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To: Members of the California Legislature

From: Dr. Aaron Kheriaty, MD Associate Professor of Psychiatry, UCI School of Medicine & Director of the Program in Medical Ethics, UC Irvine Medical Center

Regarding: Problems with Senate Bill 128

Dear Senators and Assemblymembers:

I am writing to express grave concerns regarding Senate Bill 128, the End of Life Options Act. Among the many serious problems with this bill I will mention just a few, which concern me not only as a physician and medical ethicist, but also as a clinical psychiatrist with expertise in the problem of suicide.

Like the Oregon law, SB 128 does not require physicians to refer for psychiatric consultation to rule-out the most common mental disorders or other causes that contribute to suicidal thinking and the wish to die. Many Californians already lack necessary access to mental health care services, and SB 128 places these and other vulnerable individuals at risk. The desire to end one's life, or the request for assisted suicide, is *almost always a cry for help*. It is a *distress signal* indicating that something in the patient's situation is not adequately being attended to – an untreated clinical depression, fear or anxiety about the future or about one's medical condition, untreated or under-treated pain, family or relationship strain or conflict, and so on. Research on suicide demonstrates that 80 – 90% of suicides are associated with clinical depression or other treatable mental disorders, including for individuals at the end-of-life and individuals with a terminal condition. Yet alarmingly, only 5% of the individuals who have died by assisted suicide under Oregon's law were referred for psychiatric evaluation – and this number is decreasing every year. Considering what we know about suicide risk factors, this constitutes a form gross medical negligence.

The risk that serious mental health issues will be overlooked in the application of this law is not merely theoretical: Consider the case of Michael Freeland, an Oregonian who had a 43-year history of depression and had made prior suicide attempts; and yet the physician who prescribed the deadly drug for him did not deem it necessary to refer for psychiatric evaluation or psychological counseling. While this is clearly negligent, there is nothing in the Oregon Law, or in SB 128, to prevent this. The laws are in fact designed to protect physicians, not patients: according to the SB 128, the physician is protected from all scrutiny and liability so long as he is acting "in good faith." This minimal "good faith" legal standard is found nowhere else in

medical practice, where physicians are required to practice according to the higher “medical standard of care.” The family of someone like Michael Freeland has no recourse as long as the physician claims he was simply acting in “good faith.”

The social consequences of suicide are significant and should not be ignored. *Studies have repeatedly demonstrated a “social contagion” aspect to suicide, which leads to copycat suicides*—this is known by scientists as the “Werther Effect”. Assisted suicide advocates insist that this is a purely private decision or an exercise in personal autonomy. But we can anticipate that such decisions will have social effects that adversely influence other vulnerable individuals. Indeed, it is noteworthy that the overall suicide rates in Oregon rose dramatically in the years following the legalization of physician assisted suicide in that state in 1997: after Oregon’s suicide rates had declined in the 1990s, they rose alarmingly between 2000 and 2010, surpassing the rate of increase nationally. Suicide rates are now 35% higher in Oregon than the national average. Preliminary data from Washington shows a similar trend. I recently received a paper (to be published soon in a public health journal) from my colleague, Professor David Albert Jones of the Anscombe Bioethics Center at Oxford University, who analyzed the suicide data from Oregon and Washington. After controlling for other factors that could account for the rising rates of suicide in these states, Professor Jones’ analysis demonstrated that there is indeed a causal link between the legalization of assisted suicide and an increasing in overall suicides in both states. The law is a teacher, and these laws send the message that under difficult circumstances, some lives are not worth living. This is a message that will be heard not only by terminally ill individuals, but by all vulnerable persons who are tempted to take their own lives. Suicide is now a public health crisis: according to the CDC *suicide is currently the 3rd leading cause of death among adolescents and young adults*, and the 10th leading cause of death overall for adults. We have strong evidence now that SB 128 will worsen this public health crisis.

A law allowing assisted suicide for some individuals creates two cohorts of patients, who no longer enjoy equal protection under the law or equal medical care. Assisted suicide is discriminatory, and the basis for discrimination is the patient’s health status. Robin Williams walks into my office saying his life has become unbearable and so he wants to take his life; and I intervene to protect him and get him through the crisis. Then Brittany Maynard walks into my office saying her life has become (or will soon become) unbearable and so she wants to take her life; and not only do I not intervene to prevent her, but I actively engage in helping her to take her own life? These two incompatible approaches to suicide cannot co-exist side-by-side within medicine or mental health care—something will have to give. Suicide is a cry for help, not a desire to die—and physicians should continue to treat it accordingly.

I strongly urge you to consider these public health issues and vote against SB 128.

Sincerely,

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