Good News (Maybe) About Bad News: California Joins Four Other States that Allow Terminally Ill People to End Their Lives: What Can We Learn from the Track Records?

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On June 9, 2016, California’s “End of Life Option Act” (SB 128) was enacted into law. The new law specifically includes a role for “mental health experts,” limited to psychologists and psychiatrists.

What the Law Says:

The law provides for California residents aged 18 or older and who have been properly diagnosed with a terminal illness, projected to result in death within six months and whose capacity to elect to end their lives is not impaired, to receive prescriptions for drugs that will end their lives. The law includes provisions for such individuals to change their minds about their decisions, and requires that health care professionals who may prescribe the life-ending medications assert that their patients have the capacity to make life-ending decisions. The patient must also be able to self-administer the medications.

A request for a prescription cannot be made on behalf of a patient through an agent under a power of attorney, an advance healthcare directive, a conservator or any other person. Finally, the law requires the signatures of two witnesses, only one of whom can be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual’s estate upon death, or own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

Once the prescription is filled, the patient must complete a “Final Attestation for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner” form within 48 hours before self-administering the drug. While the law is silent as to what cause of death should be identified on the death certificate, it does say that taking an aid-in-dying drug “shall not constitute suicide.” The guide that was prepared by the California Medical Association states that physicians can list the cause of death “that they feel is the most accurate,” including the underlying terminal illness, or just write “pursuant to the End of Life Options Act.”

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The Role of Psychologist-Assessors

The law requires that the decision to implement the law must be made by a patient who is competent to make such a decision, and further specifies that, in addition to the fact that the medication must be prescribed by an attending physician in the context of a relationship with a consulting physician, “mental health experts” (limited to psychologists and psychiatrists) may be asked to perform evaluations of such competence as a condition precedent to qualifying for life-ending medications.

“Mental health specialist’ means a psychiatrist or a licensed psychologist.”

“If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.”

Further, the law specifies that the mental health specialist who performs such an assessment cannot be one of the “witnesses” to the petition completed by the individual seeking end of life medications:

“The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).”

The other states: Oregon, Washington, Montana and Vermont. What can we learn from their track records?

Oregon’s “Death with Dignity” Act became operational in 1997 and has served as the catalyst and orientation followed by Washington, Montana, Vermont and California. At its core, the Oregon statute requires that a patient’s capacity and judgment must not be impaired in order to honor an otherwise lawful request. Concerns about whether non-psychiatrically-trained physicians are sensitive to the role of depression and other mental health disorders, vis-à-vis “capacity” have been raised, as referral to a mental health professional pursuant to Oregon’s law (as it also is with California), is up to the attending physician, and not a requirement of the law. (Werth, Benjamin & Farrenkopf, 2000). In terms of the assessment of capacity and judgment, these authors also discuss (p. 358) the use of a “4-factor model” including:

“1. Ability to communicate a choice. The person has the ability to reach and communicate a decision. This is the least stringent ability and is often used as a threshold determination of competence.

2. Ability to understand relevant information. The person has the ability to comprehend information and concepts related to the treatment decision. This is the most common ability required by courts but is often left ambiguously defined.

3. Ability to appreciate the nature of the situation and its likely consequences. The person can apply the information that is understood in her or his own context-dependent situation. In other words, people who, “because of cognitive deficits or emotional states, fail to accept the relevance of their disorders or potential treatment consequences for their own circumstances” lack appreciation. The key is that the person realizes the consequences associated with the decision, not whether the evaluator agrees with the decision ultimately made.

4. Ability to manipulate information rationally. The person is able to use logical thought processes to compare the risks and benefits of the treatment options and make a decision that is consistent with her or his values or preferences. Again, the process is what is important, not the outcome. The reasons need not be “rational” to others but the decision needs to follow logically from the reasons given—the person needs to use and communicate a chain of reasoning. This is the least often included component.”

However, the authors note that the above approach is highly focused on the legal, rather than mental health professional, views of capacity and judgment. With this difference in mind, they move to an extensive model of guidelines which reflect a psychological approach to the assessment of capacity and judgment, including: 1) a review of the patient’s prior and current medical and psychological records with the attending physician, nurses and prior providers; 2) the use of appropriate assessment instruments, such as the MacArthur Treatment Tool (MCAT-T), Wechsler Scales, Beck or Hamilton Depression assessments and Beck Hopelessness Scale, among others; 3) Clinical interview, assessing particularized topics relevant to the understanding of health situations and informed consent, 4) if possible, consultation with significant others in the life of the patient to gather in-
formation and their perspectives on issues such as capacity and judgment.

**Current Knowledge of Factors Associated with Competent Assessment and Implementation of Life Choices**

The current state of knowledge as to which patient and psychologist characteristics are important for end of life choices is described by Johnson, Cramer, Gardner and Nobles (2015) which involved giving a series of vignettes to both patients and psychologists to review. The vignettes involved patients with terminal illnesses (lung cancer), grouped by known scores on psychological tests (e.g., MCAT, Beck, WAIS 4, etc.) and relevant patient characteristics related to life decisions. The psychologists who responded to the vignettes all practiced in one of the states in which the right to make life-ending decisions existed in the law (Montana and Oregon). Of the 960 psychologists to whom the vignettes and research materials were mailed, 216 (approximately 25%) of those contacted, responded with complete data.

In terms of results, the only patient quality found to be significantly related to psychologists’ views as to competence of decisions by patients to terminate life was cognitive ability (as opposed to irreversibility of the condition, physical suffering, mental suffering and perceived burdensomeness), and the only test scores associated with judgments of cognitive ability were MacCAT-T Appreciation and Reasoning scores. As the authors note: “clinicians placed more weight on cognitive ability as demonstrated by logical reasoning about their condition and treatment options as opposed to performing well on assembling blocks and defining words” (p. 428).

Further, psychologists who reported that someone in their personal lives had made a suicide attempt were more likely to find a patient requesting end of life services to be competent than those without such an experience. Those who experienced completed suicidal acts were less likely to find the research patient competent.

Finally, the psychologists in the study were, surprisingly (to the authors) non-responsive to burdensomeness to others of the patient’s condition as a significant predictor of agreement to a request for end of life services.

What becomes clear when reviewing reports such as those above is that a good deal of training is needed for psychologists to develop both the assessment expertise and the appropriate mix of attitudes/beliefs, to provide the types of services and to make the types of recommendations most central to the role of “mental health expert” in end of life choice situations.

Given the nascent standards of care for these evaluations, psychologists who provide these evaluation services should consider some general takeaways from the developing literature. One of these is that psychologists appear to be prioritizing the ability of an evaluatee to engage in rational thought processes, rather than on more discrete cognitive abilities. Fortunately, the forensic literature provides several models for considering these types of decisional capacities in light of healthcare decision-making capacities (e.g., Appelbaum & Grisso, 1995; del Carmen & Joffe, 2005; Grisso, Applebaum, Mulvey, & Fletcher, 1995; Grisso & Appelbaum, 1995; Moye, Karel, Azar, & Gurrera, 2004). In that respect, a California Health & Safety Code 443.1 evaluation is much like other healthcare decisional capacity evaluations.

In addition, it appears prudent for psychologists performing these evaluations to consult liberally with colleagues. Insofar as an evaluation for capacity to end life is concerned, it may require a shift away from a commonly held belief in our field that thoughts of suicide is pathognomonic for depression. (Such a consideration would be legally at odds with the text of the bill, which excludes “suicide” as an official listed cause of death for those who choose this option.) These changes in the consideration of end of life decision making is an appropriate time for formal consultation. As with many complex clinical dilemmas, consultations with colleagues help to clarify issues. And as in other clinical consultations, discussions with colleagues about capacity determinations should involve a reasonable disclosure of pertinent clinical data and the colleague’s response should be considered in light of the information provided.

**REFERENCES**


