PATIENTS RIGHTS ACTION FUND

Review of "Our Care, Our Options Act," Iowa SF 2156 and HF 2302

Overview

Neither the Iowa constitution nor the U.S. Constitution contains a right to assisted suicide; therefore, no individual has the right to authorize another to kill him or her in violation of federal and state criminal laws. *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997). Instead, Iowa has an "unqualified interest in the preservation of human life." *Id.* at 728. Iowa's current statutory "prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to [preserving and protecting human life]." *Id*. at 735.

Importantly, suicide, including physician-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 physician-assisted suicide because it is contrary to the medical profession's role as healer and undermines the physician-patient relationship. *Washington v. Glucksberg*, 521 U.S. at 731.

The "Our Care, Our Options Act," Iowa Senate File (SF) 2156 and House File (HF) 2302, seeks to obliterate the State's "unqualified interest" in protecting and preserving human life, including the lives of the vulnerable, sick, and disabled. Maintaining Iowa's existing prohibition on assisted suicide, including physician-assisted suicide, is the only way to protect vulnerable citizens. *Id*. at 732.

***Specific Concerns with SF 2156 and HF 2302*:**

SF 2156 and HF 2302 purport to provide a legal mechanism for assisted suicide under which certain patients are able to request assistance from health care providers in committing suicide, specifically the prescription of lethal medications. There are many and significant problems with the bills' language that endanger the vulnerable, sick, and disabled.

* <u>Dangerous Policy Decision to Decriminalize Physician-Assisted Suicide</u>: Recognizing its "unqualified interest" in preserving and protecting all human life, Iowa law currently classifies assisted suicide as a crime. IOWA CODE § 707A.2. SF 2156 and HF 2302 eliminate the long-standing protections under state law for the vulnerable, sick, and disabled.

*<u>Bills' Findings Dishonestly Conflate Assisted Suicide with Legitimate Medical Treatment:</u> The bills' legislative findings are deceptive propaganda. They attempt to equate assisted suicide with

"the highest standard of medical care" and with legitimate palliative care. The goal of palliative care is to improve the quality of life of patients and their families; it is not to end the life of the patient. The findings also falsely allege that assisted suicide has been integrated "into standard end of life care" and that this integration "has demonstrably improved the quality of services delivered to terminally ill individuals."

* Expansive Category of Health Care Providers Who May Provide Lethal Medications: SF 2156 and HF 2302 define an "attending provider," a "consulting provider" (a secondary provider who evaluates the patient), and a "health care provider" as including a "licensed, certified, or otherwise authorized" person. Prescriptive authority for lethal drugs is, therefore, not limited to licensed physicians, in direct contrast to laws and legislation in many other states that feature such limits.

* Lack of Mental Health Evaluation or Counseling Requirements: While the "attending provider" or "consulting provider" may refer a patient to a "licensed mental health care provider," there is no affirmative requirement that a patient requesting assisted suicide undergo a meaningful or comprehensive mental health evaluation or counseling. Evidence suggests that 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 percent 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.

Under the provisions of SF 2156 and HF 2302, a "licensed mental health care provider" is only required to determine whether the requesting patient "has the ability to make and communicate an informed decision." Such a limited evaluation is clearly insufficient to protect vulnerable patients.

Further, SF 2156 and HF 2302 define "licensed mental health provider" to include social workers, not just licensed mental health care professionals. The inclusion of social workers only adds to the cursory and inadequate nature of any evaluation performed.

* Overly Broad Definition of "Terminal Illness": To qualify for assisted suicide under SF 2156 and HF 2302, a patient must have a "terminal illness." However, the bills' definition of "terminal illness" is incredibly broad. For example, it does not differentiate between situations where death will occur within 6 months even with treatment from situations where death is not likely to occur if the patient seeks and receives treatment. This means that someone who has a treatable disease or condition (*e.g.*, diabetes) who refuses treatment or who is denied insurance coverage for certain treatments is eligible to request and receive lethal drugs.

* Concerns with Process for Requesting Lethal Medication:

    * *Bills Only Require One Witness to the Written Request for Lethal Drugs:* SF 2156 and HF 2302 only require one attesting witness to a written request for lethal drugs. In contrast,

most other laws authorizing assisted suicide require two witnesses. Further, the witness is not required to be completely independent of patient's family members or anyone that might stand to inherit or otherwise benefit from the patient's death.

* *Bills Do Not Adequately Protect Against Coercion and Undue Influence:* The bills purport to require screening for coercion or undue influence but fail to provide adequate protection against either. Specifically, the bills' definition of "coercion or undue influence" is exceptionally broad and inexplicably includes efforts to encourage the patient not to seek assisted suicide. Section 19(3) of the bills criminalize efforts to convince the patient not to end his or her life.

* *No Requirement for In-Person Requests*: SF 2156 and HF 2302 require the patient to make two oral and one written request for assisted suicide. There is no definitive requirement that any of these requests be made in-person to the "attending provider." This deficiency opens up the request process to potential abuse.

* *Bill Language Contains Undefined and Nonsensical Requirements:* The bills further reference "[p]atient-directed care" or "patient-centered care that is not only respectful of and responsive to individual patient preferences, needs, and values, but also ensures that patient values guide all clinical decisions and that patients are fully informed of and able to access all legal end-of-life options." How precisely this care is to be provided and what standards will be imposed by state authorities are not clear.

Similarly, Section 6(1)(d)(3) of the bills require the "attending provider" to "thoroughly educate" the patient about the "choices available to the terminally ill patient that reflect the terminally ill patient's self determination." What is meant by the nebulous term "self determination" and what exact choices must be discussed is not defined.

* No Oversight of Lethal Drug Administration: The bills do not require that the prescribing provider be present when the lethal medication is ingested to ensure that the patient's decision/action was voluntary 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, or to confirm that the patient's decision was voluntary.

* Bills Affirmatively Sanction Falsehoods: The bills mandate that the cause of death be falsely treated and reported as the patient's underlying disease or condition, not assisted suicide (the actual, immediate cause of death).

* Bills Fail to Protect Conscience and Association Rights: SF 2156 and HF 2302 seek to limit the exercise of medical conscience. Specifically, Section 16(1) requires every "health care provider" to provide "sufficient information" about end-of-life options, including assisted suicide, to his or her patients. This requirement forces health care providers with objections to the practice of assisted suicide to affirmatively counsel patients about it. Moreover, the bill does not define what is meant by "sufficient information," leaving providers without adequate guidance as to their duties.

Further, Section 17(2) prohibits a "health care facility" that "fails to provide explicit, advance notice in writing" (to a patient or health care provider) of its objections to participating in assisted suicide from enforcing any policy against the practice. The exercise of the fundamental freedom of conscience is not conditional and cannot be limited by legislative fiat.

Section 18(2) provides that a "professional organization or association" cannot limit membership to those who do not support or participate in assisted suicide or require that its members affirm its opposition to the practice. This provision violates both medical conscience rights and the First Amendment right to free association. Under this provision, for example, a Catholic medical association that publicly holds to the Church's teaching on the sanctity of life cannot exclude from membership physicians who actively participate in assisted suicides.