capable, acting voluntarily, or has made an informed decision. In other words, what is the procedure, and what are the consequences, when a consulting physician provides a different diagnosis or prognosis than the attending physician? Seemingly nothing in the Act prevents an attending physician from referring the patient to different physicians to find a consulting physician who agrees with the former's assessment of the patient. This raises serious concerns that dissenting second opinions would be ignored under the Act.

* Meaningful Mental Health Evaluation Not Required: Under the Act, the attending physician shall "refer the patient for counseling if appropriate," which provides that both the attending and consulting physician shall refer the patient to counseling if either believes that the patient "may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."

The Act defines counseling as "one or more consultations as necessary between a state-licensed psychiatrist or psychologist and a patient to determine whether the patient is capable and not suffering from a psychiatric or psychological disorder or

depression causing impaired judgment." Thus, the counseling must show both that the patient is "able to make and communicate health care decisions to health care providers," and is not suffering from a condition causing impaired judgment. However, the express terms of the Act require only one counseling "consultation[]" with the patient, rending the requirement illusory since the psychiatrist or psychologist is not required to have any existing knowledge of, or relationship with, the patient, and is not required to review the patient's medical and mental health records. Moreover, a consultation need not take place in-person.

Additionally, the Act contains no affirmative requirement that all patients requesting assisted suicide undergo a complete mental health evaluation. A patient will only be referred for a counseling consultation "if appropriate" or when a physician finds reason to do so.

Many patients whose mental health concerns are properly diagnosed and treated change their minds about suicide. For example, in one study of assisted suicide in Oregon, 46% of patients seeking assisted suicide changed their minds when their physicians intervened and appropriately addressed suicidal ideations by treating their pain, depression, and/or other medical problems. Linda Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act," 342 NEW ENG. J. MED. 557, 557 (2000). Given the prevalence of suicide hotlines and counselors that could save the lives of almost half of those contemplating suicide, it is irresponsible and contrary to the State's interest in life not to require such counseling for all patients requesting assisted suicide.

* Vague Definition of "Terminal Illness": To qualify for assisted suicide under the Act, a patient must have a "terminal illness." The Act defines terminal illness as "an incurable illness that will, within reasonable medical judgment, result in death within six months." Thus, the Act seems to exclude from eligibility patients who have curative treatment options available. However, it does not differentiate between situations where death will occur within six months even with treatment, from situations where death would not likely occur within six months if the patient sought and received treatment. This means that someone who refuses treatment to prolong life beyond six months, or who is denied insurance coverage for certain treatments, is eligible to affirmatively request and receive lethal drugs.

Concerns with Process for Requesting Lethal Medication:

* *No Requirement for In-Person Consultations*: The Act does not require that the request for assisted suicide, the consulting exam, or even the counseling take place during in-person consultations. The Act requires a patient to make a written request for permission, witnessed by two others. But there is no explicit requirement that the written request be presented to the attending physician in-person. This opens the door to the inappropriate use of "telemedicine" for these requests and

consultations, increasing opportunities for coercion of the patient and for abuse of the process.

* *Unclear Request Requirements and Triggers for 15-Day Reflection Period*: The Act is exceedingly unclear by variously requiring written and oral requests for physician-assisted suicide. The Act provides that a qualified patient must "make a written request for a prescription" for lethal medication that "substantially" follows the form provided in § 36-3323, is signed, dated, and witnessed. But § 36-3311 provides that "at least fifteen days must elapse between the qualified patient's *initial oral request* and the writing of a prescription for medication." It is, therefore, unclear what the initial oral request is, given that the request for a prescription is required to be in writing. Yet, the initial oral request is critical because it apparently triggers the required 15-day reflection period. Furthermore, § 36-3312 provides that the patient's medical records must include the "attending physician's offer to the qualified patient to rescind the qualified patient's request at the time of the qualified patient's second oral request." No other provision in the Act requires that a patient make a second, affirmative oral request. Thus, the actual process for requesting assisted suicide is not clear and would be subject to different interpretations and abuses.

* *Bill Does Not Adequately Protect Against Coercion and Undue Influence*: While the attending physician must determine whether the patient's request is "voluntary" and "informed," there is no guidance in the Act to adequately protect patients from coercion, intimidation, or undue influence.

* *Witness to Request Can Have Conflict of Interest*: The Act requires that the patient's written request for assisted suicide be witnessed by at least two persons. One of the witnesses can be a relative, heir, or someone with a claim to the patient's estate. There are no requirements that the second witness be completely independent and unrelated to either the patient or the other witness. This failure could easily lead to abuses. For example, the second witness could be a friend of a person who stands to benefit financially from the patient's death.

* No Oversight of Lethal Drug Administration: While the Act requires the attending physician to "counsel the patient about the importance" of having "another person present when the patient takes the medication," it does not require that the attending or counseling physician be present when the lethal medication is ingested to ensure the patient's voluntary decision/action or to deal with possible complications. In fact, there is no requirement that any witness attest to the patient's physical or mental capacity when the drugs are ingested, to confirm that the drugs were actually self-administered (as required), or to confirm that the patient's decision was voluntary.

Moreover, with the patient's written permission, the Act permits the attending physician to deliver the prescription to a pharmacist who can dispense the life-ending medication to an "expressly identified agent of the patient." Giving an agent of the patient control over the medication without any witness requirement at the time of ingestion may interfere with a patient's right to rescind his or her request for assisted suicide up to the last second and provides ample opportunity for abuse. Even the U.S. Supreme Court has recognized "the real risk of subtle coercion and undue influence in end-of-life situations." *Glucksberg*, 521 U.S. at 732. Indeed, the Court has also recognized the very real danger that "permitting assisted suicide" can lead a state down "the path to voluntary and perhaps even involuntary euthanasia." *Id.*

* Concerning Lack of Verification: While the Act requires that various documentation be placed in the patient's medical file, it's overall lack of reporting requirements means there is no substantial verification that actions are taken in accordance with procedure and without undue influence or deception. For example, while the Act requires that a patient "self-administer" the medication through an "affirmative, conscious voluntary act," it simultaneously does not require that a witness be present during said self-administration to report on it. Thus, various alleged protections have "no teeth" and could lead to abuse.