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Analysis of Nevada Senate Bill 105

The purpose of S.B. 105 is to authorize physician-assisted suicide in Nevada. To that end, it amends Chapter 453 of the Nevada Revised Code by adding new sections 5-31, inclusive, and by making amendments to other chapters of the Code.

In its general preamble, the bill declares that "Principles of law having their roots in common law and the United States Constitution that date back to the late 19th century establish the right of every person to the possession and control of his or her own body, free from restraint or interference by others[.]"If this is meant to imply that our legal history supports the claim of a terminal patient "to ingest a drug to end his or her life[,]"it is, as the Supreme Court demonstrated in *Washington v. Glucksberg,* 521 U.S. 702 (1997), simply mistaken.

In its legislative findings, the bill declares that "***[p]patients with terminal conditions who have suffered prolonged and unbearable pain [,]"*** Section 13(1), ***should have the right "to request and receive medication that may be self-administered by the patient to peacefully end his or her life."*** § 13(2). ***Yet, nothing in the bill conditions the receipt of a lethal prescription on the patient's suffering prolonged and unbearable pain or, for that matter, any pain at all.***

Section 30(3) maintains that the bill does not "Condone, authorize or approve.
... assisted suicide." To avoid the obvious incongruency, Section 27(1) simply declares that death under the bill does not constitute suicide; and, Section 27(2) directs any public document or report to refer to practice under the bill, not as suicide, but the administration of "a controlled substance that is designed to end the life of a patient. "Further, Section 32(7)(b), defines "medical treatment" to include prescription of lethal medication under the bill. Thus, the role of the medical art in Nevada will have as its aim both to cure patients and to kill them."

There are other instances where the bill omits requirements necessary for the "safe framework" it claims to create:

For example, nothing in the definition of "attending physician," Section 6, or of "consulting physician," Section 8, requires either to have any training or experience in identifying clinical depression. As the Glucksberg Court recognized, 521 U.S. 730-731, many patients who request suicide withdraw that request when their depression is treated; but, since clinical depression is difficult to diagnose, physicians often fail to address their patients' needs.

Notably, though Section 18(1)(a) provides that the attending physician "shall" refer the patient to a psychiatrist or psychologist for an evaluation of the patient's competency, the requirement is actually discretionary depending on whether the attending or consulting physician judges that the patient may lack competency.

Nothing in the definition of "terminal condition," § 12, specifies the level of certainty the attending physician's terminal diagnosis and prognosis must have. Thus, a prediction that death is "more likely than not" within six months would satisfy the definition.

Nothing in the bill prevents the consulting physician from witnessing the patient's written request for lethal medication. If the attending physician is disqualified as an interested party from serving as such witness, Section 15(1)(b), the consulting physician should be as well.

Notably, one witness to the patient's written request can have a financial interest in the patient's estate, § 15(1)(b)(2), or can be an owner, operator, or employee of the health care facility where the patient resides, § ***15(1)(b)(3), and who may have an interest in freeing up a "Medicaid bed" for a private paying patient. Indeed, for patients residing in long-term care or hospice care facilities, Section 15(2) requires that one witness must be someone designated by the facility; and, since the examples listed are merely illustrative, an owner, operator, or employee can serve that role.***

Since Section 17(3) places no conditions on someone interpreting the private conversation between the physician and patient concerning the present of coercion or undue influence, that person can have a financial interest in the patient's estate.

Notably, ***the proofs of residency in Section 15(1)(c) are only illustrative, leaving the sufficiency of other evidence to the discretion of the attending physician. Further, though Section 22(1) states that the patient can revoke the request for lethal medication at any time, Section 22(2) indicates that it only becomes effective when communicated to the attending physician.***

There is no requirement that the patient's competency be evaluated before the lethal medication is taken, even though months have elapsed since the prescription was written. ***Under Section 32(1), if an expired prescription for lethal medication is renewed, there is no requirement that the prescribing physician reevaluate the patient's competency.***

There is no requirement that an objective witness be present at the time the medication is taken.

24 If the coroner confirms the attending physician who wrote the lethal prescription, then neither the coroner, coroner's deputy, or local health officer is required to investigate or certify the cause of death, ***§ 1(1)(a) & (b),*** even though such physician was not present when the patient died, ***§*** 3(2), and therefore would not have personal knowledge that the patient died from the lethal medication. Though the coroner can access the records of ***the Division of Public and Behavioral Health of the Department of Health and Human Services*** to confirm whether the patient died from the lethal medication, ***§*** 1(2), the coroner will not be able to

make that determination since the records cannot include personally identifying information. ***§*** 24(3).

Under Section 2(3) the prescribing physician must sign the death certificate which must list the underlying condition as the cause of death. No one is then likely to investigate the cause of death, if the family is told it resulted from the underlying condition and if the coroner has no duty to investigate if the attending physician is identified.

Section ***24(1)(b) does not require attending physicians to report to the Division the reasons why their patients requested lethal medication.*** **CF.** § ***25(1)(f). The annual reports of other states authorizing prescriptions for lethal medication routinely include such data and regularly indicate that fear of uncontrolled pain is a low priority for such patients.***

Though the annual report must list the number of physicians who prescribed lethal medication, § ***25(1)(d), it is not required to list the number of patients for whom each physician prescribed such medication.***

1 ***Finally, since physicians and pharmacist, in good faith compliance with the bill, cannot be held in violation of their respective standards of care,*** § ***27(1) & (3), the next step is to incorporate assisted suicide into such professional standards, so that, as the bill's preamble declares , "***to enroll in hospice care, to seek palliative care, to ingest a drug to end his or her life or to take any combination of those actions" are all treatment ***options terminal patients should routinely have available.***