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Mental Health Referrals in Physician Aid in Dying Laws

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Abstract

Physician aid in dying (PAD) is a practice that has grown in prevalence in the United States in recent years. In fact, of the ten U.S. jurisdictions that now allow capable terminally ill adults to obtain and self-administer medication meant to hasten death, six enacted their respective PAD statutes between 2015 and 2019, with several other states considering bills on this issue. Most jurisdictions that allow PAD have statutory requirements that set forth the steps and criteria for individuals to receive PAD medication. Comparing the different statutes, it is clear that the language used to describe mental health referrals differs between states. One state's protocol requires every patient to meet with a mental health professional at least once, whereas others require referrals under certain circumstances—such as when there are indications of a mental disorder, psychiatric or psychological disorder or depression causing impaired judgment. Additionally, when such a referral is made, the role of the mental health professional is to evaluate an individual in order to confirm eligibility, rather than to provide supportive counseling. With this being said, only one state requires that patients be informed of the availability of supportive counseling. This article examines the PAD statutes' provisions related to mental health referrals in the United States; proposes adopting the same statutory language regarding mental health referrals; and recommends adding guidance for early, continuous supportive counseling for qualified terminally ill patients requesting a medication to hasten their death.

TERMINOLOGY

In the United States, physician aid in dying (PAD) is an end-of-life treatment that allows an individual with a terminal illness to hasten their death through the voluntary self-administration of lethal medication prescribed by a physician at the patient's request.⁽¹⁾ Other terms frequently used to describe PAD include medical aid in dying, aid in dying, physician-assisted death, death with dignity, and physician-assisted suicide.⁽²⁾ Importantly, in the U.S., these terms are distinct from euthanasia, which refers to the active administration of a lethal drug by someone other than the patient. Euthanasia is illegal in the United States.

TIMELINE OF PAD IN THE UNITED STATES

In 1994, Oregon became the first state to legalize PAD when its citizens' initiative, the Oregon Death with Dignity Act (DWDA), was passed by Oregon voters by a margin of 51% in favor and 49% opposed.⁽³⁾ The law did not go into effect immediately due to a legal injunction.

In 1997, the U.S. Supreme Court rendered its landmark decisions in *Vacco v. Quill* and *Washington v. Glucksberg*, two cases that challenged the constitutionality of New York's and Washington's statutes prohibiting PAD.^{(4),(5)} In upholding the laws, the Supreme Court held that there is no fundamental constitutional right to die. Therefore, the individual states could enact legislation permitting or prohibiting PAD as long as the state law was rationally related to legitimate government interests.^{(4),(5)}

Shortly thereafter, in October 1997, the Oregon DWDA went into effect.⁽⁶⁾ In the years that followed, proponents attempted to pass PAD statutes in other states as well. In 2008, Washington voters approved the Washington Death with Dignity Act, which went into effect in 2009.⁽⁷⁾ Later that year, PAD became legal in Montana by a Montana Supreme Court decision.⁽⁸⁾

Since then, six other states and the District of Columbia have passed PAD laws: Vermont's Patient Choice and Control at End of Life Act (PCEOL) (2013);⁽⁹⁾ California's End of Life Option Act (ELOA) (2015);⁽¹⁰⁾ Colorado's End-of-Life-

Options Act (2016);⁽¹¹⁾ the District of Columbia Death with Dignity Act (2016);⁽¹²⁾ Hawaii's Our Care, Our Choice Act (OCOCA) (2018);⁽¹³⁾ New Jersey's Medical Aid in Dying for Terminally Ill Act (2019);⁽¹⁴⁾ and the Maine Death with Dignity Act (2019).⁽¹⁵⁾ (Figure 1).

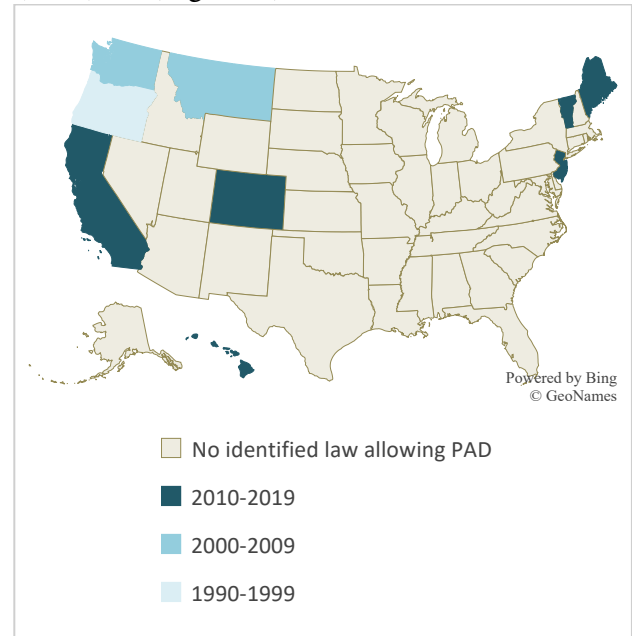


Figure 1 Legalization of Physician Aid in Dying by Decade. [District of Columbia not pictured.]

STATUTORY SAFEGUARDS

In her concurrence in *Glucksberg*, Justice O'Connor stated that one of the most challenging tasks in drafting PAD legislation would be "crafting appropriate procedures for safeguarding ... liberty interests[.]"⁽⁵⁾ This task, she found, is best left to the "laboratory of the States."⁽⁵⁾ Consequently, each state's approach to physician aid in dying may be guided by a unique set of factors, including public and physician attitudes, societal debate, research data from preceding PAD states, reasoned legislative deliberation, and a "principled desire to protect individuals at the most vulnerable moments of their lives."^{(2),(16),(17)} Research shows that public attitudes on PAD can be rooted in "cultural, religious and spiritual traditions and historical experience," which can vary across states.⁽²⁾

Since its implementation, the Oregon DWDA has been adopted or used as a starting point for states to craft their own PAD safeguards and procedures.⁽¹⁸⁾ The statutory construction of each statute is similar, with technical and substantive

changes varying state by state. Using the Oregon DWDA as a reference, the law requires the person to be (1) at least eighteen years of age, (2) a resident of the state, (3) capable of making and communicating their own health care decisions, and (4) diagnosed with a terminal illness that will lead to death within six months.⁽⁶⁾ The individual is required to meet with an attending physician and a consulting physician—each with designated responsibilities—and, in some cases, is referred to a mental health professional who determines whether the individual is capable of making an informed decision and does not have impaired judgment.⁽⁶⁾ The language used to describe referrals varies by state, but includes the terms “assessment,” “counseling,” and “evaluation.” There are many additional safeguards and procedures outlined in the statutes, such as that the individual is informed of feasible alternatives—including comfort care, hospice and palliative care, and pain control.^{(9),(10), (11), (13),(14),(15)}

REFERRALS TO MENTAL HEALTH PROFESSIONALS

The states and the District of Columbia agree that if a mental health referral is made, the patient may not receive the prescription until the mental health professional confirms the patient’s eligibility.^{(18),(19)} However, there is interstate variability in the statutory constriction of these provisions, which may hold important implications for patient care and may contribute to health disparities.⁽¹⁷⁾

The four DWDA jurisdictions—Oregon, Washington, District of Columbia, and Maine—require a “counseling” referral to confirm that the patient is capable and not suffering from impaired judgment if, “in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment[.]”^{(6),(18)} It has been reported that Oregon wrote this safeguard into the law to ensure that an individual is competent and their request for PAD is not stemming from a treatable mental illness.⁽¹⁹⁾ California uses a similar protocol for confirming a

patient’s capacity; however, the ELOA revises the statutory language to instead require referrals if “there are indications of a mental disorder[.]”⁽¹⁰⁾

Vermont, Colorado, and New Jersey also require referrals on a case-by-case basis. However, these states simply require referrals if either the attending physician or the consulting physician believes the patient may not be capable of making an informed decision.^{(9),(11),(14)} Their statutes omit any explicit reference used by other jurisdictions related to a “*mental disorder*” or a “*psychiatric or psychological disorder or depression*.” Some have argued that these less-specific referral requirements are superior because they allow physicians to observe the patient’s functioning relative to the capacity standards without searching for a specific mental disorder.⁽¹⁸⁾

Notably, the legislative history of Vermont’s Patient Choice at End of Life Act reflects that when the bill was introduced in 2013, it required referrals if, in either physician’s opinion, the individual “may be suffering from a mental disorder or disease, including depression, causing impaired judgment.”⁽²⁰⁾ However, this language was removed from the bill during legislative deliberation.^{(9),(20)}

Unlike the other eight physician aid in dying statutes, Hawaii’s OCOCA makes referrals mandatory for *every* patient that makes a request for the medication—not just when there are indications of a mental disorder or psychiatric or psychological disorder or depression causing impaired judgment.⁽¹³⁾ This decision came after a long, ongoing debate over whether states should require a referral for every patient.^{(18),(19)} Some argue that a mandatory referral requirement may create an unnecessary burden—both on the patient and the mental health professionals—and delays the process.^{(21),(22)} Some also worry that the mental health professionals’ ethical and moral views on PAD may influence their assessments.⁽¹⁹⁾ Others argue it is necessary to ensure that each individual is properly assessed to confirm that their request for medication is not rooted in a disorder or condition that can be treated.⁽²³⁾

Additionally, mental health professionals in Hawaii are required to confirm whether the patient is “suffering from undertreatment or non-treatment of depression or other conditions which may interfere with the patient’s ability to make an informed decision[.]”⁽¹³⁾ The “*undertreatment or non-treatment*” language may be in response to historical concerns that some psychiatrists believed that the presence of a mood disorder should automatically result in a finding of incapacity to consent to PAD.⁽²³⁾ By focusing on the level of treatment of depression or other conditions, Hawaii seeks to avoid any presumptions that the mere presence of a condition precludes the evaluator from finding that the patient is capable and has the ability to make an informed decision.⁽¹³⁾

CONTINUOUS SUPPORTIVE CARE SAFEGUARDS

While there is some interstate variability regarding the mental health referral criteria, these safeguards aim to ensure that a patient is competent and not requesting PAD because of a treatable mental illness.⁽¹⁹⁾ Thus, under these statutes, the mental health professional’s role, if called upon, is to evaluate an individual to confirm eligibility for physician aid in dying medication, rather than to provide supportive counseling.⁽¹⁸⁾ For this reason, among others, the majority of patients are not referred for a mental health assessment in most states. In Oregon and Washington, for example, less than 5% of patients are referred for assessments.⁽¹⁶⁾

Of the nine physician aid in dying statutes, only the District of Columbia DWDA contains a supplemental safeguard to ensure that patients are made aware of supportive counseling options.⁽¹²⁾ Specifically, in D.C., attending physicians are required to “[i]nform the patient of the availability of supportive counseling to address the range of possible psychological and emotional stress involved with the end stages of life[.]”⁽¹²⁾ The Council of the District of Columbia Committee on Health and Human Services explains that this substantive change was made to address concerns raised by members of the community over the

possibility of coercion or undue influence on vulnerable individuals.⁽²⁴⁾ This allows a mental health professional to explore the emotional distress and responses commonly experienced by patients as they approach the end of life and not just focus their evaluation on assessing whether the patient is capable of making an informed decision. Additionally, this opens the door for a mental health professional-patient relationship that can continue even after the individual is prescribed PAD medication.

Similarly, although California’s ELOA does not have a supportive counseling safeguard, some California health care systems, such as the University of California Los Angeles (UCLA), have implemented internal policies that provide continuous support for a collaborative consultation with a psychologist or social worker.⁽²⁵⁾

FURTHER CONSIDERATIONS

There is still much debate over whether mandatory or case-by-case mental health referrals are better safeguards for patients requesting PAD medication, and it is important to conduct further investigation to answer this question. Additionally, the efficacy of the various evidence-based psychotherapies for terminally ill patients should be further explored in the context of PAD, with special attention given to their effectiveness on different cultures and groups of terminally ill patients, including those with terminal illnesses outside of cancer.^{(26),(27)}

CONCLUSIONS AND RECOMMENDATIONS

In an attempt to prevent ambiguity which could lead to health disparities, this article recommends that future PAD legislation use the same language when addressing mental health referrals. It further recommends that PAD statutes include a recommendation regarding early, continuous supportive counseling for all patients. As seen in the District of Columbia, states can do this by making it the physician’s responsibility to inform all patients of the availability of supportive counseling to address the range of possible

psychological and emotional stress involved with the end stages of life.⁽¹²⁾ This takes into consideration the modern framework that interactions between practitioners and patients should be dialogues occurring over multiple meetings, rather than one-time and one-way interactions.⁽¹⁸⁾ Moreover, continuous supportive care would also help ensure that care is directed to the day-to-day life and morale of patients and not only focused on whether the patient meets certain criteria to determine eligibility for PAD.⁽²⁸⁾

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