SENATE COMMITTEE ON PUBLIC SAFETY

Senator Nancy Skinner, Chair
2017 - 2018 Regular

Bill No:	AB 282	**Hearing Date:**	May 15, 2018
Author:	Jones-Sawyer		
Version:	March 15, 2018		
Urgency:	No	**Fiscal:**	No
Consultant:	GC		

Subject: ***Aiding, Advising, or Encouraging Suicide: Exemption from Prosecution***

HISTORY

Source: Author

Prior Legislation: AB 15 X2 (Eggman), Ch. 1, Stats. of 2015
SB 128 (Wolk), 2015, held in Assembly Health
AB 2139 (Eggman), Ch. 568, Stats. of 2014
AB 374 (Berg), 2007, failed Assembly floor
AB 654 (Berg), 2005, failed Assembly floor

Support: American Civil Liberties Union; California Public Defenders Association`

Opposition: California ProLife Council; California Right to Life Committee, Inc.; Crusade for Life; Life Legal Defense Foundation; Scholl Institute of Bioethics; Seniors Against Suicide; one private individual

Assembly Floor Vote: 45-17

PURPOSE

The purpose of this bill is to prohibit persons whose actions are compliant with the End of Life Option Act from being prosecuted for deliberately aiding, advising, or encouraging suicide.

Existing law, as the End of Life Option Act, authorizes an adult who meets certain qualifications and who has been determined by his or her attending physician to be suffering from a terminal disease to request a prescription for an aid-in-dying drug. The act, with some exceptions, provides immunity from civil or criminal liability for specified actions taken in compliance with the act. Actions taken in accordance with the act do not, for any purpose, constitute suicide, assisted suicide, homicide, or elder abuse under the law. (Health & Saf. Code, § 443, et seq.)

Existing law provides that the End of Life Option Act expires on January 1, 2026. (Health & Saf. Code, § 443.215.)

Existing law specifies that a person who deliberately aids, advises, or encourages another person to commit suicide is guilty of a felony. (Pen. Code, § 401.)

COMMENTS

1. Need for This Bill

According to the author:

> When California passed the End of Life Option Act in 2015, which permits an individual, who is an adult with the capacity to make medical decisions and with a terminal disease to request and receive a prescription for an aid-in-dying drug. It also states that death resulting from actions taken in accordance with the Act shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law if all of the following conditions exist:
>
> - The attending physician has diagnosed the individual with a terminal disease;
> - The individual has voluntarily expressed the wish to receive a prescription for an aid in dying drug;
> - The individual is a resident of California and is able to establish residency, as specified;
> - The individual documents his or her request for aid-in-dying drug, as specified; and,
> - The individual has the physical and mental ability to self-administer the aid-in-dying drug. (Health & Saf. Code, § 443.2, subd. (a).
>
> However, we did not make changes to Penal Code, § 401, which makes it a felony to deliberately aid, advise, or encourage another person to commit suicide. AB 282 will clarify that a person whose actions are authorized under the provisions of the End of Life Option Act cannot be prosecuted for the crime of assisted suicide.

2. Effect of This Bill

The End of Life Option Act prohibits a person from being subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. The act permits, without civil or criminal liability, a person who is present to assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the drug. However, the End of Life Option Act did not amend the Penal Code, and aiding a person in the commission of suicide remains a felony.

This bill would make a necessary cross-reference to the Penal Code that states that so long as a person is compliant with the terms of the End of Life Option Act they cannot be prosecuted under the existing Penal Code § 401 which specifies that a person who deliberately aids, advises, or encourages another person to commit suicide is guilty of a felony. The bill would not legalize "aiding, advising, or encouraging" another to commit suicide. The bill would merely specify that if a person was compliant with existing law under the End of Life Option Act, they are not guilty of violating Penal Code § 401.

Specifically, the bill would prohibit a person from being subject to criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. Additionally, the bill would permit, without criminal liability, a person who is present to assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the drug. This bill has no other effect.

3. End of Life Option Act of 2015

California passed the End of Life Option Act in 2015. The Act permits a competent, qualified individual who is an adult with a terminal disease to receive a prescription for an aid-in-dying drug if certain conditions are met, such as two oral requests, a minimum of 15 days apart, and a written request signed by two witnesses, is provided to his or her attending physician, the attending physician refers the patient to a consulting physician to confirm diagnosis and capacity to make medical decisions, and the attending physician refers the patient to a mental health specialist, if indicated. The provisions of the act sunset on January 1, 2026.

Prior to California's passage, five states had authorized what is referred to as Death with Dignity or Aid-in-Dying. Oregon and Washington enacted their legislation through voter initiatives that took effect in 1997 and 2009, respectively. Vermont enacted legislation in 2013. In Montana and New Mexico, the courts have effectively authorized doctors to engage in the practice. Belgium, the Netherlands, Luxembourg, and Switzerland all allow for physician aid-in-dying, and next year Canada will implement the practice as well.

A 2014 report published by the Institute of Medicine, "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life," identified persistent major gaps in care near the end of life that require urgent attention. Understanding and perceptions of death and dying vary considerably across the population and are influenced by culture, socioeconomic status, and education, as well as by misinformation and fear. Engaging people in defining their own values, goals, and preferences concerning care at the end of life, and ensuring that their care team understands their wishes, has proven remarkably elusive and challenging. While the clinical fields of hospice and palliative care have become more established, the number of specialists in these fields is too small. Too few clinicians in the primary and specialty fields that entail caring for individuals with advanced serious illnesses are proficient in basic palliative care. Often, clinicians are reluctant to have honest and direct conversations with patients and families about end of life issues. Patients and families face additional difficulties presented by the health care system itself, which does not provide adequate financial or organizational support for the kinds of health care and social services that might truly make a difference to them. The report notes that a patient-centered, family-oriented approach to care near the end of life should be a high national priority and that compassionate, affordable, and effective care for these patients is an achievable goal.

In February of 2012 the California HealthCare Foundation published a survey, "Final Chapter: Californians' Attitudes and Experiences with Death and Dying". The survey found that most Californians would prefer a natural death if they became severely ill, rather than have all possible care provided. We want to die at home rather than in a hospital or nursing home, and want to talk with our doctor about our wishes for end-of-life care. However, what we want isn't what we always get, as the survey numbers illustrate:

- Seventy percent of Californians would prefer to die at home; however of deaths in 2009, 32% occurred at home, 42% in a hospital, and 18% in a nursing home;

- Almost 80% say they definitely or probably would like to talk with a doctor about end of life wishes, but only 7% have had a doctor speak with them about it; and,

- The survey also found that what matters most at the end of life varies by race and ethnicity, for example, Latinos rate living as long as possible more highly than do other groups. African Americans and Latinos are much more likely to place importance on being at peace spiritually. Asians and white/non-Latinos place the least importance on living as long as possible. Sixty percent of *all* respondents say it is extremely important that their family not be burdened by decisions regarding their care.

The American Medical Association (AMA) code of medical ethics (opinion 2.201) states the duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients. Palliative sedation to unconsciousness is the administration of sedative medication to the point of unconsciousness in a terminally ill patient. It is an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation. Palliative sedation is an accepted and appropriate component of end-of-life care under specific, relatively rare circumstances. Indeed, the AMA code states, when symptoms cannot be diminished through all other means of palliation, including symptom-specific treatments, it is the ethical obligation of a physician to offer palliative sedation to unconsciousness as an option for the relief of intractable symptoms.

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. In 2011 the Oregon Public Health Division published a summary of DWDA activity up to 2010 which also examined the larger trends seen over 13 years of DWDA. The first prescriptions and deaths under DWDA occurred in 1998, with 24 prescriptions written and 16 self-administered deaths. At the end of 2010, a total of 821 prescriptions had been written and 525 patients had died from ingesting medication prescribed under DWDA. The report noted that demographic characteristics remained relatively unchanged over 13 years. Of the 65 patients who died under DWDA in 2010, most (70.8%) were over age 65; the median age was 72. One hundred percent of decedents were white, well-educated (42.2% had at least a baccalaureate degree), had cancer (78.5%), or amyotrophic lateral sclerosis (11%). As in previous years, the most commonly mentioned end of life concerns among those who died in 2010 were loss of autonomy (93.8%), decreasing ability to participate in activities that made life enjoyable (93.8%), and loss of dignity (78.5%). Since the law was passed in 1997, a total of 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under DWDA. Over 90% of patients who used DWDA were enrolled in hospice.

4. End of Life Drug

The following narrative describes how end of life drugs are prepared and ingested. It was received from a retired Oregon family physician who wrote approximately 15 prescriptions for aid-in-dying drugs over the course of his career:

> The most common drug prescribed is 10 grams of secobarbital (Seconal). A standard size Seconal capsule is 100 mg. This drug was very commonly used as a sleeping pill before the invention of the benzodiazepines (e.g. Dalmane, or Valium) and then later zolpidem (Ambien). The 100 Seconal capsules are delivered in a bottle with a label stating they are for use in the Oregon Death with Dignity Law. In all of the cases I've been involved with, family members, volunteers, and hospice workers have all been very aware that the patient has been in possession of the medication, and I am not aware of a dose that is unaccounted for. In Oregon it is important to understand that it would be very unusual for a patient to actually obtain the drug and then not use it. It is much more common for the patient to request that the prescription be held on file at the pharmacy until they decide to use it. Pharmacies have been very willing to do this. When the patient decides to take the drug the capsules are opened and emptied by the pharmacist, a volunteer or family member, and the powder is mixed with about three ounces of liquid for use.

Seconal is not the only drug used in DWDA. According to the Oregon Public Health Division, DWDA 2013 annual report, since 2010, the trend has shifted to predominant use of pentobarbital (90% of all prescriptions in 2013). Patients are usually also prescribed an anti-nausea medication to take before ingesting an aid-in-dying drug.

5. Argument in Support

According to the American Civil Liberties Union:

> In 2015, California took the humane step of authorizing qualified terminally ill persons to request a prescription for an aid-in-dying drug under the End of Life Option Act ("the Act"). Under the Act, a physician is authorized to prescribe an aid-in-dying drug under specified circumstances, and a person who assists the individual in preparing the drug is given civil and criminal immunity, so long as the person does not assist the person in ingesting the drug. However, the provisions of Penal Code section 401, which makes it a felony to assist someone in committing suicide, do not exempt the actions of physicians or other persons as allowed under the Act. AB 282 will correct this omission and protect those who assist persons who seek to end their lives, legally, on their own terms.

Argument in Opposition

According to the *Life Legal Defense Foundation*:

> Medical literature indicates that up to 77% of people diagnosed with a terminal illness suffer from major depression. A study published in the Journal of Clinical Psychology found a "statistically significant association between clinical depression and the desire for hastened death." Under AB 282, terminally ill patients-many of whom are suffering from depression, anxiety, and other mental health conditions-may be aided, advised, or encouraged to request and inject a lethal prescription. Decriminalizing behavior that may lead someone to be talked into committing suicide is in direct conflict with the State's suicide prevention policies.

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