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MEMORANDUM

TO: Senator Claire Ayer
Chair, Senate Committee on Health and Welfare

FROM: William H. Sorrell
Attorney General

DATE: February 17, 2015

Summary of the Attorney General's Concerns About the Sunset Provision of Act 39, Patient Choices at End of Life

As you know, in 2013 I supported end-of-life legislation modeled on existing laws in Oregon and Washington. Act 39, passed by the Legislature in 2013, adopted 18 V.S.A. § 5283. That statute establishes a patient-driven process with safeguards to prevent abuse and ensure that a patient is competent and making an informed decision. This current law gives terminally ill patients the option to hasten death while giving clear direction to medical professionals, law enforcement, and patients about what is permissible. Unfortunately, this part of Act 39 will sunset in 2016 and be replaced by statutes that do not provide adequate guidance or safeguards.

I urge the Legislature to repeal the sunset provision and allow 18 V.S.A. § 5283 to remain in effect.

1. The statutes that will replace 18 V.S.A. § 5283 have inadequate safeguards.

The recordkeeping requirements and other provisions in § 5283 provide an essential framework that protects patients and gives needed guidance to medical professionals. The statutes that will replace § 5283, namely §§ 5289 and 5290, do not include these safeguards. These statutes have:

- No requirement that a patient even ask for a prescription for a drug to hasten death, much less requirements that requests be written, witnessed, repeated, or followed by a waiting period
- No requirement that the physician make any record of a patient's request, prognosis, or competency – indeed, the statues call for no records at all

- No requirement for a second opinion confirming the patient's diagnosis, or any consultation with another medical professional
- No requirement for a waiting period between a patient's request for the drug and its delivery to the patient

I have serious concerns about the absence of safeguards – such as a second opinion or waiting period – that protect patients from abuse and ensure patients are making an informed, competent decision. Moreover, as the state's chief law enforcement officer, I question what may happen if a patient dies after taking a lethal dose of medication and family members, health care providers, or law enforcement later inquire about the patient's competency, diagnosis, or intent to hasten death. There could be no way to evaluate the patient's intent or the appropriateness of the doctor's actions. The procedural safeguards and recordkeeping requirements in the current law not only protect patients, but also physicians and caregivers.

2. The statutes that will replace 18 V.S.A. § 5283 are vague.

I am also concerned that the statutes that will replace 18 V.S.A. § 5283 are too vague to govern a matter as sensitive and important as this one. Section 5283 is clear and patient-driven: a patient must make a request for a drug that would hasten death, and – where the statutory requirements are satisfied – a physician may prescribe a drug knowing that the patient intends to self-administer it to hasten death. The statutes that would replace § 5283 make no mention of any request by a patient, and refer only to a prescription that "may be lethal," 18 V.S.A. § 5289(3), and a patient's "independent decision to self-administer a lethal dose.' *Id.* § 5289(4). Nothing in the replacement statutes addresses dispensing of the drug by a pharmacist, or contemplates any role for a medical professional other than the treating doctor.

The language in the current statute leaves no doubt that physicians and patients may have open, candid discussion about the patient's interest in hastening death; that a physician may convey a prescription to a pharmacist with that understanding; and that a physician may refer a patient for a second opinion or a consultation with a mental health professional. Although one might infer that the same conduct is permitted under § 5289, it is not clear, and that lack of clarity may deter physicians from having candid conversations or consulting other providers, and may also deter pharmacists from filling prescriptions.

The change in statutory language, specifically the elimination of recordkeeping requirements, may also suggest to physicians that they should not make accurate and complete records of their discussions with patients. That may well not be the intent of the statute, but a deliberate change from requiring these records to omitting any mention of them may be interpreted that way. That would not serve the interests of patients, families, or physicians.

3. The immunity provision in the replacement statute does not include pharmacists or other medical professionals.

The language in the replacement statute that shields physicians from liability is limited to the physician with a "bona fide physician-patient relationship" who is acting "in good faith compliance with the provisions of this chapter." *Id.* §§ 5289, 5290. This language does not extend to a pharmacist who dispenses a drug knowing it will be used to hasten death. This is a concern with the current statute as well, but the current statute expressly sets out a role for a pharmacist, and my office was available to provide some guidance to pharmacists on complying

with the statute. The same is true for doctors providing a second opinion or consultation, who are also expressly mentioned in the current law. If the current law sunsets and is replaced by §§ 5289 and 5290, pharmacists may be unwilling to dispense a lethal dose of medication, because the statute does not specifically acknowledge that they are permitted to do so.

In addition to raising this concern about the replacement statutes, I also recommend that the current statute, if it is retained, be amended to expressly shield pharmacists and consulting medical professionals from liability for actions taken in compliance with the statute.