LEGAL ANALYSIS OF SB 3499 –

THE ILLINOIS PHYSICIAN-ASSISTED SUICIDE BILL

Illinois's Physician-Assisted Suicide Bill:

- Dangerously and unnecessarily expands access to assisted suicide
- Fails to protect vulnerable groups from manipulation and abuse
- Leaves individuals to die alone, without any supervision
- Risks reducing the standard of care and insurance coverage for treatment options
- Infringes on fundamental freedoms of religion and conscience

OVERVIEW

Neither the Illinois Constitution nor the U.S. Constitution contains a right to assisted suicide. Indeed, Illinois criminal law makes it a felony to assist a person in committing suicide by providing them with the physical means to do so.[1] This prohibition reflects and advances the state's interest in preserving human life. Illinois also has "an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes" since there is a "real risk of subtle coercion and undue influence in end-of-life situations," and there is a risk that some might resort to physician-assisted suicide "to spare their families the substantial financial burden of end-of-life health-care costs."[2] Yet, the "End-of-Life Options for Terminally Ill Patients Act" (Senate Bill (SB) 3499)

[1] 720 Ill. Comp. Stat. Ann. 5/12-34.5.
[2] *Washington v. Glucksberg*, 521 U.S. 702, 731–32 (1997).

undermines Illinois's interests and puts vulnerable people at risk. It misleadingly carves out an exception to Illinois criminal law and permits physicians to provide vulnerable patients with lethal drugs that lead to their demise.

CONCERNS WITH ILLINOIS'S PHYSICIAN-ASSISTED SUICIDE BILL

Dangerously and Unnecessarily Expands Access to Assisted Suicide

The bill permits the prescription of lethal drugs to a patient with a "terminal disease"—broadly defined as "an incurable and irreversible disease that will, within reasonable medical judgment, result in death within 6 months." This could apply to situations where a patient is expected to die within six months *with* or *without* appropriate medical treatment.

According to this definition, even common and controllable diseases, like diabetes, could be considered a "terminal disease." For example, a patient with Type 1 diabetes who stops taking insulin will, within reasonable medical judgment, die within days or weeks.[3] With insulin, however, that patient could live essentially a normal life for many years.[4] Under the bill, insulin-dependent diabetics would qualify as having a "terminal disease" and be eligible for assisted suicide. A patient suffering from anorexia may also be eligible for assisted suicide even if, with appropriate treatment, she could live much longer than six months.[5]

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[3] Health, *How Can You Die From Untreated Diabetes?* (Dec. 23, 2022), https://rb.gy/wda6bh.

[4] In Oregon's official report of physician-assisted suicide deaths for 2022, diabetes is listed as the underlying terminal illness resulting in the death of several patients. Oregon Public Health Division, *Oregon Death with Dignity Act 2022 Data Summary*, p. 13, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf (last accessed Feb. 1, 2024).

[5] A Denver doctor reportedly provided lethal drugs to two patients suffering from anorexia nervosa. The Colorado Sun, *Denver doctor helped patients with severe anorexia obtain aid-in-dying*

Additionally, providers cannot reliably determine whether a disease *will* produce death within six months. Medical prognoses are based on often incorrect estimates of life expectancy and individuals frequently outlive "terminal" prognoses. Indeed, reports show that almost 20% of hospice patients are discharged alive[6]—meaning those patients did not die within six months of their terminal diagnosis and may even no longer be terminally ill.

Endangers Individuals with Mental Health Conditions

Mental capacity to choose assisted suicide means that, in the opinion of the health care provider, the individual "has the ability to make and communicate an informed decision." The bill does not require patients to have any psychological or psychiatric evaluation prior to obtaining lethal drugs. The bill precludes an individual from qualifying for assisted suicide "solely because of … a mental health condition, including depression." But it lacks any requirement for a mental health assessment to evaluate mental health conditions or to rule them out as a motivating or contributing factor to the patient's request for lethal drugs.

Many individuals who contemplate suicide, including the terminally ill, suffer from treatable mental disorders such as clinical depression. Yet, SB 3499 would

medication, spurring national ethics debate (Mar. 14, 2022), https://coloradosun.com/2022/03/14/denver-doctor-gaudiani-aid-in-dying-aneroexia-patients/.

[6] A national study of live discharges from hospices in 2010 found that, although there were variations based on geography and hospice programs, approximately 1 in 5 hospice patients were discharged alive. Joan M. Teno, et al., *A National Study of Live Discharges from Hospice*, J. Palliat. Med. (October 2014), https://bit.ly/3LP57z1. "Of the 1.6 million Medicare recipients hospices serve each year, hospices discharge 17.4% alive." Stephanie P. Wladkowski, et al., *The Forgotten and Misdiagnosed Care Transition: Live Discharge From Hospice Care*, Gerontol. Geriatr. Med. (Jan.-Dec. 2022), https://rb.gy/5515fk.

allow mental disorders to go undiagnosed and untreated in patients considering suicide.

In Oregon in 2022, physicians wrote 431 prescriptions for lethal drugs, but only three (3) patients were referred for psychological or psychiatric evaluation.[7] The intentional omission of a mental health evaluation in Illinois's bill fails to protect vulnerable individuals who are more likely to change their minds about dying when their physicians appropriately address underlying pain, depression, or mental health conditions.[8]

Creates "Fast-Track" Process for Receiving Lethal Drugs

The bill mandates only a five-day waiting period between a patient's initial oral request for lethal drugs and the required second oral request. But even this minimal waiting period can be waived if the individual's physician determines, within reasonable medical judgment, that the patient will die within five days after making the initial oral request. This waiver provision allows assisted suicide to be "fast-tracked"—denying patients and health care providers adequate time for a thorough medical evaluation and proper reflection.

Self-Administration Provision Lacks Protections

The bill's reckless self-administration provision leaves vulnerable individuals to die *alone* and fails to monitor lethal drugs. A patient does not need to notify next of kin of his or her decision to die, and no one needs to be present when the patient

[7] *Oregon Death with Dignity Act 2022 Data Summary*, at pp. 6 and 9.
[8] A study about Oregon's law found that it "may not adequately protect all mentally ill patients." Linda Ganzini, et al., *Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey*, BMJ, Oct. 25, 2008, pp. 973–78, https://pubmed.ncbi.nlm.nih.gov/18842645/.

self-administers lethal drugs. A patient is left without medical supervision or care while dying and is left alone to deal with any potential complications.

There is also no assurance that the patient self-administers drugs by an "affirmative, conscious, voluntary action" because no one is there to ensure compliance. The self-administration provision can be easily abused—especially because the bill allows drugs to be mailed or dispensed to another person "designated" by the patient to pick up lethal drugs on his or her behalf. There is no meaningful protection to prevent an abuser or self-interested individual from administering drugs to a sick, elderly, or disabled patient against his or her wishes.

Even more concerning, the bill allows a patient or a "designated" agent to obtain not only the prescribed lethal drugs but also potentially addictive sedatives or painkillers, which can also be delivered by mail. There is no obligation that lethal drugs or ancillary medications be self-administered after they are obtained and no monitoring of unused drugs. Although the bill purports to require safekeeping and proper disposal of unused drugs, it recklessly permits dispersal of lethal drugs to vulnerable individuals without supervision. Of the 431 prescriptions for lethal drugs issues in Oregon in 2022, only 278 deaths were reported.[9] Knowing that lethal drugs are often left unused, SB 3499 fails to adequately prevent these dangerous drugs from getting into the wrong hands.

Fails to Protect Vulnerable Patients and Can be Easily Exploited

[9] *Oregon Death with Dignity Act 2022 Data Summary*, at p. 6.

Under SB 3499, a written request for lethal drugs must be signed by the patient and witnessed by at least two individuals. The bill inappropriately allows one of the witnesses to be the patient's relative; an individual entitled to a portion of the patient's estate; an owner, operator, or employee of the health care facility where the patient is receiving treatment; the patient's attending physician; or the patient's interpreter. The bill inexplicably allows a person who stands to benefit financially from the patient's death to serve as the first witness. And the second witness could be the first witness's best friend. This witness requirement easily leaves vulnerable individuals at risk of exploitation.

Risks Reducing Standard of Care and Treatment Options

With the availability of physician-assisted suicide, the standard of care will foreseeably deteriorate. Although the bill requires that patients be informed of "feasible end-of-life care and treatment options," this does not mean all *available* treatment options. Assisted suicide is significantly less expensive than other care options, such as palliative care. Legalizing physician-assisted suicide will likely lead insurance companies to drive patients toward death, which is easier and cheaper than care options that extend a patient's life and eliminate pain. SB 3499 intends to prevent an insurance plan from denying or altering benefits to a covered patient with a terminal disease based on the availability of assisted suicide. But the fact remains, in states where assisted suicide is legal, insurance companies have turned down coverage for cancer treatment while offering to pay for lethal drugs instead.[10]

[10] ABC News, *Death Drugs Cause Uproar in Oregon* (Sept. 30, 2008), https://abcnews.go.com/Health/story?id=5517492&page=1.

Jeopardizes Health Care Providers' Freedom of Conscience

SB 3499 muddies the waters of whether health care providers' conscience rights are protected when it comes to helping their patients commit suicide.

Illinois law protects the conscience rights of physicians and health care personnel by protecting them from having "to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience."[11] And SB 3499 purportedly makes participation in physician-assisted suicide voluntary. At the same time, the bill erodes conscience protections by requiring an *unwilling* health care provider to (1) refer the individual to a health care professional who is able and willing to qualify the individual for suicide or assist them in seeking assisted suicide; and (2) note in the medical record the individual's date of request.

These requirements risk forcing health care providers with religious, ethical, or moral objections to killing their patients to be complicit in assisted suicide. The documentation requirement satisfies an essential step in the process of a patient obtaining lethal drugs: the initial request. This is problematic because the bill elsewhere states that "a transfer of medical records does not toll or restart the waiting period." Meaning a conscientiously objecting physician must document a patient's request, which starts the five-day clock to obtaining lethal drugs, and then refer the patient to a willing provider. The failure to transfer a patient and the

[11] 745 Ill. Comp. Stat. Ann. 70/6.

patient's medical records documenting the date of a request for assisted suicide constitutes "coercion or undue influence" under the bill.

Violates Religious Employers' Rights

The bill infringes on a religious health care entity's right to expect its employees to affirm or abide by its sincerely held religious beliefs. Under SB 3499, a health care entity may prohibit health care providers from practicing assisted suicide while performing duties for the entity. But it cannot prohibit its employees from providing patients with information about assisted suicide and how to access it or from practicing assisted suicide outside the scope of their employment or contract with the objecting entity. Even worse, a health care entity is still required to transfer a patient and his or her medical records in order to facilitate assisted suicide. This means, for example, a Catholic hospital[12] must allow physicians to counsel patients on assisted suicide even if doing so would violate the hospital's mission and values. The bill could violate a ministry's First Amendment right to require that all employees affirm the ministry's sincerely held religious beliefs when adhering to them is necessary to fulfill its religious mission.

CONCLUSION

Illinois SB 3499 undermines the state's interest in the preservation of human life and exposes vulnerable individuals, including the elderly, disabled, mentally ill, and depressed, to manipulation to end their lives.

[12] Approximately 15% of hospitals in the U.S. are Catholic hospital systems.