I. INTRODUCTION.

I am a lawyer in Washington State where assisted suicide is legal.¹ Our law is based on a similar law in Oregon. Both laws are similar to the proposed California bill, ABX2-15.² Enacting the proposed bill to legalize assisted suicide is a recipe for elder abuse, coercion and outright murder. I urge you to reject this measure. Do not make Washington’s and Oregon’s mistake.

II. PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA.

A. Definitions: Physician-Assisted Suicide; Assisted Suicide; and Euthanasia.

The American Medical Association (AMA) defines physician-assisted suicide as occurring when “a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act.”³ The AMA gives this example:

[A] physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.⁴

¹ I have been licensed to practice law in Washington State since 1986. I am a former Law Clerk to the Washington State Supreme Court and a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am also president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. See www.margaretdore.com, www.choiceillusion.org and www.margaretdore.org.

² ABX2-15 is, in substance, the same bill as SB 128, which failed to pass during the regular session. A copy of ABX2-15 is attached hereto at A-1 through A-12.


⁴ Id.
“Assisted suicide” is a general term in which the assisting person is not necessarily a physician. “Euthanasia,” by contrast, is the direct administration of a lethal agent with the intent to cause another person’s death.5

B. Definition: Withholding or Withdrawing Treatment Is Not Assisted Suicide or Euthanasia.

Withholding or withdrawing treatment (“pulling the plug”) is not assisted suicide or euthanasia: The purpose is to withhold or remove burdensome treatment, i.e., as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. Consider this quote from an article in Washington state regarding a man removed from a ventilator:

[I]nstead of dying as expected, [he] slowly began to get better.6

C. The American Medical Association Rejects Physician-Assisted Suicide and Euthanasia.

The AMA rejects physician-assisted suicide and euthanasia, stating that they are:

[F]undamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.7

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5 Id, Opinion 2.21, Euthanasia. (Attached at A-57).


7 See AMA Code of Medical Ethics, Opinions 2.211 and 2.21, supra.
D. Most States Reject Assisted Suicide.

In the last five years, four states have strengthened their laws against assisted suicide. These states are: Arizona, Idaho, Georgia and Louisiana. For more information, please see the materials attached hereto at A-16 though A-19.

Last month, the New Mexico Court of Appeals struck down a lower court ruling that had allowed physician-assisted suicide in that state.\(^8\) Physician-assisted suicide is once again prohibited in New Mexico.\(^9\)

There are just three states where physician-assisted suicide is legal: Oregon; Washington; and Vermont.\(^10\) In a fourth state, Montana, case law gives doctors who assist a suicide a potential defense to a homicide charge.\(^11\) In both Montana and Vermont, there are active movements to repeal any and all types of assisted suicide legalization.\(^12\)

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\(^9\) Id.

\(^10\) Valerie Richardson at note 7, supra.


\(^12\) This year in Montana, HB 477, which would have reversed case law giving doctors who assist a suicide a defense to a homicide charge, passed the House, but was unable to clear the Senate. See http://www.montanansagainstassistedsuicide.org/2015/05/hb-477-passes-house.html

1 SB 202, seeking to actually legalize physician-assisted suicide was defeated. See http://www.montanansagainstassistedsuicide.org/2015/05/sb-202-dead.html
III. ELDER ABUSE

A. Elder Abuse Is a Large and Uncontrolled Problem.

In 2009, MetLife Mature Market Institute released its landmark study addressing financial elder abuse nationwide.\textsuperscript{13} The estimated financial loss by victims was $2.6 billion per year.\textsuperscript{14}

The study describes financial elder abuse as a crime "growing in intensity" in which perpetrators are often family members, some of whom feel themselves "entitled" to the elder’s assets.\textsuperscript{15} They start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or coercing elders to sign over the deeds to their homes, change their wills, or liquidate their assets.\textsuperscript{16}

In California, prominent elder abuse cases include: Victorino Noval, whose daughters allegedly instructed doctors to medically kill him so as to obtain quick inheritances; and the "Black Widow" murders in which two elderly women insured the lives of homeless men and then killed them to collect the

\textsuperscript{14} Id., p. 4, Key Findings.
\textsuperscript{15} Id., pp. 13-14, 16.
\textsuperscript{16} Id., p. 14.
money. Paul Vados, a 73-year-old man, was one of the victims. Consider also People v. Stuart, 67 Cal.Rptr.3d 129 (2007), in which a daughter killed her elderly mother with a pillow under circumstances that dovetailed with the daughter's financial interests. Stuart observed:

Financial considerations [are] an all too common motivation for killing someone.

Id., at 143.

B. Victims Do Not Report Abuse.

Elder abuse is prevalent in part because victims do not report. One study estimated that just one in 24 cases is reported to the authorities. The California Department of Justice explains:

Elder abuse victims often live in silent desperation . . . . Many remain silent to protect abusive family members . . . .


18 See Id.


IV. ABX2-15.

A. How the Bill Works.

ABX2-15 has an application process to obtain the lethal dose, which includes a written lethal dose request form with two required witnesses.21

Once the lethal dose is issued by the pharmacy, there is no oversight over administration.22 The death is not required to be witnessed by disinterested persons.23 No one is required to be present.24

B. Doctor Independence Is Not Required; Suicide Proponents “Doctor Shop.”

Under ABX2-15, the initial determination of whether a patient “qualifies” for the lethal dose is made by the “attending physician.”25 Under ABX2-15, this doctor is required to obtain a second opinion from a “consulting physician.”26 There is no requirement that the consulting physician be independent.27 In practice, suicide proponents, themselves, find the second doctor:

Barbara Coombs Lee of Compassion and Dying [now Compassion and Choices] told the

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22 See ABX2-15 in its entirety, at A-1 through A-12.
23 Id.
24 Id.
25 ABX2-15, § 443.5
26 Id., § 443.5(a)(3).
27 See ABX2-15 in its entirety. (Attached hereto at A-1 through A-12)
Washington Post: “if I get rebuffed by one doctor, I can go to another to get the necessary signatures.”

Consider also this incident related by Oregon doctor Charles Bentz:

[My patient’s cancer doctor] asked me to be the "second opinion" for his suicide . . . I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur . . . Approximately two weeks later my patient was dead from an overdose prescribed by this doctor . . .

C. ABX2-15 Invites Duress, Menace, Fraud and Undue Influence.

ABX2-15 allows one of two witnesses on the lethal dose request form to be the patient’s heir who will financially benefit from the patient’s death. This is an extreme conflict of interest. Indeed, under California’s Probate Code, similar conduct (an heir acting as one of two witnesses on a will) creates a presumption that the will was procured “by duress, menace, fraud or undue influence.”

ABX2-15, which specifically allows the patient’s heir, who will financially benefit from the patient’s death, to be a

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29 Charles Bentz MD, Letter to the Editor, “Don’t Follow Oregon’s Lead: Say No to Assisted Suicide,” The Advocate, official publication of the Idaho State Bar, December 2010 [I verified the content with him].

30 § 443.11 (allowing one of two witnesses be an heir “entitled to a portion of the person’s estate upon death”). (Attached at A-6)

31 California’s Probate Code, § 6112.
witness on the lethal dose request form, does not promote patient choice. It invites duress, menace, fraud and undue influence.

D. No Witnesses at the Death.

ABX2-15 does not require witnesses at the death. Without disinterested witnesses, the opportunity is created for someone else to administer the lethal dose to the patient without the patient’s consent. Even if the patient struggled, who would know?

Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, elaborates:

With assisted suicide laws in Washington and Oregon [and with ABX2-15], perpetrators can . . . take a “legal” route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. . . . [I]f a patient struggled, “who would know?” (Emphasis added).33

E. Any Study Claiming that Oregon’s Law is Safe, is Invalid.

In 2011, the lack of oversight over administration of the lethal dose in Oregon prompted Montana State Senator Jeff Essmann to make this observation: the Oregon studies claiming that assisted suicide is safe are invalid. He stated:

[All] the protections end after the


prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].

So frankly, any of the studies that come out of the state of Oregon’s experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.34

F. "Eligible" Patients May Have Years, Even Decades, to Live.

ABX2-15 applies to “terminal” patients, meaning those predicted to have less than six months to live. Such persons may actually have years, even decades, to live. This is true for at least three reasons:

1. If California follows Oregon’s interpretation of “terminal disease,” assisted suicide will be legalized for people with chronic conditions such as diabetes.

ABX2-15 states:

“Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.35

Oregon’s law has a nearly identical definition:

“Terminal disease” means an incurable and


35 ABX2-15, § 443.1(q). (Attached at A-2).
irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.36

In Oregon, this nearly identical definition is interpreted to include chronic conditions such as chronic lower respiratory disease and insulin dependent diabetes. Government reports from Oregon list these conditions as qualifying underlying illnesses for the purpose of assisted suicide. See, for example, the Oregon government report attached hereto at A-33 and A-34.37 The report lists "chronic lower respiratory disease" and "diabetes mellitus" (better known as "diabetes") as underlying illnesses.38

Oregon doctor William Toffler explains:

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions . . . . Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live. (Emphasis added).39

If California enacts ABX2-15 and follows Oregon's interpretation of "terminal disease," assisted suicide will be legalized for people with chronic conditions such as diabetes. Dr. Toffler states:


37 The entire report is attached hereto at A-29 through A-34.

38 Per William Toffler, MD, "diabetes mellitus" is the same thing as "diabetes."

Such persons, with treatment, could otherwise have years or even decades to live.\footnote{Id.}

2. Misdiagnosis occurs; predictions of life expectancy can be wrong, sometimes way wrong.

Patients may also have years to live due to misdiagnosis and because predicting life expectancy is not an exact science; doctors can be wrong, sometimes way wrong. See, for example: Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, April 17, 2014, available at http://www.cbsnews.com/news/12-million-americans-misdiagnosed-each-year-study-says; and Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?", The Seattle Weekly, January 14, 2009. (Attached hereto at A-13).

Consider also John Norton, who was diagnosed with ALS (Lou Gehrig’s Disease) at age 18.\footnote{Affidavit of John Norton, ¶ 1 (Attached hereto, beginning at A-36).} He was told that he would get progressively worse (be paralyzed) and die in three to five years.\footnote{Id.} Instead, the disease progression stopped on its own.\footnote{Id, ¶1.} In a 2012 affidavit, at age 74, he states:

If assisted suicide or euthanasia had been
available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.


3. Treatment can lead to recovery.

Oregon resident Jeanette Hall was diagnosed with cancer in 2000 and wanted to do assisted suicide.\textsuperscript{44} Her doctor convinced her to be treated instead.\textsuperscript{45} In a 2012 affidavit, she states:

This last July, it was 12 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.\textsuperscript{46}

G. Assisted Suicide Can Be Traumatic for Family Members as Well as Patients.

1. The Swiss study.

In 2012, a study was published addressing trauma suffered by persons who witnessed a legal assisted suicide in Switzerland.\textsuperscript{47} The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized. These persons:

[E]xperienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted

\textsuperscript{44} Affidavit of Kenneth Stevens, MD, Jeanette Hall discussed at A-40.

\textsuperscript{45} Id.

\textsuperscript{46} Affidavit of Jeanette Hall, ¶¶ 5-9. attached hereto at A-49 to A-50. Jeanette is still alive today, 15 years later.

2. My cases involving the Oregon and Washington assisted suicide laws.

I had two clients whose fathers signed up for the lethal dose. In the first case, one side of the family wanted the father to take the lethal dose, while the other did not. The father spent the last months of his life caught in the middle and traumatized over whether or not he should kill himself. My client, his adult daughter, was also traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client that the client's father refused to take the lethal dose when it was delivered ("You're not killing me. I'm going to bed"), but then took it the next night when he was high on alcohol.

H. Enactment Will Allow California Health Care Providers to Steer Patients to Suicide; The Bill Does Not Prevent Steerage.

If ABX2-15 is enacted, California health care providers and insurers will be able to steer patients to suicide through coverage incentives, a practice that is well documented in Oregon. For more information, see the attached affidavit of

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48 Id.

49 These cases are described in: Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus (an article about elder abuse, guardianship abuse and assisted suicide)," The Voice of Experience, ABA Senior Lawyers Division Newsletter, Vol. 25, No. 4, Winter 2014, available at http://www.choiceillusion.org/2014/02/preventing-abuse-and-exploitation.html
Oregon doctor Kenneth Stevens at A-39 through A-48 (beginning with paragraph 10).

Dr. Stevens’ affidavit describes steerage in the Oregon Health Plan (Medicaid). The Plan will not necessarily pay for a patient’s treatment to live, but it will pay for the patient’s suicide. Dr. Stevens explains:

The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in [your state], your government health plan could follow a similar pattern. Private health plans could also follow this pattern. If so, these plans would pay for you . . . to die, but not to live. (Emphasis added).

Proponents may counter that the bill, § 443.13(c), prevents steerage. That section, however, merely restricts how the steerage can be communicated to the patient by an insurer (the insurer may not “include both the denial of treatment and information as to the availability of an aid-in-dying drug” in the same communication to an individual; two separate communications are permissible). In addition, § 443.13(c) does not prevent a doctor or anyone else from providing such

50 Affidavit of Kenneth Stevens, MD, ¶ 16. (Attached hereto at A-42).

51 ABX2-15, § 443.13(c) states:

An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. (Attached hereto at A-8).
information to the patient. Under ABX2-15, insurers will be still be able to “pay for you . . . to die, but not to live.”

I. In Oregon, Other (Conventional) Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost Is “Enormous.”

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. The statistical correlation is consistent with a suicide contagion in which legalizing and normalizing physician-assisted suicide encouraged other suicides. Please consider the following:

Oregon's assisted suicide act went into effect “in late 1997.”

By 2000, Oregon's conventional suicide rate was "increasing significantly."

By 2007, Oregon's conventional suicide rate was 35% above the national average.

By 2010, Oregon's conventional suicide rate was 41% above the national average.

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52 Id.
53 Id.
54 Oregon’s assisted suicide report for 2014, first line, attached at A-29.
56 Id.
According to the Oregon Health Authority, the financial cost of these other suicides is "enormous" for Oregon, a much smaller population state than California.\textsuperscript{58} One reason is that people who attempt suicide (and fail) can injure themselves or become disabled by the attempt. The Oregon Health Authority states:

The cost of suicide [and attempted, but unsuccessful suicides] is enormous [for Oregon]. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.\textsuperscript{59}

The Oregon Health Authority also states:

The loss to families and communities broadens the impact of each death.\textsuperscript{60}

Oregon is the only state where there has been legalization of assisted suicide long enough to have statistics over time. The significant financial cost due to increased conventional suicides in Oregon, positively correlated to physician-assisted suicide legalization, is a significant factor for this body to consider regarding the proposed bill, which seeks to legalize physician-assisted suicide in California.

If California, with its larger population, enacts the proposed bill and has the same experience as Oregon, the

\textsuperscript{58} Oregon has 3.9 million people compared to California, at 39 million people. See https://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_population

\textsuperscript{59} Quoted material can be viewed at A-78.

\textsuperscript{60} Id.
financial cost could be substantial. The emotional cost could also be substantial.

J. **If California Follows Washington State, the Death Certificate Will Be Required to Reflect a Natural Death: This Will Allow the Perfect Crime.**

ABX2-15 states:

> Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.\(^61\)

Washington State’s law has similar language, as follows:

> Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.\(^62\)

In Washington State, this similar language is interpreted to require the death certificate to reflect a natural death if Washington’s law was used. Moreover, there must not be even a hint that the actual cause of death was assisted suicide or euthanasia. The Washington State Department of Health, “Instructions for Medical Examiners, Coroners and Prosecuting Attorneys: Compliance with the Death with Dignity Act,” states:

> Washington’s Death with Dignity Act (RCW 70.245) states . . . "Actions taken in accordance with this chapter do not, for any

\(^61\) ABX2-15, § 443.18, second sentence. (Attached at A-10).

\(^62\) RCW 70.245.180, second sentence. (Attached at A-26).
purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."

If you know that the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record: . . .

2. The manner of death must be marked as "Natural."

3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
   a. Suicide
   b. Assisted suicide
   c. Physician-assisted suicide
   d. Death with Dignity
   e. I-1000
   f. Mercy killing
   g. Euthanasia
   h. Secobarbital or Seconal
   i. Pentobarbital or Nembutal (Emphasis added)

Attached hereto at A-27.

With the death required to be treated as "Natural" simply because the act was used, a perpetrator who tricked the patient into taking the lethal dose, or who administered the lethal dose to the patient while he/she was asleep, or who directly killed the patient over the patient’s vehement objection, cannot be convicted of murder. The Medical Examiner, the Coroner and the Prosecutor must certify the death as Natural without any indication of the true cause of death.

If California adopts a similar interpretation based on ABX2-
15's similar language, there will be a similar result. Patients will be unprotected under the law. There will be no legal ability to prosecute outright murder and the death certificate will provide official cover. ABX2-15 will create the perfect crime.

K. ABX2-15 Legalizes Euthanasia.

Generally accepted medical practice allows a doctor, or "a person acting under the direction of a doctor," to administer drugs to a patient. Common examples of persons acting under the direction of a doctor, include: (1) nurses who administer drugs to patients in a hospital setting; (2) parents who administer drugs to their children in a home setting; and (3) adult children who administer drugs to their parents in a home setting.

Under ABX2-15, an "aid-in-dying drug" is a drug that a patient "may choose to self-administer" to bring about his or her death. There is, however, no language making self-

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63 Declaration of Dr. Kenneth Stevens, MD, ¶10. (Attached A-54).
64 Id.
65 ABX2-15, § 443.1(b) states:

"Aid-in-dying drug" means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease. (Emphasis added)
administration mandatory.\textsuperscript{66} For example, there is no language stating that administration of the drug "must" be by self-administration.\textsuperscript{67}

With self-administration not mandatory, generally accepted medical practice allows a doctor, or a person working under the direction of a doctor, to administer an aid-in-dying drug to a patient. This is euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 2.21, states:

Euthanasia is the administration of a lethal agent by another person to a patient . . . .
(Emphasis added).\textsuperscript{68}

ABX2-15 legalizes euthanasia.

I. Euthanasia Is Not Prohibited.

Proponents may counter that euthanasia is prohibited under ABX2-15, § 443.18, which states:

Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia.

Attached at A-10.

This prohibition is, however, defined away in the next sentence, which states:

\textsuperscript{66} See ABX2-15 in its entirety, at A-1 through A-12.

\textsuperscript{67} Id.

\textsuperscript{68} AMA Code of Ethics, Opinion 2.21 —"Euthanasia." (Attached hereto at A-57).
Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide [another word for “euthanasia”], or elder abuse under the law.

Id.

V. CONCLUSION

If ABX2-15 becomes law, people with years to live will be encouraged to throw away their lives; patients and their families will be traumatized; healthcare providers will be able to steer people to suicide.

The bill, regardless, is a recipe for elder abuse with the most obvious reason being a complete lack of oversight at the death. Even if the patient struggled, who would know? The required falsification of the death certificate to reflect a natural death creates the perfect crime.

Even if you are for the concept of assisted suicide, ABX2-15 is the wrong bill.

DATED THIS ___ DAY OF SEPTEMBER 2015.

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Attachments

Margaret Dore Memo

Vote NO on ABX2-15

Submitted to the

California State Assembly

on

September 7, 2015
SECTION 1. Part 1.85 (commencing with Section 443) is added to Division 1 of the Health and Safety Code, to read:

PART 1.85. End of Life Option Act
443. This part shall be known and may be cited as the End of Life Option Act.

443.1. As used in this part, the following definitions shall apply:

(a) "Adult" means an individual 18 years of age or older.
(b) "Aid-in-dying drug" means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.
(c) "Attending physician" means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.
(d) "Attending physician checklist and compliance form" means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.
(e) "Capacity to make medical decisions" means that, in the opinion of an individual’s attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual 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.
(f) "Consulting physician" means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual’s terminal disease.
(g) "Department" means the State Department of Public Health.
(h) "Health care provider" or "provider of health care" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code; and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of this code.
(i) "Informed decision" means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual’s life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

(1) The individual’s medical diagnosis and prognosis.
(2) The potential risks associated with taking the drug to be prescribed.
(3) The probable result of taking the drug to be prescribed.
(4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.
(5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.