Physicians for Compassionate Care Education Foundation (PCCEF)

info@pccef.org www.pccef.org P.O. Box 7122, Bonney Lake, WA 98391 253-501-7011

Reasons to Oppose Colorado SB24-068
Sharon Quick, MD, MA (Bioethics)
President, Physicians for Compassionate Care Education Foundation (PCCEF)
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I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation. We advocate for the terminally ill, who often have compromised capacity to choose, making them vulnerable to abuse. I have expertise in pediatric anesthesiology, critical care, and medical ethics. On behalf of our Colorado members, we urge you to oppose SB24-068 which demolishes voter-approved safeguards, violates patient autonomy, and discriminates against those with depression and disabilities who are most likely to pay for these changes with their lives.

- Respect for patients' choices includes ensuring that they have the right to change their minds—this bill denies that option. When a patient says they want to hasten death, this often is a plea for help, not a real desire to kill themselves, and this wish usually abates with supportive care.[1] Lethal drugs are not usually sought for pain but for psychological distress over new onset disabilities. A patient who says they want to die might really mean "I'm afraid I'm a useless burden." Vulnerable patients make rash decisions out of fear, depression, compromised decision-making capacity, embarrassment, subtle pressure by a tired caregiver who makes them feel like a burden, etc. All may go unrecognized by doctors. Given time, palliative care and mental health interventions, patients often change their minds, but this bill allows a bad day to become their last day. Fifteen days may be inadequate to do this but chopping it to 48 hours or eliminating it entirely represents patient abandonment under a guise of "autonomy." It takes two weeks for anti-depressants to begin to work; 48 hours is too short to ensure due diligence has been done.
- Shortening the waiting period has no advantages for patients and will only violate patient autonomy and increase discrimination against the most vulnerable. By not allowing adequate time and sufficient expertise to assess what may be rash requests to hasten death in the midst of fear or depression, this bill not only infringes on patient autonomy by violating patients' rights to change their minds, but it allows injustice and discrimination, because the people most likely to be adversely affected by these changes are those with mental illness and disabilities. There is no scientific data or plausible reason to eliminate the safeguards of time and expertise—the risk of harms for doing so outweigh any benefits.
- The provision to eliminate the waiting period demonstrates reckless disregard for patients. The determination that death is near is difficult and imprecise for experts, and patients typically have loss of both mental capabilities and swallowing function as death nears. By the time one knows a patient is near death the chance of obtaining a valid consent is unlikely, and it is doubtful that the patient could ingest the lethal concoction. Patients must take antiemetics and numb their mouths with popsicles before swallowing substantial amounts of a bitter tasting, sometimes burning cocktail of lethal drugs dissolved in liquid. Risks include painful ingestion, nausea, vomiting, aspiration, prolonged death, and not dying. Patients are more likely to have complications, such as dying from choking on their vomit, when they are close to death. If a patient is already in the process of dying because death is within a few days, lethal drugs are contraindicated. Allowing one practitioner, who could be a non-physician, without specialization and without a second opinion to assess prognosis and decision-making capacity and provide immediate lethal drugs demonstrates reckless disregard for the complexity and dangers of this situation. In addition to the ethical

violations and untenable medical risks inherent in eliminating the waiting period, a patient's autonomy is violated by removing a chance to change his/her mind.

- Lethal drugs are never necessary for pain or symptom management, and shortening or eliminating the waiting period should never be done for reasons of symptom management. Even a physician who advocates for lethal drug prescriptions admits this.[2] Patients rarely seek lethal drugs for inadequate pain control, but usually for psychological distress over new onset disabilities associated with terminal illness. Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care. It is unethical to get consent for lethal drugs from patients in severe pain which compromises a person's decision-making capacity.
- Removing the CO residency requirement opens Pandora's box for substandard patient evaluation and care, increased pressure on patients to ingest lethal drugs quickly, insurance fraud, and unclear legal problems.
    - CO practitioners are unlikely to know out-of-state patients and are more likely to miss depression, coercion, and cognitive deficits.
    - Patients traveling to CO are less likely to be accompanied by extended family and/or friends, depriving them of sharing this crucial life experience. Traveling to CO creates pressure on patients to follow through with taking lethal medications to justify the time, effort, and money spent, when they might otherwise have changed their minds and decided not to take the drugs or to wait longer.
    - If a patient does not need to travel to CO, virtual evaluations are substandard with inadequate confirmation of voluntary consent and absence of coercion. Trying to contain controlled substances to prevent their nefarious use would be hampered by interstate mailing of lethal drugs—and the legality of using federal mail service for a federally prohibited practice is questionable.
    - If the patient dies in CO and the death certificate lists the underlying terminal illness rather than the actual cause of death due to lethal drugs, this would be considered insurance fraud in the patient's home state.
    - If the person dies in their home state, legal ramifications are unclear. If it is known how the patient died or if there is an autopsy to discover the cause of death is a lethal overdose, then anyone in the presence of these patients when they died could be guilty of assisting a suicide. Perhaps the prescribing doctor could also be indicted on felony charges. Knowledge of the complications arising for dying in one's own state could create undue pressure for a patient to take lethal drugs immediately upon obtaining them in CO.

- The bill adds a potentially conscience-violating provision by requiring an unwilling "health-care provider" to record the individual's request for lethal drugs and the date of this request in the chart. If this recording starts the waiting period, then the recording "provider" is complicit in the act of providing lethal drugs. It also could potentially allow the patient to get same-day lethal drugs if at least 48 hours has elapsed since the request was recorded and the time at which the attending/consulting "providers" are seen.
- Current law requires medical record documentation of participation in this act (Section 25-48-111) and the Department of Public Health and Environment has adopted rules for reporting.[3] Physicians are currently required to submit a list of information within 30 days of writing a lethal prescription and within 10 days of dispensing a lethal prescription. Hundreds of forms are missing that document that the patient was eligible for and voluntarily consented to lethal drugs, including 20% of patient consent forms, 15% of attending physician forms, and 22% of consulting physician forms. (See details in the Table below.) No investigations have been done or sanctions introduced, although noncompliant physicians are potentially guilty of a felony for not following the letter of the law. Why does this bill propose removing safeguards when current safeguards are not being followed and patient safety is in jeopardy?
- This bill violates Medicare hospice regulations, which prohibit nurse practitioners from certifying a patient as terminally ill.[4]

CO Reporting Statistics[5] for Lethal Drug Prescriptions with Missing Forms

	2017	2018	2019	2020	2021	2022	2017-2022 Total (2022 Report)	2017-2022 Missing Forms[iii]
Patients prescribed lethal drugs	72	124	170	188	220	316	1090	
Patients to whom lethal drugs dispensed	56	, 85	137	150	164	246	838	
Patients who died	71	119	165	178	203	243	979	
Attending or prescribing physician form/ missing	63/**9**	108/**16**	146/**24**	160/**28**	188/**32**	260/**56**	925	165 (15%)
Patient's completed written request/ missing	50/**22**	93/**31**	130/**40**	157/**31**	185/**35**	258/**58**	873	217 (20%)
Mental health provider's confirmation	1	0	1	3	0	3	8 (0.7%)	
Consulting physician's written confirmation /missing	30/**42**	89/**35**	130/**40**	156/**32**	185/**35**	259/**57**	852 (849 actual)*	241 (22%)
Medication dispensing form	56	85	137	150	164	247**	839	
Death certificate[i]	71	119	165	178	203	243	979	
Totals Missing[ii]	73 (34%)	82 (22%)	104 (20%)	91 (16%)	102 (15%)	171 (18%)		623 (19%)

Note: Numbers in boxes represent those recorded in the most recent 2022 report from 2017-2022 except for the 2017 column from the 2021 report. Missing forms are in red print. Only 0.7% of all patients who are prescribed lethal drugs have a mental health consultation.

* Adding the final number in this row produces a sum of 849, but 852 is listed in the 2022 Report. Used 849 to calculate percentage of missing forms.

**Unclear why one more form received than patients to whom lethal drugs dispensed

[i] Note that death certificates are not documented for all the patients who received prescriptions for lethal drugs. It is unclear if these patients have not yet died—making their prognosis longer than 6 months in most cases—or if the death certificates have not been received or recorded.

[ii] Calculated using the added number of missing forms in each of three categories (attending, consulting, and patient request forms) divided by three times the number of patients prescribed lethal drugs for that year.

[iii] Calculated using the added number of missing forms in each row divided by 1090 (the number of patients prescribed lethal drugs from 2017-2022).

References

1. Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995; **152**(8): 1185-91.
2. "[No] patient should take medications to die because they're receiving inadequate symptom management at the end of their life. Hospice care is a way of assuring that patients aren't forced to consider aid in dying because of inadequate end-of-life-treatment." Shavelson, Lonny. Medical Aid in Dying: A Guide for Patients and Their Supporters. American Clinicians Academy on Medical Aid in Dying, 2022. (p. 36)
3. Department of Public Health and Environment Reporting and Collecting Medical Aid-in-Dying Medication Information (https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7163&fileName=6%20CCR%201009-4)
4. "No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill." (Medicare Benefit Policy Manual, Sec. 20.1, p.5; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf)
5. See: 2022 Data Summary (https://drive.google.com/file/d/1DLML5hCvII0Udvt0vCalCziN9g9Lhgf9/view?pli=1) and 2021 Report (https://drive.google.com/file/d/1fnWB83wb9nnr0mXlr30t2fFSkJ55Zi-h/view).