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End the Patient's Pain Instead of the Patient:
Focusing on Palliative Care Simultaneously with the Rise of Legalized Physician-Assisted
Suicide
Sheena Shah*

I. Introduction

There is a necessity for accompanying access to physician-assisted suicide with improvements in palliative care. Improving palliative care is particularly urgent in states that have legalized physician-assisted suicide. Physician-assisted suicide allows an ill patient to end his life with a lethal prescription prescribed by a physician. Palliative care is care for an ill patient to relieve his suffering, usually near the end of his life. Increasing palliative care in states may lead to a decrease in the overall use of physician-assisted suicide. It would also lead to many other benefits such as helping patients to treat mental illnesses, increase his quality of life, and effectively navigate his goals of care.

Physician-assisted suicide occurs when a mentally competent patient chooses to end his life by self-ingesting a lethal prescription prescribed by a physician.¹ California resident Brittany Maynard, who ended her life on November 1, 2014, refueled the debate on the legalization of physician-assisted suicides. Brittany Maynard was twenty-nine years old when she finally visited her physician after suffering from major headaches.² After months of various testing and doctor consultations, she was diagnosed with brain cancer, something that she had never imagined.³

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¹ Katherine A. Chamberlain, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61, 61 (2009).

² See Brittany Maynard, *My Right to Death with Dignity at 29*, CNN (Nov. 2, 2014, 10:44 PM), <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/>.

³ *Id.*

This was tragic news, especially for a newly married twenty-nine year old trying to start a family.⁴ Brittany thought she had her whole life ahead of her and the doctor’s devastating news crushed her dreams. As time went on, her condition worsened and her physician told her that she had less than six months to live.⁵ Brittany was about to undergo brain radiation, but when she researched the side effects, she was horrified. She knew that her quality of life would never be the same.⁶ She talked over the options with her family and realized that “there [was] no treatment that would save [her] life, and the recommended treatments would have destroyed the time [she] had left.”⁷ As Brittany was considering her options, she started to look into physician-assisted suicide.⁸ If Brittany lived in Oregon, a state that has legalized physician-assisted suicide, she could obtain a lethal prescription from a physician and self-ingest the drug to end her life.⁹ This option is for qualified individuals who are mentally competent and terminally ill with a diagnosis of less than six months to live.¹⁰

Brittany knew that this was the option for her; although she was only twenty-nine years old, she knew her quality of life was diminished forever, and she wanted to end her life.¹¹ The only problem with her plan was that California had not legalized physician-assisted suicide. As a result, Brittany uprooted her whole life to Oregon, where she could terminate her life legally under the

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ Maynard, *supra* note 2.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

physician-assisted suicide law there.¹² She wanted to die on her own terms and California was not a state that would let her do that in the manner she wished.¹³ Brittany stated:

I would not tell anyone else that he or she should choose death with dignity. My question is: Who has the right to tell me that I don't deserve this choice? That I deserve to suffer for weeks or months in tremendous amounts of physical and emotional pain? Why should anyone have the right to make that choice for me?¹⁴

Brittany knew that she wanted to end her life surrounded by those that she loved and became an advocate for California to make physician-assisted suicide a choice for all.¹⁵ Brittany Maynard chose to end her life in November 2014.¹⁶

Brittany's story grabbed the attention of many people, and her YouTube video currently has over eleven million views.¹⁷ She has fueled a nationwide debate and over twenty states have introduced legislation reconsidering policies on physician-assisted suicide.¹⁸ Most recently, on October 5, 2015, Governor Jerry Brown signed legislation regarding physician-assisted suicide in California, joining four other states that do not criminalize physician-assisted suicide.¹⁹ Governor Jerry Brown had a tough decision to make and, after giving it a lot of thought, he realized that this is an option that should be available to all qualified patients.²⁰ Brittany's story has influenced

¹² *Id.* Brittany had to make many changes that others may not have had the ability to make: she had to become a resident of Oregon, purchase a new home, change her license and voter registration to Oregon, obtain new physicians, and more. *Id.*

¹³ *Id.*

¹⁴ Maynard, *supra* note 2.

¹⁵ *Id.*

¹⁶ *Id.* ("Having this choice at the end of my life has become incredibly important. It has given me a sense of peace during a tumultuous time that otherwise would be dominated by fear, uncertainty and pain.")

¹⁷ See Dennis Thompson, *Did Brittany Maynard Change Minds About Right-to-Die Laws?*, CBS NEWS (Dec. 5, 2014, 11:59 AM), <http://www.cbsnews.com/news/brittany-maynard-poll-right-to-die-laws>.

¹⁸ *Id.*

¹⁹ See April Dembosky, *California Governor Signs Landmark Right-to-Die Law*, NPS (Oct. 5, 2015, 5:06 PM); <http://www.npr.org/sections/health-shots/2015/10/05/446107800/california-governor-signs-landmark-right-to-die-law>. (The other states that allow for physician-assisted suicides are Oregon, Washington, Montana and Vermont. New Mexico's Supreme Court is currently hearing the case after an appeal from a previous ruling that physician-assisted suicides were going to be allowed by the State.)

²⁰ *Id.*

many people across the nation and she will forever be remembered for allowing others to make the choice that she could not make in California.

This note considers the current state of physician-assisted suicides and palliative care, specifically in California. Patients that currently consider physician-assisted suicide are more likely to suffer from a mental illness and may not have thoroughly explored all of their options. Part II explains the background of physician-assisted suicide. Part III analyzes California's recent legislation, the End of Life Option Act. Part IV examines palliative care as a measure for patients considering physician-assisted suicide. Part V argues for decreased physician-assisted suicide by increasing the amount of palliative care available and accessible to patients. Part VI examines national palliative care measures that are being implemented. Part VII specifically looks at California's palliative care measures with recommendations for improvement. Palliative care provides patients with a better quality of life and makes them less likely to end their life prematurely with a physician-assisted suicide.

II. Background

Traditionally, most states banned physician-assisted suicide to preserve human life.²¹ In *Cruzan v. Director, Missouri Department of Health*, Justice Scalia noted that case law around the mid-1800s indicated that assisting suicide was a criminal offense.²² Majority of states at the time had laws prohibiting assisted suicide.²³ However, there have been many medical developments over the years that allow death to be perceived differently.²⁴ The attitude towards death, especially when faced with terminal illnesses, is not the same as it once was. “[C]hanging attitudes about end-of-life care have caused some states to amend or enact laws that meet the varying needs of

²¹ *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997).

²² *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 294–95 (1990) (Scalia, J., concurring).

²³ See Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQUESNE L. REV. 1, 76 (1985).

²⁴ See *id.* at 716.

particular patients, such as ‘dignity and independence,’ including laws that allow patients to have living wills or to refuse life-sustaining medical treatment.”²⁵

In 1997, the Supreme Court held that although there is a right to refuse life-sustaining medical treatment, there is no fundamental right to physician-assisted suicide.²⁶ In the landmark case of *Washington v. Glucksberg*, three doctors wanted to invalidate the Washington statute that criminalized physician-assisted suicide as a violation of the Due Process Clause of the Fourteenth Amendment.²⁷ However, the statute was held to be valid under the Due Process Clause because it was “reasonably related” to the state’s interest.²⁸ The Supreme Court stated, “[t]he experimentation that should be out of the question in constitutional adjudication displacing legislative judgments is entirely proper, as well as highly desirable, when the legislative power addresses an emerging issue like assisted suicide.”²⁹ States can regulate this area of the law; some states have already legalized physician-assisted suicide by statute or case law while others have banned it.³⁰

Alongside *Washington v. Glucksberg*, *Vacco v. Quill* was also argued in the Supreme Court.³¹ This case reaffirmed that there is no right in the Constitution for physician-assisted suicide.³² Several public officials and terminally ill patients brought a suit to invalidate the New York statute that criminalized physician-assisted suicide, but this time under the Equal Protection Clause of the

²⁵ Chamberlain, *supra* note 1, at 64.

²⁶ *Glucksberg*, 521 U.S. at 702 (holding that the liberty interest found in the due process clause cannot be extended to cover the right for physician-assisted suicide).

²⁷ *Id.* at 705–07.

²⁸ *Id.* at 735. The tier of review used in this case was rational basis because there is no fundamental right to a physician-assisted suicide. The government has a legitimate interest to preserve human life and the statute was a rational means of accomplishing this interest. *Id.* at 728.

²⁹ *Glucksberg*, 521 U.S. at 789.

³⁰ Compare *Baxter v. State*, 224 P.3d 1211 (Mont. 2009) (holding that under the state Constitution, consent to physician-assisted suicide consists of a statutory defense to a charge of homicide) with *Krishcer v. McIver*, 697 So.2d 97, 100 (Fla. 1997) (holding that Florida’s interests outweighed the plaintiff’s interest and the court would not disturb the legislature’s stance on opposing physician-assisted suicide).

³¹ *Vacco v. Quill*, 521 U.S. 793, 793 (1997).

³² *Id.*

Fourteenth Amendment.³³ The plaintiffs argued that refusing life-sustaining medical treatment was essentially the same thing as allowing physician-assisted suicide and should receive equal protection, but the Court did not agree.³⁴ States can make physician-assisted suicide illegal without violating the Equal Protection Clause as well.³⁵ With both *Washington v. Glucksberg* and *Vacco v. Quill*, the Court found that there is no fundamental right to a physician-assisted suicide but states are free to legalize or illegalize them. The states that do not criminalize physician-assisted suicides include Oregon, Washington, Montana, and Vermont.³⁶

The pioneer state to implement physician-assisted suicide was Oregon. Oregon legalized physician-assisted suicide with the Death with Dignity Act in 1997.³⁷ There are a list of requirements that must be met before a patient can qualify for the lethal prescription. If the requirements are not met, the conduct is illegal and physicians can be held liable.³⁸ The biggest advocate for physician-assisted suicide was and continues to be a non-profit organization called Compassion & Choices.³⁹ Washington was the next state to follow Oregon's lead and enacted its Death with Dignity Act in 2008, which was closely modeled after Oregon's statute.⁴⁰

Both pieces of legislation allow for a physician to prescribe lethal medication to a terminally ill patient.⁴¹ The adult patient must be a resident of the state.⁴² The patient seeking this prescription

³³ *Id.* at 797–98.

³⁴ *Id.* at 800 (“Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide.”).

³⁵ *Id.* at 793.

³⁶ See Dembosky, *supra* note 19.

³⁷ See Oregon Death with Dignity Act § 2.01, Or. Rev. Stat. § 127.805 (West 2015).

³⁸ See Katherine Ann Wingfield, *Physician-Assisted Suicide: An Assessment and Comparison of Statutory Approaches among the States*, 32 SETON HALL LEGIS. J. 13, 48 (2007).

³⁹ *Timeline*, COMPASSION & CHOICES, <https://www.compassionandchoices.org/who-we-are/timeline/> (last visited Jan. 26, 2016) (Compassion & Choices had its client be the first one to take the lethal medication under Oregon's Death with Dignity Act).

⁴⁰ Wash. Rev. Code Ann. § 70.245.020 (West 2015).

⁴¹ Or. Rev. Stat. § 127.805 (West 2015); Wash. Rev. Code Ann. § 70.245.020 (West 2015).

⁴² Or. Rev. Stat. § 127.860 (West 2015); Wash. Rev. Code Ann. § 70.245.130 (West 2015).

must have a prognosis of six months or less to live.⁴³ The patient must be mentally capable of making this decision on a voluntary and informed basis.⁴⁴ He must also be aware of the alternatives and the probable result of taking the medication.⁴⁵ The patient must make written and oral requests for the medication with witnesses present.⁴⁶ If the patient chooses to take the medication, he must self-ingest it.⁴⁷ Both statutes call for annual reporting to monitor patients that request the medication.⁴⁸

Montana has not made physician-assisted suicide legal through statute but court decisions have held that it is not against public policy to allow it.⁴⁹ The Supreme Court has allowed for physician-assisted suicide but the legislature has not said anything about the practice and thus, there is uncertainty of the outcome for people seeking to end their life with a physician-assisted suicide in Montana.⁵⁰ In 2013, Vermont passed the Patient Choice at the End of Life Act, which legalized physician-assisted suicide and closely follows Oregon's Death with Dignity Act.⁵¹

In 2015, after the tragic story of Brittany Maynard, California passed the End of Life Option Act and became the latest state to recognize physician-assisted suicide. Governor Brown signed the highly-contested bill after giving it much thought. He stated, "I do not know what I would do if I were dying and in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to

⁴³ *Id.* (defining "terminal disease" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, product death within six months").

⁴⁴ Or. Rev. Stat. § 127.800(3) (West 2015); Wash. Rev. Code Ann. § 70.245.010(3) (West 2015).

⁴⁵ Or. Rev. Stat. § 127.815(1)(c)(A)-(E) (West 2015); Wash. Rev. Code Ann. § 70.245.010(7)(a)-(e) (West 2015).

⁴⁶ Or. Rev. Stat. § 127.810 (West 2015); Wash. Rev. Code Ann. § 70.245.030(1) (West 2015).

⁴⁷ Or. Rev. Stat. § 127.845 (West 2015); Wash. Rev. Code Ann. § 70.245.100 (West 2015).

⁴⁸ See Andrew I. Batavia, *So Far So Good: Observations on the First Year of Oregon's Death with Dignity Act*, 6 PSYCHOL. PUB. POL'Y & L. 291, 294-95 (June 2009).

⁴⁹ See Baxter, 224 P.3d at 1222 (holding that physician-assisted suicides are not against the state's public policy and would not be criminalized).

⁵⁰ See Browne C. Lewis, *A Graceful Exit: Redefining Terminal to Expand Availability of Physician-Facilitated Suicide*, 91 OR. L. REV. 457, 465 (2012).

⁵¹ See Vt. Stat. Ann. tit. 18, § 5283 (West 2015).

others.”⁵² California had previously tried to pass legislation called “Proposition 161” in 1992, but failed due to receiving only forty-six percent of the popular vote.⁵³ In its history, California had eight unsuccessful previous attempts at legalizing physician-assisted suicide.⁵⁴ The amended bill, SB 128, was passed to allow an adult with a terminally ill prognosis to request the lethal prescription and end his life.⁵⁵ The bill establishes the guidelines and procedures for when the adult makes this request to his physician.⁵⁶

III. Analysis of California’s End of Life Option Act

California’s End of Life Option Act is largely modeled after Oregon’s Death with Dignity Act. There are many requirements with which an individual must comply in order to be eligible for the doctor-prescribed suicide.⁵⁷ The bill defines many important terms that help to clarify the provisions.⁵⁸ Some important requirements are that the individual must be a resident,⁵⁹ make two oral requests for the lethal prescription that are fifteen days apart, and make a written request that is signed by witnesses.⁶⁰ If the attending physician agrees that the patient is qualified and

⁵² Memorandum from Governor Edmund Brown for California State Assembly, *available at* https://www.gov.ca.gov/docs/ABX2_15_Signing_Message.pdf.

⁵³ See Antonios P. Tsarouhas, *The Case Against Legal Assisted Suicide*, 20 OHIO N.U. L. REV. 793, 797 (1993).

⁵⁴ See Bill Analysis of End of Life Option Act, S. 128, (Cal. 2015).

⁵⁵ End of Life Option Act, S. 128, (Cal. 2015).

⁵⁶ *Id.*

⁵⁷ End of Life Option Act, *supra* note 56, at § 443.2.

⁵⁸ *Id.* at § 443.1. The Act defines “aid-in-dying drug” as a prescribed drug by a physician to a qualified patient who must self-ingest the medication. *Id.* at § 443.1(b). “Capacity to make medical decisions” is defined as an individual who “has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the individual’s manner of communicating, if that person is available.” *Id.* at § 443.1(d). An informed decision means an individual comes to a decision based on knowing and understanding the relevant facts and circumstances. *Id.* at § 443.1(i). The attending physician must make the individual aware of his medical diagnosis, the lethal medication’s risks, the likely result of taking the lethal medication, the fact that the patient has a choice in the matter, and the alternatives can be taken. *Id.* “Terminal disease” is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.” *Id.* at § 443.1(q).

⁵⁹ *Id.* at § 443.2.

⁶⁰ *Id.* at § 443.3.

successfully runs through the checklist of prerequisites that must be completed,⁶¹ the patient becomes eligible for the self-ingesting medication. If a physician complies with all the necessary requirements of the statute in good faith, he cannot be held civilly or criminally liable.⁶²

Although California's new piece of legislation resembles Oregon's Death with Dignity Act, there are a few notable differences. California's End of Life Option Act will have to be reconsidered in the future, does not allow insurance carriers to include information about the lethal prescription in letters denying treatment to patients, and requires physicians to privately consult with their patients about the alternatives.

The End of Life Option Act will have to be approved again in ten years.⁶³ The ten-year window will allow California to gather information and data as to the implementation and efficiency of legalized physician-assisted suicide in California. This data will be useful to the citizens of the state and the legislature. Also, by requiring an approval again in a decade, there is a guarantee that the discussion regarding physician-assisted suicide will arise again.

In 2008, Oregon received a lot of criticism for physician-assisted suicide because of the story of Barbara Wagner.⁶⁴ Barbara was suffering from lung cancer and was running out of hope; she had learned that her cancer would kill her soon.⁶⁵ Her last chance of survival, for at least some more time, was a medication with a \$4000 monthly cost.⁶⁶ However, her insurance company, the Oregon Health Plan, denied her this treatment and instead offered to cover the cost of the lethal

⁶¹ *Id.* at § 443.5.

⁶² *Id.* at § 443.14.

⁶³ See Assisted Suicide Bill in California Heads to Governor for Signature, JDJOURNAL (Oct. 14, 2015), <http://www.jdjjournal.com/2015/09/14/assisted-suicide-bill-in-california-heads-to-governor-for-signature/>.

⁶⁴ See Susan Donaldson James, *Death Drugs Cause Uproar in Oregon*, ABC NEWS (Aug. 6, 2008), <http://abcnews.go.com/Health/story?id=5517492&page=1>.

⁶⁵ *Id.*

⁶⁶ *Id.*

prescription that would be available as an alternate route.⁶⁷ Barbara stated, “It was horrible. I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won’t give you the medication to live.”⁶⁸ California has learned from the uproar that this caused among the nation. The End of Life Option Act has a provision stating that insurance carriers are not permitted to include information about the availability of the lethal prescription in a letter denying treatment to a patient.⁶⁹ Although Oregon no longer offers the lethal medication as an alternative when other methods of treatment are denied, California has codified this measure to safeguard against part of the problem. However, California’s legislation still does not address the underlying issue that for some people, the lethal medication may be the only affordable option for them because life-savings drugs are costly.

Additionally, physicians will be responsible for privately discussing all the options and alternatives that a patient has when considering a physician-assisted suicide.⁷⁰ This is important because the patient must make a purely voluntary decision that is well-informed by knowing all the alternative routes that can be pursued. The physician must make sure that the patient is not coerced into making a decision. The bill explicitly penalizes anyone for “knowingly coercing or exerting undue influence” on the patient to request the lethal medication for a physician-assisted suicide.⁷¹ However, there may be some subtle coercion from the patient’s family and/or friends that does not fall under categories of coercion or undue influence because it is not illegal for others to encourage, advise, or suggest the patient to request the medication.⁷² Thus, the patient may be

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ End of Life Option Act, *supra* note 56, at § 443.13(c).

⁷⁰ See Or. Rev. Stat. § 127.800 (12).

⁷¹ End of Life Option Act, *supra* note 56, at § 443.14 (b).

⁷² *Analysis 2015 California “End of Life Option Act” SB 128*, PATIENTS RIGHTS COUNCIL, n.8. http://www.patientsrightscouncil.org/site/analysis-2015-california-end-of-life-option-act-sb-128/#_edn2 (“For example: ‘coercion’ generally means imposing one’s will on another by means of force or threats and ‘undue

subtly influenced by external factors when considering his decision to request the lethal medication. The added provision that the doctor must privately speak with the patient is a safeguard that may help to alleviate this problem. The patient and physician will have the opportunity to speak openly with each other while the patient can share any questions or concerns he may have in private with his physician. The physician can walk through all the options available for the alternatives with the patient, such as hospice and palliative care.⁷³

IV. Palliative Care as an Alternative Measure to Patients

Palliative care is the care of a sick patient that focuses on relieving a patient's suffering and improving his quality of life, especially as he nears the end of his life.⁷⁴ This is done by focusing on pain relief and symptom control.⁷⁵ It is "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care involves addressing physical, intellectual, emotional, social, and spiritual needs and, to facilitate patient autonomy, access to information and choice."⁷⁶ The patient is "provided with access to symptom relief and pain management, counseling, and emotional and material support, such as housekeeping."⁷⁷

Palliative care is mentioned in California's End of Life Option Act a few times and is something that is expressly mentioned in the written request for the lethal prescription that the patient must sign.⁷⁸ The patient must attest that he has been fully informed of the potential and

influence' includes such activities as controlling the necessities of life such as medication, access to information, interaction with others or access to sleep.").

⁷³ End of Life Option Act, *supra* note 56, at § 443.5.

⁷⁴ See Laura P. Gelfman & Diane E. Meier, *Making the Case for Palliative Care: An Opportunity for Health Care Reform*, 8 J. HEALTH & BIOMED L. 57, 58 (2012) ("The primary focus of palliative care is to improve the quality of life for patients and their families, with an emphasis on the needs and goals of the patient and family, independent of prognosis.").

⁷⁵ See *id.*

⁷⁶ See Comments to Author of End of Life Option Act, S. 128, at 10 (Cal. 2015).

⁷⁷ See Symposium, *Regulation and Reimbursement: Economic Parameters of End-of-Life Care: Some Policy Implications in an Era of Health Care Reform*, 31 W. NEW ENG. L. REV. 305, 311 (2009).

⁷⁸ End of Life Option Act, *supra* note 56, at § 443.11(a).

additional treatment options that include palliative and hospice care.⁷⁹ The physician must make sure that the patient is aware of his options.⁸⁰ The passage of California's law creates renewed urgencies to the issue of palliative care.

This care is critical, especially for patients considering physician-assisted suicide. Justice O'Connor's concurrence in *Washington v. Glucksberg* suggested that there may be a right to palliative care rooted in the Fourteenth Amendment if the facts indicate that a state's laws "obstruct the provision of adequate palliative care, especially for the alleviation of pain and other physical symptoms of people facing death."⁸¹ Thirty-three percent of hospitals nationally still do not offer any palliative care services to its patients,⁸² including patients considering physician-assisted suicide.

Hospice care is a specific type of palliative care that is focused on patients with a short prognosis.⁸³ Usually when a patient decides to enroll in hospice care, there are a few weeks or months left in the patient's life.⁸⁴ The prognosis is a determining factor as to what care will be received, since to currently be eligible for hospice care, a patient must be terminally ill with six months or less to live if the disease is on its natural course,⁸⁵ a prognosis that is also necessary to be eligible to receive the lethal prescription for physician-assisted suicide. Because this type of palliative care limits a lot of patients who do not have a prognosis that fits the necessary criteria,

⁷⁹ *Id.*

⁸⁰ *Id.* at § 443.5(a)(1)(E).

⁸¹ Symposium, *supra* note 78, at 309 (citing Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1234 (1997); *Glucksberg*, 521 U.S. at 742 (O'Connor, J., concurring)).

⁸² *America's Care of Serious Illness, A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*, CENTER TO ADVANCE PALLIATIVE CARE (2015), <https://reportcard.capc.org/wp-content/uploads/2015/08/CAPC-Report-Card-2015.pdf>.

⁸³ See R. Sean Morrison & Diane E. Meier, *Palliative Care*, 350 NEW ENG. J. MED. 2582, 2583 (2004).

⁸⁴ *Id.* (explaining that when a patient's condition worsens, a cost versus benefit analysis may be more important to engage in to examine different available treatment options).

⁸⁵ See John J. Mahoney, *The Medicare Hospice Benefit – 15 Years of Success*, 1 J. PALLIATIVE MED. 139, 141 (1998).

non-hospice palliative care has grown immensely.⁸⁶ After giving a terminally ill prognosis, a physician usually refers the patient to hospice care, although referrals can also be done by the family or the patients themselves in some circumstances.⁸⁷ Hospice care usually starts within two days of a referral.⁸⁸ After discussions with the patient and his family, a hospice nurse creates a fully developed plan of care for the patient that takes into account everyone's needs.⁸⁹ Hospice care can usually be provided in a variety of locations including the patient's home, hospice facilities, nursing homes, and hospitals.⁹⁰

A 2012 study done by the Center to Advance Palliative Care and National Palliative Care Research Center concluded that there is a higher correlation between larger hospitals and having a palliative care team.⁹¹ However, this does not address the smaller hospitals and how they still need palliative care teams but do not have the resources.⁹² "Many programs remain too understaffed and under-resourced to reach all the patients in need."⁹³ Additionally, for-profit hospitals, on average, have lower rates of palliative care service to patients in comparison to nonprofit hospitals.⁹⁴

V. Increased Palliative Care May Lead to Decreased Physician-Assisted Suicides

⁸⁶ See Diane E. Meier et al., *America's Care of Serious Illness, A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*, 14 J. PALLIATIVE MED. 1094, 1095 (2008), <http://reportcard-live.capc.stackop.com/pdf/state-by-state-report-card.pdf>.

⁸⁷ Comments to Author, *supra* note 77, at 10.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ See Symposium, *supra* note 78, at 311.

⁹¹ Comments to Author, *supra* note 77, at 10 ("More than 81% of hospitals in the U.S. with more than 300 beds have a palliative care team, while less than one-quarter of hospitals with fewer than 50 beds reported having a palliative care team.")

⁹² *America's Care of Serious Illness*, *supra* note 83 ("Availability is highly variable by region and by state. Even in those hospitals that report palliative care services, only a small fraction of the patients that could benefit receive palliative care.")

⁹³ *Id.*

⁹⁴ *Id.* (In hospitals with more than fifty beds, 23 percent of for-profit had palliative care services in comparison to 78 percent of nonprofit hospitals and in hospitals with more than 300 beds, the services were 54 percent for for-profit and 94 percent for nonprofit.)

The legalization of physician-assisted suicide does not undermine palliative care since both are alternatives that can co-exist with each other. “Assisting death in no way precludes giving the best palliative care possible but rather integrates compassionate care and respect for the patient’s autonomy and ultimately makes death with dignity a real option.”⁹⁵ The rise of physician-assisted suicide has contributed to a rise in palliative care. The National Hospice and Palliative Care Organization noted a growth from 2312 to 5800 in the number of hospice providers between 1994 and 2013.⁹⁶ In 2013, the median duration for patients to receive hospice care was around eighteen days.⁹⁷ Additionally, the Center to Advance Palliative Care has reported that hospitals with over fifty beds with palliative care programs grew from about twenty-five percent to about seventy-two percent between 2000 and 2013.⁹⁸ Continuing to increase palliative care can lead to a decreased amount of physician-assisted suicides.

Palliative care is one of the alternatives that must be discussed by a physician with the patient before a final decision is made about physician-assisted suicide. When this conversation occurs, there are important benefits to both parties because it facilitates an open discussion.⁹⁹ Oregon’s legalization of physician-assisted suicide has brought more awareness to palliative care and there has been a substantial qualitative and quantitative increase in the palliative care that is available to patients.¹⁰⁰ Oregon’s data shows that, in 2014, ninety-three percent of patients who took the lethal

⁹⁵ GERRIT KIMSMA & EVERT VAN LEEUWEN, *Assisted Death in the Netherlands: Physician at the Bedside when Help is Requested*, in *PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE & PATIENT CHOICE* 221 (Timothy E. Quill & Margaret P. Battin eds., 2004).

⁹⁶ See Nat’l Hospice & Palliative Care Org., *NHCPO FACTS AND FIGURES: HOSPICE CARE IN AM.* 8, 10 (2014).

⁹⁷ *Id.*

⁹⁸ See Charlotte Huff, *End-of-Life Care: The Growing Role of PCPs*, MODERNMEDICINE NETWORK (Nov. 10, 2015), <http://medicaleconomics.modernmedicine.com/medical-economics/news/end-life-care-growing-role-pcps?page=0%2C1>; but see *America’s Care of Serious Illness*, *supra* note 83 (noting that in 2015, thirty-three percent of hospitals with over fifty beds reported no palliative care teams offered in the hospital).

⁹⁹ See Dale G. Larson & Daniel R. Tobin, *End-of-Life Conversations: Evolving Practice and Theory*, 248 J. AM. MED. ASS’N 1573, 1576–77 (2000).

¹⁰⁰ See Kathryn L. Tucker, *Choice at the End of Life: Lessons from Oregon Constitution*, AM. SOC’Y FOR LAW & POLICY 9 (2008), <http://www.acslaw.org/files/Kathryn%20L.%20Tucker%20Issue%20Brief.pdf>.

prescription were enrolled in hospice care either when the prescription was written or when it was taken.¹⁰¹ However, in Oregon, it has been noted that patients are not fully aware of their choices and often misunderstood their options.¹⁰² “[A] significant proportion of outpatients surveyed in Oregon appears to misunderstand patients’ options in end-of-life care.”¹⁰³ Thus, although ninety-three percent of patients were enrolled in hospice care, the patient may not be making an informed decision and not fully understanding the benefits of palliative and hospice care.

Mental illness plays a huge factor when a patient is considering physician-assisted suicide.¹⁰⁴ “Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated.”¹⁰⁵ Last year, under Oregon’s law, only three out of the 105 patients that used the lethal prescription to cause their death were referred for psychiatric or psychological evaluation.¹⁰⁶ This means that less than three percent actually underwent an evaluation, although mental illness has proven to be commonplace among patients who choose to end their life with a physician-assisted suicide. Thus, physicians did not diagnose or treat mental illness in most of their patients. The End of Life Option Act attempts to address this issue by requiring a mental health specialist assessment if the physician finds signs of a mental disorder in the patient.¹⁰⁷ Once this referral is made, a lethal prescription cannot be given to the patient until the mental health specialist clears

¹⁰¹ See 2014 REPORT ON OREGON’S DEATH WITH DIGNITY ACT, Oregon Public Health Division (Feb. 12, 2015), <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>.

¹⁰² See Maria Silveira et al., *Patient’s Knowledge of Options at the End of Life: Ignorance in the Face of Death*, 248 J. AM. MED. ASS’N 2483, 2487 (2000).

¹⁰³ *Id.*

¹⁰⁴ Herbert Hendin, *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH* 34–35 (W.W. Norton 1998).

¹⁰⁵ See *id.*; Barraclough, Bunch, Nelson, & Salisbury, *A Hundred Cases of Suicide: Clinical Aspects*, 125 BRIT. J. PSYCHIATRY 355, 356 (1976); see also *Washington v. Glucksberg*, 521 U.S. 702, 730 (1997) (“Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.”).

¹⁰⁶ See 2014 REPORT ON OREGON’S DEATH WITH DIGNITY ACT, *supra* note 102.

¹⁰⁷ End of Life Option Act, *supra* note 56, at § 443.5 (a)(1)(A)(ii).

the patient for having the capacity to make medical decisions and does not have an impaired judgment from the mental disorder.¹⁰⁸ Although California’s legislation purports to deal with mental disorders facially, it does not sufficiently protect patients that suffer from mental illnesses. A safeguard is not put in place to make sure that a patient has a psychiatric evaluation before choosing to end his life with a physician-assisted suicide. Additionally, a safeguard is not put in place to ensure that physicians are well trained to look for signs of mental illness. The problem is that the physician must find indicators of a mental disorder and often are not properly trained to do find these signals. These safeguards would result in ensuring that a patient choosing a physician-assisted suicide came to that conclusion without having a mental illness affect his decision.

When patients considering physician-assisted suicides “are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears.”¹⁰⁹ Palliative care can provide methods against mental illness by increasing the patient’s quality of life and relieving patient suffering.¹¹⁰ In fact, palliative care may extend a terminally ill patient’s life.¹¹¹ Palliative care may reduce the need for a patient to undergo a psychiatric evaluation because it provides a different kind of care. It is a different kind of care that is not seen when a doctor writes a lethal prescription for a patient who he may have met that week. When patients speak with their physician about the several options for end-of-life care, they are more likely to choose “less aggressive treatment” which includes palliative or hospice care that would allow for an increased

¹⁰⁸ End of Life Option Act, *supra* note 56, at § 443.5 (a)(1)(A)(iii); § 443.8.

¹⁰⁹ Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1625–26 (2008).

¹¹⁰ Katherine B. Ledden, *A Nudge in the Right Direction with a Stick the Size of CMS: Physician-Patient Communication at the End of Life*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 389, 393 (2013).

¹¹¹ *Id.* at 394.

quality of life and perhaps a longer life.¹¹² A study done on lung cancer patients who received palliative care early revealed that such patients lived for an average of two months longer than expected.¹¹³ These patients also had “clinically meaningful improvements in quality of life and mood.”¹¹⁴ The importance of considering palliative care cannot be underestimated because of the powerful effect it has on patients.

Patients must be educated and informed about their choices. Informed specialists, such as certified hospice nurses, are specially trained in patient education.¹¹⁵ They are sensitive to the patient’s needs and can understand and gauge how the patient absorbs information that will be used to make this vital decision.¹¹⁶ Patients that engaged in end-of-life conversations with their physicians obtained less aggressive medical care and had a higher probability of receiving hospice services for over a week.¹¹⁷ Hospice care was associated with improved quality of life—not only for the patient, but also for the patient’s caregiver—as the patient’s death approached.¹¹⁸ “[P]alliative care teams improve physical and psychological symptoms, caregiver well being, and family satisfaction.”¹¹⁹ This may reduce an individual’s desire to go through a physician-assisted suicide.

¹¹² See Jennifer W. Mack et al., *End-of-Life Care Discussions Among Patients With Advanced Cancer*, 156 ANNALS INTERNAL MED. 204, 204-07 (2012).

¹¹³ See Jennifer S. Temel et al., *Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer*, 363 NEW ENG. J. MED. 733, 739 (2010).

¹¹⁴ *Id.*

¹¹⁵ See Donald E. Spencer, *Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment*, 18 SEATTLE UNIV. L. REV. 545, 546 (1995).

¹¹⁶ *Id.*

¹¹⁷ See Alexi A. Wright et al., *Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment*, 300 J. AM. MED. ASS’N 1665, 1670–71 (2008).

¹¹⁸ See *id.* See also Nicholas A. Christakis & Theodore J. Iwashyna, *The Health Impact of Health Care on Families: A Matched Cohort Study of Hospice Use by Decedents and Mortality Outcomes in Surviving, Widowed Spouses*, 57 SOC. SCI. & MED. 465, 472 (2003).

¹¹⁹ Laura P. Gelfman et al., *Making the Case for Palliative Care: An Opportunity for Health Care Reform*, 8 J. HEALTH & BIOMED L. 57, 60–61 (2012).

A patient that elects to undergo palliative care will also be facing a cost reduction. Although palliative care is not cheaper than acquiring a one-time fee for a lethal prescription, it is cheaper than receiving more aggressive medical treatment in the future.¹²⁰ “Such cost savings can be attributed to the change in trajectory that a palliative care consultation creates in a systematic, ‘avert death at all costs’ hospital environment.”¹²¹ Not only does palliative care avoid the problem of having patients obtain care in critical emergencies that can rack up medical bills quickly, but palliative care also reduces costs by addressing the patient’s care goals and helping the patient choose which treatment option best fits within those goals.¹²² This type of care has the effect of reducing costs that would be subsequently incurred by the patient, such as “preventable hospitalizations, readmissions, and emergency department visits.”¹²³ Patients are likely to go to the palliative care programs that most hospitals have in place instead of being placed in a costly intensive care unit.¹²⁴

VI. National Palliative Care Measures

Palliative care should be made easily available and accessible to patients. Medicare, a government agency for elders that provides medical insurance, has hospice coverage for those that are over sixty-five years old and qualified.¹²⁵ The hospice coverage includes: “physician and nursing care for the relief of symptoms and for pain management; medical appliances, equipment,

¹²⁰ See Joan D. Penrod et al., *Hospital-Based Palliative Care Consultation: Effects on Hospital Cost*, 13 J. PALLIATIVE MED. 973, 976 (2010) (finding “palliative care during hospitalizations was associated with significantly lower direct hospital costs”).

¹²¹ Ledden, *supra* note 111, at 394.

¹²² See Gelfman et al., *supra* note 120, at 61; AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, MED. EXPENDITURE PANEL SURVEY: THE CONCENTRATION AND PERSISTENCE IN THE LEVEL OF HEALTH EXPENDITURES OVER TIME: ESTIMATES FOR THE U.S. POPULATION, 2008–2009 http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.pdf.

¹²³ Gelfman et al., *supra* note 120, at 65.

¹²⁴ *See id.*

¹²⁵ See MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: NEW APPROACHES IN MEDICARE 140-41 (2004), available at [http://www.medpac.gov/documents/June04 Entire Report.pdf](http://www.medpac.gov/documents/June04%20Entire%20Report.pdf).

and supplies; outpatient drugs for symptom management; and pain relief.”¹²⁶ Medicare has covered hospice care for over thirty years now.¹²⁷ It has become one of the main sources of payment given for hospice services and in 2013, 87.2 percent of hospice patients had Medicare coverage.¹²⁸ Thus, there is a huge incentive to make sure that Medicare provides high-quality palliative and hospice care services for its patients.

The patient must have less than six months to live in order to use Medicare for hospice benefits.¹²⁹ A patient in need of hospice care may be ineligible simply because his doctor has given a less than six month prognosis.¹³⁰ Medicare should re-evaluate this requirement because a patient may be in serious need of palliative care but lack the necessary six-month prognosis. “The decision about whether to put a patient in hospice care should not be based on unreliable predictions about how long he has left to live but rather on his needs for specialized care, like morphine infusions.”¹³¹ How can a physician determine that a patient who has less than six months to live qualifies for hospice care under Medicare but one who has a prognosis of a day more does not? What if the latter patient needs the palliative care more, especially if he is suffering from a mental illness, such as depression? Having a bright-line rule of six months should be highly indicative but not determinative, as Medicare should be able to look at exceptional patients and their qualifications for palliative care payments on a case-by-case basis.

¹²⁶ Symposium, *supra* note 78, at 312.

¹²⁷ See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, § 121, 96 Stat. 324, 356 (1982) (*amended* by 42 U.S.C. § 1395(d) (2012)).

¹²⁸ See Nat’l Hospice & Palliative Care Org., *supra* note 97, at 10.

¹²⁹ See *id.* at 312 (stating that the patient can use the benefit “essentially indefinitely” if he lives longer than the six months as long as the physician fixes the diagnosis).

¹³⁰ Better, if not Cheaper, Care by Emanuel Ezekiel, N.Y. TIMES, http://opinionator.blogs.nytimes.com/2013/01/03/better-if-not-cheaper-care/?_r=0 (last visited Nov. 15, 2015).

¹³¹ *Id.*

Additionally, the patient must give up any curative treatments in order to take advantage of the hospice benefit through Medicare.¹³² A patient may receive palliative treatment simultaneously with curative treatment but once palliative care becomes hospice care, the Medicare benefits disappear, although Medicare has launched a new beta program for 140 hospice providers to provide concurrent treatment.¹³³ Medicare is currently reconsidering this qualification because a patient ultimately has to consider giving up and accepting the pain and suffering for which he is in hospice care eligibility. These two actions should not be mutually exclusive and will hopefully not remain that way for long.¹³⁴ Because of these requirements, not all patients may receive the palliative care they need under Medicare.¹³⁵ Although there are other non-hospice cares available, the patient may need something more, such as “nursing care, medical social services, physical therapy, counseling, and short-term inpatient care.”¹³⁶

Recently, on October 30, 2015, Medicare announced that it will now reimburse and provide a separate billing code for physicians to conduct end-of-life discussions with patients, starting on January 1, 2016.¹³⁷ Thus, Medicare will compensate doctors for having important conversations that may affect the patient’s life decisions, something that was contemplated but not put into the

¹³² See Tsarouhas, *supra* note 54; but see Melanie Evans, *CMS to Test Concurrent Coverage of Hospice and Curative Care*, MODERN HEALTHCARE (July 20, 2015),

<http://www.modernhealthcare.com/article/20150720/news/150729994> (explaining that the CMS has introduced a limited new program to 140 hospice providers where the patient will not have to give up curative treatments to receive hospice benefits through Medicare. This program will launch in two phases).

¹³³ See Charles F. Von Gunten et al., *Coding and Reimbursement Mechanisms for Physician Services in Hospice and Palliative Care*, 3 J. PALLIATIVE MED. 157, 158 (2000); *America’s Care of Serious Illness*, *supra* note 83. See also Melanie Evans, *CMS to Test Concurrent Coverage of Hospice and Curative Care*, MODERN HEALTHCARE (July 20, 2015, 4:27 PM), <http://www.modernhealthcare.com/article/20150720/NEWS/150729994>.

¹³⁴ See Evans, *supra* note 133 (“Experts have argued that offering both palliative and curative care concurrently improves quality of life and won’t raise costs because patients . . . are more likely to choose hospice care if it doesn’t eliminate opportunities for lifesaving treatment.”).

¹³⁵ *Id.* (“Last year, the CMS said only 44% of Medicare patients use the hospice benefit at the end of life and most use it for only a short period of time.”).

¹³⁶ Kelly Noe et al., *Calls for Reform to the U.S. Hospice System*, 37 AGEING INT’L. 228, 229 (2012).

¹³⁷ See 42 C.F.R. § 405, 410, 411, 414, 425, 495 <https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>.

final version of the Affordable Care Act.¹³⁸ A Centers of Medicare and Medicaid Services (CMS) news release stated, “The rule also finalizes a proposal that will better enable seniors and other Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it.”¹³⁹ The new rule will give patients the comfort of having these essential conversations with the patients and their families by talking through the options and consequences.¹⁴⁰

The rule provides more incentive for physicians to have important conversations with their patients, but there is still more work to be done to make sure patients are well-informed before making a decision about end-of-life care and physician-assisted suicide. Currently, there is a lack of uniform standards and protocols for palliative care in nursing homes and hospitals.¹⁴¹ There is no mandated integration of palliative care and a hospice program in the new delivery and payment model of the Affordable Care Act, which could be an area for improvement.¹⁴²

There are many concerns that a patient will often choose the lethal medication instead of considering palliative care because it can be viewed as the “cheaper” choice.¹⁴³ Although it is true that the medication may cost less than palliative care, which entails having many caretakers and lasts longer than a one-time medication, palliative care should still remain accessible and viable

¹³⁸ See Adam Rubenfire, *Medicare Pay for End-of-Life Planning Adopted by Obama Administration*, MODERN HEALTHCARE (Oct. 30, 2015), <http://www.modernhealthcare.com/article/20151030/NEWS/151039981>.

¹³⁹ CTRS. FOR MEDICARE & MEDICAID SERVS., PROPOSED POLICY, PAYMENT, AND QUALITY PROVISIONS CHANGES TO THE MEDICARE PHYSICIAN FEE SCHEDULE FOR CALENDAR YEAR 2016 (2015) <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-2.html>.

¹⁴⁰ See *id.*

¹⁴¹ H.L. Smits & M. Vladeck, B.C. *Palliative Care: An Opportunity for Medicare*, NEW YORK: INSTITUTE FOR MEDICAL PRACTICE MT. SINAI SCHOOL OF MEDICINE 1, 10 (2000).

¹⁴² Diane E. Meier, *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care*, 89 MILBANK Q. 343, 366 (2011), http://www.milbank.org/uploads/documents/featured-articles/pdf/Milbank_Quarterly_Vol-89_No-3_2011.pdf.

¹⁴³ Leon R. Kass et al., *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 DUQ. L. REV. 395, 406 (1996) (“Because the quick-fix of suicide is easy and cheap, it will in many cases replace the use of hospice and other humanly-engaged forms of palliative care, for there will be much less economic incentive to continue building and supporting social and institutional arrangements for giving humane care to the dying.”).

so that patients, physicians, and health-care providers are not making their decisions based on economics.¹⁴⁴ Studies show that palliative care substantially decreases hospital costs, which is the biggest driver behind health care spending.¹⁴⁵ “Physicians who determine that a patient is a suitable candidate for assisted suicide or euthanasia may be far less inclined to present treatment alternatives, especially if the treatment requires intensive efforts by health care professionals.”¹⁴⁶ There must be better ways to promote palliative care for all parties so that there are no monetary incentives for a physician or health-care provider to advocate a patient to consider physician-assisted suicides. CMS’s new rule to provide compensation for end-of-life discussions is a step in the right direction.

VII. California’s Current Palliative Care Measures and Ways for Improvement

In the Center to Advance Palliative Care’s 2015 Report Card, California received a “B” rating for its palliative care services across the country.¹⁴⁷ There are currently 168 palliative care programs out of the 227 hospitals in California.¹⁴⁸ In 2011, the percentage of hospitals in California with palliative care went from forty-three percent in 2007 to fifty-three percent in 2011.¹⁴⁹ The percentage of public hospitals in the same time frame went from twenty-two percent to seventy-one percent.¹⁵⁰ In 2012, all seventeen of California’s public hospitals had palliative

¹⁴⁴ Ryan T. Anderson, *Physician-Assisted Suicide Corrupts the Practice of Medicine*, HERITAGE FOUND. (Apr. 20, 2015), <http://www.heritage.org/research/reports/2015/03/always-care-never-kill-how-physician-assisted-suicide>.

¹⁴⁵ *America’s Care of Serious Illness*, *supra* note 83.

¹⁴⁶ Anderson, *supra* note 145, n.17 (quoting NEW YORK DEP’T OF HEALTH, TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 124 (1994), https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/).

¹⁴⁷ *America’s Care of Serious Illness*, *supra* note 83. This report card “provides an analysis of whether seriously ill patients in the United States are receiving equitable access to palliative care services in hospitals.” *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ University of California, San Francisco Palliative Care Program et al., *Palliative Care in California: Innovations in Hospital-Based Programs*, CAL. HEALTHCARE FOUND., May 2009, at 15, <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20P/PDF%20PalliativeCareInnovations.pdf>.

¹⁵⁰ *Id.*

care programs.¹⁵¹ “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.”¹⁵² Over the years, as the number of hospitals have increased, the number of palliative care programs have also increased, but the numbers must keep increasing, especially if physician-assisted suicide is offered to patients in California. Additionally, palliative care programs in the home and in nursing homes have not been strongly considered by California. The focus should not be solely on hospitals, since in 2009, sixty percent of deaths happened outside the hospital. This indicates the need to prioritize and emphasize the alternative of palliative care to patients that are considering participating in physician-assisted suicides. The legalization of physician-assisted suicide in California reinforces and promotes the need for the best palliative care possible. In 2012, Governor Jerry Brown created the Let’s Get Healthy California Task Force.¹⁵³ One of the focuses of this Task Force was on palliative care within California.¹⁵⁴ The Task Force raised awareness to the issues faced regarding palliative care and the state decided to make changes.¹⁵⁵ Two years later, California passed legislation that made the Department of Health Care Services (DHCS) create standards and regulations for Medicaid managed-care plans that helped establish palliative care teams.¹⁵⁶ The other states that have legalized physician-assisted suicide on the Pacific Coast, such as Oregon and Washington, received “A” ratings in 2015 for its palliative care services.¹⁵⁷ California has also legalized physician-assisted suicide and improvements to palliative care must now be made as patients consider their options for treatment with a terminally ill prognosis.

¹⁵¹ *Id.*

¹⁵² Comments to Author, *supra* note 77, at 10.

¹⁵³ *America’s Care of Serious Illness*, *supra* note 83.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

A problem that patients may have when considering physician-assisted suicide is clinical depression, and talking to a physician is very important because the depression alone can compromise a patient's voluntary decision.¹⁵⁸ "Almost 80% [of patients] 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."¹⁵⁹ This means that an overwhelming majority of patients have not talked to a physician about end of life wishes and would like to do so. According to the current legislation, there is nothing prohibiting a patient who seeks a physician-assisted suicide to obtain a lethal prescription from another physician if his current physician denies him the prescription.¹⁶⁰ There is no qualification that the attending physician who is responsible for the patient's care must have a certain relationship or be the patient's physician for a certain amount of time. A safeguard that can be implemented against this is to "require a physician who has a long-term physician relationship with the patient and a physician (who may very well be the same physician) with specific training in holistic care of terminally-ill patients. Most proposed safeguards require two medical opinions."¹⁶¹ By allowing "doctor shopping" to occur, a physician will not have the same emotional investment in his patient before prescribing him the lethal prescription.

Currently, in California, the patient must ask for counseling for end-of-life care options and alternatives.¹⁶² "When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall, *upon the patient's request*, provide the patient with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section."¹⁶³ In

¹⁵⁸ See Andrew Benton, Comment, *Personal Autonomy and Physician-Assisted Suicide: The Appropriate Response to a Modern Ethical Dilemma*, 20 OHIO N.U. L. REV. 769, 779 (1994).

¹⁵⁹ Comments to Author, *supra* note 77, at 10.

¹⁶⁰ See generally Bill Analysis, *supra* note 55 (defining "attending physician" as the physician that his primarily responsible for the patient's health care and treatment of the terminal illness).

¹⁶¹ Donald E. Spencer, *Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment*, 18 SEATTLE UNIV. L. REV. 545, 549 (1995).

¹⁶² See Cal. Health & Safety Code § 442.5 (West 2015).

¹⁶³ *Id.* (emphasis added).

California, the health care provider is not required to provide this vital information on counseling unlike other states, such as New York. In New York, the Palliative Care Information Act provides that counseling must be provided to the patient by the health-care provider unless the patient refuses.¹⁶⁴ In order to promote awareness of palliative care, California should adopt New York's measure requiring counseling for patients to improve their accessibility to palliative care because patients may be unaware of this possibility.¹⁶⁵ "[I]t represents a logical extension of existing patient rights to receive information about diagnosis, prognosis, and treatment options while retaining flexibility for health care providers to exercise their professional judgment in a number of ways."¹⁶⁶

The patient-physician communication must not be understated because it adds value to the patient when making a decision regarding the end of his life.¹⁶⁷ Physicians work with patients to come up with treatment plans that reflect the patient's desires.¹⁶⁸ "Those who speak with their physician about end-of-life care are more likely to choose less aggressive treatment, to die at home or in hospice, and to have their treatment preferences followed."¹⁶⁹ The Institute of Medicine (IOM) has stated, as guidelines, that providers should be sensitive when consulting with patients and patients should ask them about questions or concerns they may have.¹⁷⁰ These guidelines, however, are not requirements and physicians have not always adhered to them.¹⁷¹ Physicians

¹⁶⁴ N.Y. Pub. Health Law § 2997-c (West 2015).

¹⁶⁵ See Symposium, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 WHITTIER L. REV. 109, 133 (2011).

¹⁶⁶ *Id.* at 133.

¹⁶⁷ See Eburn Abarshi et al., *Discussing End-of-Life Issues in the Last Months of Life: A Nationwide Study Among General Practitioners*, 14 J. PALLIATIVE MED. 323, 323 (2011).

¹⁶⁸ See *id.*

¹⁶⁹ Ledden, *supra* note 111, at 401.

¹⁷⁰ See Approaching Death: Improving Care at the End of Life 62-63, Comm. On Care at the End of Life, Inst. Of Med. (Marilyn J. Field & Christine K. Cassel eds., 1997).

¹⁷¹ See Mack, *supra* note 113 at 204 (reporting that less than forty percent of patients suffering from advanced cancer had end-of-life discussions with their physicians).

realize the difficult situation the patient is in and discussions may make the patient feel uncertain and worried.¹⁷² Physicians must be adequately prepared—starting from medical school—to deal with tough situations with patients, such as having discussions regarding end-of-life care.

One thing that California, as well as other states, should do is improve its curriculum in medical schools to make sure there is enough training in palliative care before entering the workforce.¹⁷³ After leaving professional schools, there are not enough trained nurses, physicians, and social workers to handle these fragile situations.¹⁷⁴ California State University established the Institute for Palliative Care, which “provides professional development opportunities through online certification programs for nurses, social workers, chaplains and other health professionals to ensure that they have the skills they need to provide high-quality palliative care.”¹⁷⁵ To improve this situation on a national level, the IOM has made the following recommendations: “(1) faculty development; (2) education materials and curriculum development; (3) coordination among training programs for the variety of professionals involved in the care of dying patients; (4) guidelines for residency programs and increased palliative and end-of-life content in licensing and certifying examinations; and (5) improving the research base for palliative care education.”¹⁷⁶ Doctors, nurses, and social workers should be trained in the emotional discussions that may result with patients when discussing end-of-life care.

¹⁷² See *Approaching Death*, *supra* note 171, at 61.

¹⁷³ See Michael J. Malinowski, *Throwing Dirt on Doctor Frankenstein’s Grave: Access to Experimental Treatments at the End of Life*, 65 HASTINGS L.J. 615, 648 (2014) (“The 2001 Institute of Medicine (IOM) report *Improving Palliative Care for Cancer* states that: ‘most new physicians leave medical school and residency program with little training or experience in caring for dying patients.’”).

¹⁷⁴ See *id.*; University of California, *supra* note 150, at 19.

¹⁷⁵ *America’s Care of Serious Illness*, *supra* note 83.

¹⁷⁶ *Id.*

The curriculum regarding pain management and palliative care in medical schools currently contains gaps that must be addressed.¹⁷⁷ There are five public medical schools in California, which means that the state government would be in a position where this issue can be addressed. Although many California medical schools have implemented programs for palliative care, many of the curricular offerings are optional electives.¹⁷⁸ A study done by the California HealthCare Foundation reveals how many people do not have access to palliative care in county hospitals, which is disturbing¹⁷⁹ because these county hospitals may offer physician-assisted suicide as an alternative to patients. Although there has been some integration into the required curriculum, there is still a long way to go, especially in trying to fight the “hidden curriculum” stigma, which can undermine palliative care measures.¹⁸⁰ That is not enough, however, and there must be more safeguards put in place to make sure that patients are receiving the best palliative care, especially if they are considering physician-assisted suicide as an alternative.

VIII. Conclusion

Brittany Maynard’s story has refueled the debate over physician-assisted suicide. California became the most recent state to legalize physician-assisted suicide with its End of Life Option Act, closely modeled after Oregon’s Death with Dignity Act with a few differences and room for improvement. Patients considering physician-assisted suicide should also consider the alternative

¹⁷⁷ See, e.g., J. Andrew Billings et al., *Palliative Care in Undergraduate Medical Education: Status Report and Future Directions*, 278 JAMA 733, 733 (1997); Sidney H. Schnoll et al., *Medical Education for Pain and Addiction: Making Progress Toward Answering a Need*, 22 J. L. MED. & ETHICS 252, 252–54 (1994). See also George E. Dickinson et al., *Death Education in U.S. Medical Schools: 1975–95*, 71 ACAD. MED. 1348, 1349 (1996); David E. Weissman et al., *ACGME Requirements for End-of-Life Training in Selected Residency and Fellowship Programs: A Status Report*, 77 ACAD. MED. 299, 301 (2002).

¹⁷⁸ University of California, *supra* note 150, at 16 (explaining that there are no uniform curriculum or training requirements for social workers, which is being proposed and should be highly considered because physicians are not the only ones dealing with patients during end-of-life care.).

¹⁷⁹ *Id.* at 27.

¹⁸⁰ *Id.*

of palliative care when making their decision. Palliative care is care aimed at improving the patient's quality of life, usually when he is near the end of his life. Unlike physician-assisted suicide, palliative care is more focused on the patient's needs and goals and provides more interaction that may decrease their mental illness. Preserving human life has always been a national goal and increasing palliative care may increase that goal. By increasing the palliative care measures in California and the nation, the overall amount of physician-assisted suicide may decrease.