



*Representing California's Catholic  
Health Systems and Hospitals*

**AB 374 (Berg/Levine/Nunez) - Physician Assisted Suicide  
Assembly Judiciary Committee Advocacy Toolkit**

AB 374: Talking Points

Sample Letter – Hospital/System Leadership

Sample Letter – Health Professional

Assembly Judiciary Committee Roster

Policy Deficiencies

## AB 374 Talking Points

- Assisted Suicide is opposed by the American Medical Association, the California Medical Association, the California Hospice and Palliative Care Association, the California Disability Alliance, the Disability Rights Education and Defense Fund, the League of United Latin American Citizens, La Raza Roundtable of Santa Clara County, and the Sacramento NAACP, as well as numerous other organizations representing the poor, uninsured, and people with disabilities.
- It is remarkable that the legislature is considering assisted suicide at a time when millions of low-income Californians and their families still have no access to health care. Is the legislature saying to low-income people, "We won't provide health care, but we will make it easier for you to commit suicide when you're at your most vulnerable and uninsured"? Large numbers of people, particularly among those less privileged in society, would be at significant risk of harm.
- The six month prognosis threshold used in this bill and under the Oregon law is generally not viewed as medically useful: Many individuals given this prognosis frequently live longer and even recover with appropriate treatment. People with disabilities and chronic illnesses often live many years after a "terminal" diagnosis, yet initial depression and temporary thoughts of suicide are common. Physicians who specialize in end-of-life care know that these feelings are transitory, and that patients respond to support from health care professionals, family and hospice workers. But legalizing assisted suicide would allow anxious, depressed patients to become trapped by their own request for death, and die in a state of unrecognized terror, even though the depression can be treated in most cases.
- Most of those who died under Oregon's assisted suicide law participated in the lethal procedure because they had psychological distress, not because they were in pain. Statistics from the Netherlands confirm that pain is not the reason most users of euthanasia resort to it.
- The pretense that assisted suicide will be limited to the terminally ill is a protection only on paper that will quickly be breached, as has already happened in Oregon. The so-called "safeguards" in the Oregon law, touted by assisted suicide proponents, are easily avoided. For example, if one's doctors say no, a family can shop for another doctor who will say yes. In the Netherlands, assisted suicide for people with terminal illness has spread to full-blown euthanasia (lethal injections by doctors) for people with chronic illness, people with mental health distress, and even depressed teenagers and infants with disabilities.
- The Oregon approach is not something California should copy. In Oregon, doctors who fail to report assisting in suicides face no penalty. The Oregon law gives the state no resources or even the authority to investigate violations or abuses. The state destroys its paperwork after each annual report, so it's impossible to independently verify their conclusions. The press has reported troubling cases including examples of "doctor shopping," the medication failing, coercion, and use with people who do not meet the eligibility criteria, but none of this has ever appeared in the official public record. Because of these limitations, it is impossible to know what abuses and irregularities exist. The Oregonian, the state's major newspaper, complained in 2005 that the law's reporting

system “seems rigged to avoid finding” the answers. Yet the California bill contains these same serious flaws.

- Assisted suicide purports to be about free choice and self-determination, but there is significant danger that many people would take this escape due to external pressure. For example, elderly individuals who don't want to be a financial or caretaking burden on their families will sometimes choose assisted death, as Oregon's own statistical reports indicate. Furthermore, research has documented widespread elder abuse in this country. The perpetrators are very often family members (two-thirds, according to the California Attorney General's Office). Such abuse could easily lead to pressures on elders to “choose” assisted suicide, as the Oregon news media have brought to light. Despite extensive efforts by California's legislature and law enforcement to deter elder abuse, assisted suicide could facilitate the ultimate abuse.
- Assisted suicide poses real danger to people with new disabilities or chronic diseases. Research overwhelmingly shows that people with new disabilities often initially experience despondency and even suicidal feelings, but later adapt well and find great satisfaction in their lives. Working through this initial despondency often takes longer than the mere two-week waiting period in Oregon's law and the California bill. In that early period, before one learns the truth about how good one's quality of life can be, it would be all too easy to succumb to this irrevocable step.

## **Sample Letter from Hospital or Health System Leadership**

Dear Assemblymember xxxxx:

[name of hospital] strongly opposes AB 374 (Berg/Levine/Nunez), the bill that legalizes assisted suicide in California. We provide compassionate aid-in-dying to our patients each and every day in our hospital. AB 374 is not about the right of patients to refuse life-sustaining treatment, nor is it about physicians providing medications to relieve a patient's pain or suffering – those practices are both legal and ethical. AB 374 is an extreme and unwarranted response to the needs of terminally-ill patients and their families.

California should not spend its health care resources on helping people end their lives because they fear suffering or feel they are a burden to their loved ones. Rather, we should be diligent in removing the barriers that feed those fears. We believe a more meaningful response to the public's concern about end of life care would be to promote and support existing efforts to increase access to hospice and other palliative care programs, rather than legalizing assisted suicide.

[cite examples of hospice programs and other palliative care services provided by your hospital or health system].

Proponents of assisted suicide claim that people have a right to choose the time and manner of their deaths. With over 7 million uninsured in California and countless others underinsured, how does "choice" extend to low-income people who do not have access to necessary health care? We believe this bill would encourage already desperate patients to make decisions they otherwise would not.

[name of hospital] urges you to vote "no" on AB 374.

Sincerely,

Hospital CEO and/or Medical Staff Leadership

## Sample Letter from Health Professional

Dear Assemblymember xxxxx:

As a health care professional, I strongly urge you to oppose AB 374 (Berg/Levine/Nunez), a measure to legalize assisted suicide. Oregon's tragic experiment with similar legislation has produced convincing data that this bill is unnecessary.

In Oregon, the victims of this legislation cite depression, not pain, as the reason they desire assisted suicide. Many patients experience depression, but it is also a temporary and treatable condition. Because of advanced pain management technologies and medications, and the superb hospice programs available, the compassionate choice is to continue to provide and expand such end-of-life care, not to sanction assisted suicide.

[Cite experiences of positive programs/services for persons at end-of-life or your personal experience in working with terminally-ill patients.]

Those who have dedicated their lives to the health care profession are virtually united in their opposition to this legislation. We should not spend our health care resources on helping people end their lives because they fear suffering or feel they are a burden to their loved ones. Rather, we should be diligent in removing the barriers that feed those fears.

Please join the California Medical Association, hospice workers and disability advocates in opposing AB 374.

Sincerely,

(ethics committee member, doctor, nurse, social worker, hospice staff, etc.)

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## AB 374 (Berg/Levine): Compassionate Choice Act Policy Deficiencies in California's Assisted Suicide Legislation

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### Overview

AB 374 (Berg-Levine-Nunez) authorizes certain terminally-ill patients who wish to end their lives to request and obtain a lethal dose of drugs for that purpose. The bill also sets forth various requirements that physicians and patients must follow before a lethal dosage can be dispensed. If the requirements are followed, the bill grants participating physicians and patients certain legal protections.

The purpose of this document is to discuss specific provisions of AB 374 and point out troubling aspects and shortcomings. Although AB 374 contains a “process” for patients and physicians to go through, there are too many substantive deficiencies in its drafting to characterize these processes as true “safeguards.”

### Limits on “Eligibility” Will Be Challenged

**California Provision:** Under AB 374, an eligible applicant must be deemed “terminal, with less than six months to live.” However, the applicant must also be at least 18 years of age, a resident of California (for at least six months), and must not suffer from a psychiatric or psychological disorder or depression.

**Comment:** Over time, we do not believe it will be legally possible to limit eligibility for lethal dosages to only certain terminal patients. Once the principle of assisted suicide is established as a legal right, it will be extremely difficult or impossible to argue that the application of that right should be limited to a relatively small group of terminal patients.

We say this for the following reasons. First, the language of AB 374 which says that the bill is to be *strictly construed and not expanded in any manner* is only intent language. It is not written as a statutory requirement of AB 374. Second, excluded terminal patients and other persons with disabilities may be able to successfully argue in court that they are being denied a right which other terminal patients have been granted and that they are entitled to equal protection under the law. Moreover, others who are suffering with incurable medical problems but who are not classified as terminal patients with six months or less to live will, no doubt, be able to argue that their suffering and prognosis are as severe as those of terminal patients.

**Oregon Case in Point:** In the opinion of Oregon Deputy Attorney General David Schuman, the state's assisted-suicide law more than likely violates both the Oregon Constitution and the federal Americans with Disabilities Act by discriminating against patients who are too disabled to swallow legally prescribed lethal drugs.

***In Their Own Words:*** In addition to who will be eligible, we believe that several of the “safeguards” will be legally challenged. One example is the “waiting period safeguard.” Kathryn Tucker, Compassion and Choices legal counsel (sponsors of AB 374), discussed how their strategy evolved to successfully pass an assisted suicide law in Oregon: "In my view, the Oregon measure, in some sense, became overly restrictive. It has a fifteen-day waiting period. And my own view of the federal constitutional claim is that a fifteen-day waiting period would be struck down immediately as unduly burdensome. As we've seen in the reproductive rights context, you can't have a waiting period of that kind of duration. But in the legislative forum, to pass, you need to have measures that convince people that it's suitably protective so you see a fifteen day waiting period." [*Tucker, Seattle Pacific University, 7/12/97*]

## Determining Competency

***California Provision:*** AB 374 establishes mechanisms for determining which patients are and are not “capable” of giving informed consent to receive a lethal dosage of drugs. Generally speaking, the bill gives attending and consulting physicians the responsibility for determining which patients are and are not capable. The language of the bill allows physicians to make these determinations within very broad parameters.

***Comment:*** There is no general requirement in AB 374 that the patient be professionally evaluated to determine that he or she is mentally competent to make life and death decisions. Instead the attending or consulting physician may (or may not) call in a licensed psychiatrist or psychologist to determine whether a patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

In practice, the psychiatric evaluation is used only infrequently in Oregon. It is worth noting that the psychiatric evaluation is the mechanism in AB 374 for insuring that the patient has a sound mind and is capable of requesting a lethal dose of drugs.

Another shortcoming is that the language of the bill instructs the licensed psychiatrist or psychologist to determine only if the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment. Clearly there are other causes of impaired judgment, including certain medications and certain physical conditions, which should be evaluated to determine if they have impaired a patient’s judgment.

In addition, the language of AB 374 which guides the attending physician and the consulting physician in making determinations about the patient’s capability to make important decisions is circular and largely meaningless. The language states that, “‘Capable’ means that in the opinion of the patient’s attending physician or consulting physician, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”

This definition seems to say that a patient is deemed capable (i.e. competent) if and when the attending and consulting physician say he is, even in cases where the physician has to ask relatives or others interpret what the patient means to say.

As written, AB 374 lacks the procedural safeguards needed to insure that only competent patients whose mental faculties are unimpaired by illness or medication are able to request lethal drugs with which to end their lives.

***Oregon Case in Point:*** During the first five years of Oregon’s Death with Dignity Act on average 18% of the eligible patients were referred for psychiatric evaluation. The latest report from the Oregon Health Department indicates that only 4% of patients who committed assisted suicide were referred for psychiatric evaluation.

## Clinical Problems of Drug Administration

**California Provision:** There is no requirement in AB 374 that the patient's prescribing physician be present at the time the patient takes the prescribed lethal drugs. AB 374 is silent on the question of what physicians and others who are present should do if a patient does not die and/or is having problems after ingesting lethal drugs. The reporting requirements of AB 374 will not provide information on what happens if and when complications arise.

**Comment:** Yale University School of Medicine has studied drug administration problems that have arisen in the Netherlands in assisted suicide cases. The Yale study reviewed 114 Dutch cases where the original intent was to provide assisted suicide rather than euthanasia. In 21 of the 114 cases (18 percent) there were complications and the physician intervened and ended the life of the patient.

We know from experience in the Netherlands that some patients linger and do not die within the time period expected after administration of lethal drugs. Occasionally some patients do not become comatose and some awake from coma. In other cases the patient had difficulty swallowing the oral dosage, vomited after swallowing it or become unconscious before swallowing all of it.

The Yale report states that, "Studies in the United States and in the Netherlands have shown that many physicians lack knowledge about the use of lethal drugs and that recommendations about which drugs to use are not always followed." The Yale report also points out that oral administration of lethal drugs is more likely to have complications than other methods of drug delivery. We believe complications are particularly likely in situations where the patient is expected to ingest the lethal drug on his or her own without assistance.

**Oregon Case in Point:** The annual Oregon Health Department reports provide very little information about how cases with complications are handled. The most recent report indicates that the prescribing physician was present in only one-third of the cases (during the first three years after legalization of assisted suicide, physicians were present half or more of the time), and in 16% of the cases no physician was present. In addition, 51% of the patients ingested the lethal drugs in the presence of another health care provider/volunteer. However, there is no information in the Oregon reports about the job titles of such other health providers or "volunteers" and their capacity to manage the patient in the event of complications.

The Oregon press has reported that Compassion & Choices has participated in more than three-quarters of the state's cases of assisted suicide. If it is generally correct that an assisted suicide advocacy group is present 75% of the time and the prescribing physician is present only 33% of the time (again it is reported that this physician oftentimes is associated with Compassion & Choices) then one must ask what happens when there are complications and the patient does not die as expected?

The reporting requirements established by AB 374 are entirely inadequate to provide insight how cases with complications are handled in real life situations.

If suicide-advocacy groups are commonly in attendance at the patient's suicide and if it is the intent of the legislature not to permit "active euthanasia" then the question of what safeguards should be put in place to prevent euthanasia should be discussed. As written, AB 374 has no safeguards to insure that others present in the room at the time of the attempted suicide do not cross the line and actively end the life of the patient.

**Assemblymember Berg's Words.** In her March 2005 newsletter, Assemblymember Berg concludes her article on her assisted suicide bill by stating, "The role of the physician is limited to the clerical function of writing the prescription." Relegating the role of the physician to a "clerical function" seems to undermine the notion that safeguards are in place in the event there are complications with an attempted suicide.

## Active Euthanasia

**California Provision:** AB 374 states, "Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia." There is no definition of what constitutes active euthanasia. There is no penalty for engaging in active euthanasia. This bill requires that the patient self-administer the medication.

**Comment:** AB 374 appears to be built upon the presumption that the terminal patient will always be able to successfully self-administer a lethal dosage. However, it is clear that some debilitated patients will not be able to ingest a lethal dose of drugs without assistance. Based on the information in the Yale study, there will be complications for about 18% of the patients who attempt suicide without assistance. This puts persons who are in the room with the patient in a dilemma. Presumably any person who physically puts a lethal drug in the mouth of a patient would be engaged in "active euthanasia."

As written, AB 374 neither allows nor prohibits anyone to "assist" the patient in taking the lethal drug or take other measures that would end the life of the patient. Clearly, this is an important issue that may be open to interpretation

In Oregon there are reports of persons in attendance mixing the lethal drugs into some sort of edible substance (juice, pudding, etc.) and then feeding the lethal dose to the patient. If the question of whether anyone may assist the patient in taking a lethal drug is not squarely addressed in the bill, then it will be left to those in attendance to decide what is or is not allowed. Based on the experience in Oregon it is probable that district attorneys and courts will find, for the reason discussed above, that it is legal for others to feed patients a lethal dosage of drugs in some circumstances. In our opinion this would, in effect, constitute a backdoor method of legalizing euthanasia.

**Oregon Case in Point:** In March 1999 the Oregonian reported on the details of the death of Patrick Matheny, aged 43 who had Lou Gehrig's disease (ALS). Mr. Matheny had asked his brother-in-law, Joe Hayes to be with him. Mr. Matheny tried to swallow the barbiturates mixed into a nutrition drink. Reportedly, he experienced difficulty swallowing the concoction. Hayes told the Oregonian that he had to "help" Matheny to die, but would not say how. According to Hayes, it was too personal. "It doesn't go smoothly for everyone," Hayes explained. "For Pat it was a huge problem. It would have not worked without help," he added.

Coos County District Attorney Paul Burgett told reporters that he was satisfied that Hayes simply assisted Matheny in a legal act, which Matheny intended to commit. He went on to state he thought disabled people who cannot swallow should have an equal right to assisted suicide as long as they meet the other requirements of the law.

Derek Humphry – the father of the assisted suicide and euthanasia movement – sent the following e-mail to his supporters. This e-mail contains some information which directly bears on this issue. The e-mail says,

*"My book 'Final Exit' has always carried warnings that sometimes -- rarely -- even 9 or 10 grams of Seconal or Nembutal taken by mouth does not prove lethal. Exactly why is not understood. That's why I say a plastic bag should be handy.*

*"Dutch doctors have always warned that oral ingestion of barbiturates occasionally is not fatal. Only the injection of this substance (not permitted by Oregon law) is 100 percent fatal.*

*"Those who drafted and operate the Oregon physician-assisted suicide law were told this back in 1993-94 and ignored it. They scoffed at suggestions of failures, and ridiculed plastic bags.*

*"The miserable path to death of David Pruitt ("Why Am I Not Dead") shows why the Oregon Death With Dignity Act should be improved and strengthened.*

*"First, at least one of the doctors who wrote the lethal prescription should be obliged to be at the bedside when it is ingested; usually they are nowhere near.*

*"Second -- as in the Netherlands -- when the patient has elected to drink the barbiturate, a doctor should be able to give a lethal injection if the patient has not died after four hours. Barbiturates can be unreliable.*

*"In a real and compassionate world, if we are going to allow legal, medical, hastened deaths by request of the terminally and hopelessly ill, then let us do it efficiently, with lethal injection overdose as a fallback position and bedside medical oversight always.*

*"The Oregon law as it stands allows doctors to duck out of the final supervisory responsibility. It's not good enough."*

## **The Right to Refuse to Participate in Assisted Suicides**

**California Provision:** AB 374, in general, protects the right of individual doctors, nurses, pharmacist and other health providers to refuse to participate in assisted suicide and protects them from loss of license, discipline, loss of staff privileges and other penalty if they do participate. Specifically, the two sections of the bill that deal with these issues state,

7198 (b). No professional organization or association, or *health care provider*, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter.

7198 (d). No health care provider shall be under any duty, whether by contract, by statute, or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

7198 (e) Notwithstanding any other provision of law, a general acute care hospital ... may prohibit a licensed physician from carrying out a patient's request under this chapter on the premises of the hospital if the hospital has notified the licensed physician of its policy regarding this chapter.

**Comment:** Although the rights and protections of individual health care providers and acute care hospitals are clearly articulated, the rights and protections of hospices owned by or affiliated with a hospital or health system are not clear. If a hospice does not want to participate, it appears to have that right and can probably require the patient to move to another hospice program that does participate in assisted suicides.

It appears, however, that a non-participating hospice *in its capacity as a health care provider* lacks the authority to discipline health care staff who engage in assisted suicide in spite of the affiliated institution's wish not to participate. The same is true for long-term care providers.

## De Facto Change of Penal Code Making Assisted Suicide a Felony

**California Provision:** Section 7197.7 states: “Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing, or active euthanasia. **Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.**” [emphasis added]

**Comment:** AB 374 makes a de facto change to current criminal law. Penal Code Section 401 currently provides “that every person who deliberately aids or advises, or encourages another to commit suicide, is guilty of felony.” AB 374 provides a good faith standard, which states that no one will be subject to any legal liability if they act in “good faith,” something nearly impossible to disprove, making all the other rules unenforceable. In other areas of criminal law when killing is allowed (e.g., justifiable homicide or lethal use of force by a police officer), there is a very public process for accountability of actions.

**Oregon Case in Point:** The Oregon Department of Human Services has no authority or resources to investigate actual cases. In its 1999 report on the practice of assisted suicide, the Oregon DHS stated “...the reporting requirements can only ensure that the process for obtaining lethal medications complies with the law. We cannot determine whether physician-assisted suicide is being practiced outside the framework of the Death With Dignity Act.” As noted in a previous section, according to the most recent Oregon DHS report, the prescribing physician is present at the assisted suicide only 33% of the time. As stated in its annual reports, *“Because physicians are not legally required to be present when a patient ingests the medication, not all have information about what happened when the patient ingested the medication. If the prescribing physician was not present, we accepted information they had based on discussions with family members, friends or other health professionals who attended the patients’ deaths. We also accepted information directly from these individuals.”* It would be impossible to disprove any wrongdoing when the only reliable witness to a potential felony is now deceased.

## Oregonians Experience More Pain Post-DWDA

In July 2004, the AP reported on a new study by a team of Oregon Health & Science University researchers who found that dying patients in Oregon are twice as likely to experience pain during their last week of life than they did prior to the passage of landmark legislation in 1997. As stated in this AP story, *“It’s a conclusion which throws into doubt the widespread view that pain control has improved markedly in Oregon following the enactment of the 1997 Oregon Death with Dignity Act.”*

As discussed in this study – **Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002** – *“Despite the national attention received by end-of-life care, have greater resources actually been apportioned to provide better care? In Oregon, there is evidence that these resources have been stretched more thinly. Medicare patients in Oregon have among the lowest reimbursement in the United States during the last 6 months of life and have fallen significantly during the study period.”*

The study concludes by saying, *“Despite its limitations, this study demonstrates that pain or distress are still substantial problems for dying patients in Oregon, despite multiple efforts to improve end-of-life care. End-of-life care has not been ‘fixed’ and there is plenty of room for improvement, particularly in the final week of life. Clinicians, health care organizations, and policy makers must continue to improve the quality and availability of hospice care and palliative care services if dying patients are to get the care they need and deserve.”*

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### ***Post Script: The Language of Assisted Suicide Proponents***

It is by not accident that AB 374 is now titled the “Compassionate Choices Act” rather than “Death with Dignity Act,” as it is called in Oregon. The same is true of the name of the sponsors of AB 374 – Compassion & Choices. Compassion & Choices is a newly-formed organization that resulted from the merger of Compassion in Dying and End of Life Choices (formerly the Hemlock Society). As described during the 2001-2002 mediated dialogue group convened in cooperation with the Assembly Select Committee on Palliative Care, the representative from “Americans for Death with Dignity” (the sponsors of the 1999 assisted suicide bill authored by Dion Aroner), indicated that a great deal of resources were invested in public relations experts and political strategists, including many focus groups, to test the name of these assisted suicide organizations, as well as what to call their movement. Now, we have “aid in dying” rather than “assisted suicide” or “euthanasia.” “Death” and “dignity” are replaced by “compassion” and “choices.”

Again, in a speech last fall, Derek Humphry states: “In closing my remarks, please allow me to make a plea for more honest use of words and phrases throughout our movement. In recent years there has been an obvious backing away from words like ‘euthanasia’ and ‘assisted suicide’ and ‘mercy killing’. I am quite aware that this was done for political correctness, trying not to scare off the politicians and the voters.

“But not calling ‘a spade a spade’ – as the English say – is playing into the hands of our opponents, who increasingly are teasing us that we are more sinister than we say we are. Speaking in euphemisms – softened speech – develops into muddled thinking and mistaken actions.” [Speech by Derek Humphry at the 15th World Conference, Tokyo 2004 (September 2004).]

And finally, in the End of Life newsletter when a name change for this organization was being promoted, staffer Jane Sanders wrote: “We [also] need access to the halls of government in the states and in Washington DC – access that the name Hemlock is currently denying us. The name Hemlock has a history of earnest defiance but much of it is also baggage, baggage that we can no longer afford to have weighing us down or interfering with our being able to partner with such important and powerful organizations as AARP.” (A Rose is a Rose. Hemlock by Any Other Name, End-of-Life Choices magazine, Vol.2 No.2 / Spring 2003.)