Belgian doctors take legal euthanasia practice to new lows, without sanctions

After ten years of legalized euthanasia practice, Belgian doctors are stretching the law well beyond the limits set by lawmakers in 2002 when the euthanasia law was enacted.

The law is specific on who legally qualifies for euthanasia: only competent adults and emancipated minors with serious and incurable medical conditions that cause constant and unbearable physical or mental suffering that cannot be alleviated. Also, qualified patients’ death requests have to be voluntary, well-considered, repeated over time, and not the result of any outside pressure.

According to a recent report issued by the European Institute of Bioethics (EIB), however, euthanasia in Belgium has become normal practice, too commonplace, and trivialized.

In the face of certain high profile cases, the evident relaxation of the [law’s] very strict conditions has caused many reactions but also a total absence of any sanctions... and a very conciliatory silence from the political establishment has given rise to a feeling of impunity on the part of some concerned medical practitioners, and to a feeling of powerlessness in those worried about where things are leading. [EIB, “Euthanasia in Belgium: 10 Years On,” 4/12, p. 7]

EIB’s report also revealed that nearly half of the members of the Commission for Control & Assessment, the group charged with officially overseeing euthanasia practice, are also members of Belgium’s Right to Die in Dignity Association. That explains in large part why, after over 5,500 euthanasia deaths, the commission never once reported questionable cases to authorities. [EIB, pp. 5-6]

An elastic law

As reported in the last Update, there have been at least nine patients since 2007 who have been voluntarily euthanized with their vital organs harvested for transplantation—a highly questionable practice. Given the compelling need for an increasing supply of organs for transplantation, coupling organ retrieval with euthanasia can place undue pressure on vulnerable, depressed patients to give their lives meaning by donating their organs to others. It’s a practice that was not sanctioned by the euthanasia law in 2002. Yet, Dr. Dirk Van Raemdonck, Belgium’s leading organ transplant specialist, has openly declared—without any fear of (continued on page 4)

Eleven states targeted for legal doctor-assisted suicide in 2013

The beginning of a new year is the time when assisted-suicide advocates usually reveal their plans to push doctor-prescribed suicide in targeted states. This year, 2013, is no different.

The assisted-suicide advocacy groups Compassion & Choices (C&C) and the Death with Dignity National Center (DWDNC) have eleven states in their sights: Vermont, New Jersey, Massachusetts, Connecticut, Maryland, California, New Hampshire, Kansas, Hawaii, Montana, and New Mexico. It appears that DWDNC will be most active in the New England states, while C&C will oversee the western states that have bills or court cases aimed at assisted-suicide legalization. [DWDNC, Living with Dying Blog, 1/9/13, Emailed Update, 2/1/13; C&C, All News, 1/4/13]

Vermont

Vermont has been targeted eight times for bills to legalize prescribed suicide, all of which have failed. But 2013, advocates say, will be different. Vermont’s Democratic governor, Peter Shumlin, has vowed to get an assisted-suicide bill passed during his term as governor, and the state’s legislature is predominantly left on the political scale.

It was thought that the 2013 bill would be identical to last year’s failed bill. A series of hearings—including a public hearing where opponents far outnumbered supporters—were held the last week of January by the Senate Health & Welfare Committee. Incredibly, despite expert testimony that the bill would put patients at risk, the committee opted to (continued on page 2)
Eleven states targeted for legal doctor-assisted suicide in 2013, continued from page 1

weaken some of the 2012 bill’s provisions, and, since all five committee members were co-sponsors of the bill, quickly passed the measure on February 1. The bill now goes to the Senate Judiciary Committee where it likely will be voted down. However, the Judiciary chairman, who opposes the bill, has agreed to send it, with an unfavorable recommendation, for a full Senate vote. That vote is expected to be very close. [Burlington Free Press, 1/21/13, 2/1/13; Fox 44 News, 2/1/13] In addition to the Vermont Medical Society, experienced opposition coalitions, comprised of disability rights activists, health care professionals, citizen groups, and others, are working hard to defeat the bill. “We are the only ones who can stop this, and we will.” [True Dignity VT, Update, 1/30/13]

New Jersey

Last September, Assemblyman John Burzichelli, introduced the “New Jersey Death with Dignity Act” (A 3328), a bill to legalize Oregon-style doctor-prescribed suicide. In December, Burzichelli tried to use the release of New Jersey’s Farleigh Dickinson University PublicMind poll to promote his bill. The poll found that 46 percent of the 433 voters surveyed would likely support it, while 38 percent would not. Most significant, however, was the fact that 55 percent said they had never heard of the “Death with Dignity Act.” The poll’s analyst, Dan Cassino, explained that this lack of awareness about the issue shows there is plenty of room for people to change their minds about the bill. [nj.com, 12/3/12; Newsmax, 12/4/12; South Jersey Times, 12/6/12] Burzichelli’s bill, which has been sitting in the Assembly Health and Senior Services committee since last September, is scheduled for a committee hearing on February 7.

Massachusetts

Just two months after Massachusetts voters defeated a ballot initiative that would have legalized assisted suicide, Peg Sandeen, executive director of the DWDNC, the group that spearheaded the initiative campaign, said she would get a bill before the Massachusetts legislature rather than waiting until 2016 to get another prescribed-suicide initiative on the ballot. [PRWeb, 1/15/13] In January, Rep. Louis Kafka did just that and filed HD 1183, the text of which is not yet available.

Connecticut

A bill to legalize prescribed suicide in Connecticut was introduced on January 9, and referred to the Joint Committee on Judiciary. However, as of February 1, the complete text of the bill had not been posted on the legislature’s website. What is posted is a cover page of sorts indicating the bill’s number (Proposed Bill No. 48 - LCO No. 96), its title (“An Act Concerning Physician-Assisted Suicide”), and a “Statement of Purpose” (“To permit a competent person who is suffering from a terminal illness to take his or her life through the self-administration of prescribed medication”). C&C and DWDNC have targeted Connecticut before. In 1995, 1997, and 2009 legislators rejected their bills, and a C&C instigated lawsuit was dismissed outright by a judge in 2010 before it was fully heard. Any support for the current bill may be overshadowed by the state’s fiscal issues. [Yale Daily News, 11/27/12; Branford Seven, 1/9/13]

Maryland & California

While C&C and DWDNC have indicated that they will push their “aid-in-dying” (assisted suicide) agenda in Maryland and California, there have been no bills introduced or court actions initiated as of February 1 to challenge the assisted-suicide laws in these states. However, C&C is looking closely at California because the generally-friendly-to-assisted-suicide Democrats in California currently hold a two-thirds majority in both legislative houses. According to C&C’s website, “[W]e’ve spearheaded an effort in California to assess the variety of options available to move aid in dying and other end-of-life issues forward.” [C&C, All News, 1/4/13]

New Hampshire & Kansas

New Hampshire bill HB 403, introduced on January 3, would create a commission to “study” the state’s prior assisted-suicide bills and the prescribed-suicide laws in other states. Between 1996 and 2011, five NH bills to legalize the practice were all defeated.

For the first time, an assisted-suicide bill has been introduced in Kansas. The “Kansas Death with Dignity Act” (HB 2068) was introduced on January 23 and referred to the Committee on Health & Human Services on January 24.

Hawaii

Hawaii is a perennial target for assisted-suicide legislation—11 times since 1998. The latest bill (HB 606) was introduced by House Speaker Calvin K.Y. Say on January 22 and referred to the House Health Committee. The bill seems at odds with C&C’s ongoing campaign to convince doctors and others that “aid-in-dying” is already legal in Hawaii, a claim rejected by the state attorney general, who said it’s a felony. Last December, the Hawaii Medical Association reaffirmed its staunch opposition to the practice in response to C&C’s formation of the Physician Advisory Council for Aid in Dying, a small group of doctors who are ready to write lethal prescriptions to test just how willing authorities are to uphold the law. [Civil Beat, 12/5/12, 12/20/12]

Montana & New Mexico

In 2009, the Montana Supreme Court ruled that there is no legal state precedent or statue that makes assisted suicide against public policy, leaving it up to the legislature to explicitly legalize or ban the practice. At present, one bill (SB 220) to legalize prescribed suicide was introduced on January 31, and another bill to clarify Montana’s law against assisted suicide is in the drafting process.

In New Mexico, a lawsuit is pending in state district court. C&C, the ACLU of New Mexico, a cancer patient, and two doctors are challenging the state’s law banning assisted suicide. Their argument—C&C’s mantra—is that doctors who provide aid-in-dying to end the lives of the terminally ill are not assisting suicides and, therefore, are not violating the assisted-suicide law.
Oregon’s 2012 assisted-suicide report: more deaths & unknowns

According to Oregon’s latest annual report on assisted-suicide deaths, 61 doctors wrote 115 prescriptions for lethal drugs in 2012, resulting in the reported deaths of a record high 77 patients. That brings Oregon’s reported assisted-suicide body count to 673 since the Death with Dignity Act (DWDA) was enacted in 1997.

In 2012, the doctor-prescribed death rate reached a record 23.5 per 10,000 total deaths in Oregon. That’s sobering, considering the 1998 rate was 5.5 assisted suicides per 10,000 total deaths.

Of the 115 patients who were prescribed lethal drugs in 2012, 67 took them and 66 died. The remaining patient regained consciousness two days after ingesting the overdose, but was “minimally responsive.” The patient died six days later, and the death was not added to the assisted-suicide total. Twenty-three patients who received the drugs did not take them and eventually died of other causes. Eleven patients, who had been prescribed the fatal overdose in 2011, took them in 2012 and died.

According to the 2012 report, the Oregon Public Health Division (OPHD), the state agency responsible for overseeing compliance with the DWDA, does not know what happened to 25 of the patients who received prescriptions. The OPHD knows that 14 died, but how they died is unknown, and, regarding the remaining 11 patients, the OPHD has no clue whether they are alive or dead.

When it comes to the DWDA, the OPHD has many unknowns. It has acknowledged that it has no idea how many doctor-assisted suicides were not reported in any given year. Moreover, the OPHD has no authority whatsoever to investigate individual prescribed-suicide cases, even though the law mandates that the agency “collect information on compliance.”

Not surprisingly, in 2012, the OPHD referred no physicians to the Oregon Medical Board for failure to comply with the DWDA. [OPHD, Oregon’s Death with Dignity Act—2012, 1/16/13]

### Reported Assisted-Suicide Deaths in Oregon 1998-2012

Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates. Figures are those reported by the state.

<table>
<thead>
<tr>
<th>Categories</th>
<th>1998 - 2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of reported assisted-suicide deaths</td>
<td>460</td>
<td>65</td>
<td>71</td>
<td>77</td>
<td>673</td>
</tr>
<tr>
<td>No. of unreported assisted-suicide deaths</td>
<td>Unknown1</td>
<td>Unknown1</td>
<td>Unknown1</td>
<td>Unknown1</td>
<td>Unknown1</td>
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<tr>
<td>No. of reported lethal prescriptions written</td>
<td>724</td>
<td>97</td>
<td>114</td>
<td>115</td>
<td>1050</td>
</tr>
<tr>
<td>No. of doctors who wrote lethal prescriptions in a given year</td>
<td>?1</td>
<td>59</td>
<td>62</td>
<td>61</td>
<td>?1</td>
</tr>
<tr>
<td>No. of cases where prescribing doctor was present when lethal drugs were ingested</td>
<td>88</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>108</td>
</tr>
<tr>
<td>Other care provider present</td>
<td>218</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>235</td>
</tr>
<tr>
<td>No provider present</td>
<td>63</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>73</td>
</tr>
<tr>
<td>Unknown</td>
<td>21</td>
<td>45</td>
<td>57</td>
<td>64</td>
<td>187</td>
</tr>
<tr>
<td>No. of cases where prescribing doctor was present at the time of death</td>
<td>77</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>96</td>
</tr>
<tr>
<td>Other care provider present</td>
<td>233</td>
<td>19</td>
<td>2</td>
<td>4</td>
<td>258</td>
</tr>
<tr>
<td>No provider present</td>
<td>69</td>
<td>39</td>
<td>63</td>
<td>66</td>
<td>237</td>
</tr>
<tr>
<td>Unknown</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>No. of patients referred for psychiatric evaluation</td>
<td>38 [8.2%]</td>
<td>1 [1.5%]</td>
<td>1 [1.4%]</td>
<td>2 [2.6%]</td>
<td>42 [6.2%]</td>
</tr>
<tr>
<td>Patients’ reasons for requesting assisted suicide:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of autonomy</td>
<td>414 [90%]</td>
<td>61</td>
<td>93.8%</td>
<td>63</td>
<td>88.7%</td>
</tr>
<tr>
<td>Inability to do enjoyable activities</td>
<td>398 [86.5%]</td>
<td>61</td>
<td>93.8%</td>
<td>64</td>
<td>90.1%</td>
</tr>
<tr>
<td>Loss of dignity</td>
<td>282 [61.3%]</td>
<td>51</td>
<td>78.5%</td>
<td>55</td>
<td>74.6%</td>
</tr>
<tr>
<td>Lost control of bodily functions</td>
<td>264 [57.3%]</td>
<td>30</td>
<td>46.2%</td>
<td>24</td>
<td>33.8%</td>
</tr>
<tr>
<td>Being a burden</td>
<td>167 [36.3%]</td>
<td>17</td>
<td>26.2%</td>
<td>30</td>
<td>42.3%</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it</td>
<td>101 [21.9%]</td>
<td>10</td>
<td>15.4%</td>
<td>23</td>
<td>32.4%</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>12 [2.7%]</td>
<td>1</td>
<td>1.5%</td>
<td>2</td>
<td>2.8%</td>
</tr>
<tr>
<td>Complications after lethal drugs were ingested:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regurgitation</td>
<td>20</td>
<td>1</td>
<td>1.5%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Patient awakened</td>
<td>101</td>
<td>2</td>
<td>1.5%</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>11</td>
<td>37</td>
<td>59</td>
<td>66</td>
<td>177*</td>
</tr>
<tr>
<td>Reported incidents of physician non-compliance with the assisted-suicide law</td>
<td>21</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Penalties imposed for non-compliance with the assisted-suicide law</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Notes:
1. The Oregon Public Health Division (OPHD), the agency responsible for overseeing the practice of doctor-prescribed suicide, has acknowledged that it has no way of knowing if deaths went unreported or if the data provided by prescribing doctors are accurate or complete. The Pharmacy Dispensing Report simply asks for general information (i.e., patient-physician names and drugs prescribed) but no data on patient cases.
2. Death certificates, by law, do not even indicate drug overdose as the true cause of death.
3. Six patients (1 in 2005, 2 in 2010, 2 in 2011, 1 in 2012) did not die after ingesting the lethal drugs. They regained consciousness and eventually died of their underlying illnesses. Before 2011, OPHD listed these cases under “Complications.” Now OPHD includes them in the text of the “Summary” and does not include them in the totals for assisted-suicide deaths.
4. OPHD’s 2012 report lists a total of 177 cases since 1997 where it was unknown whether complications resulted from the lethal overdose. But, according to the statistics in all the prior reports, that figure should be 173.


All 15 annual reports are available online at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx
legal or professional sanctions—that Belgium is the world leader in organ harvesting after euthanasia. [demaakbarrenens.org, 9/30/12; BioEdge, 10/5/12]

It was also revealed in 2012 that Belgium is now stretching the law to include prisoners. The first-ever prisoner euthanasia was performed early last year. The unidentified man, who was serving a long prison sentence, sought permission to be euthanized several times before doctors decided that his suffering could not be alleviated. His illness was not revealed. A second prisoner, sentenced to 27 years in prison for two murders, has also asked to be euthanized. The Flemish TV channel VTM reported that this prisoner should satisfy the law’s legal requirements as well. [Medical Express News, 9/13/12]

**Twin brothers euthanized**

The euthanasia deaths of 45-year-old twin brothers is yet another example of how broadly the euthanasia law is being interpreted. Marc and Eddy Verbessem, identical twins who were born deaf, had spent their entire lives together and never married. They shared a flat in Putte, a village near Brussels, and both worked as cobblers. They were not terminally ill, nor were they experiencing physical pain. Their suffering was the result of fear and depression after they both were diagnosed with a genetic form of glaucoma, and the prospect of going blind in the future, of not being able to see each other, was reportedly more than they could bear. They also were terrified that they would end up in an institution because they would no longer be able to care for themselves. “I sometimes think,” their older brother, Dirk Verbessem, said, “if they had their wives and children, perhaps they would have had something to live for.”

When they went to their local hospital with their euthanasia requests, they were turned down. Reportedly, the doctor said, “If any blind or deaf are allowed to euthanize, we are far from home. I do not think this was what the [euthanasia] legislation meant by ‘unbearable suffering.’”

It took the Verbessem twins nearly two years to find a hospital and doctors willing to kill them. On December 14, 2012, at Brussels University Hospital in Jette, the twins were given lethal injections and quickly died. Dr. David Dufour, who supervised their deaths, told reporters, “They were very happy. It was a relief to see the end of their suffering.” Dr. Wim Distelmans, a clinical professor of palliative care at Brussels University and a longtime euthanasia activist, was the one who approved the twins for induced deaths. He was quoted as saying, “It is certain that the twins meet all the conditions for euthanasia.” [Daily Telegraph, 1/13/13, 1/14/13; Daily Mail, 1/15/13; Reuters, 1/15/13; USA Today, 1/14/13; CBS News, 1/14/13]

Few in the news media questioned whether Distelmans’ assessment of the legality of the twins’ euthanasia deaths was accurate. Overall, most just accepted what they were being told. The International Business Times, however, took it a step further. Its article on the deaths was titled, “Euthanasia Victory for Deaf Belgian Twins Marc and Eddy.” [IBT, 1/15/13]

But most in the disability community view the twins’ deaths as anything but a “victory.” Dr. Marc Maurer, president of the National Federation of the Blind (NFB), issued a press release stating, “[T]he technology and services available today have vastly improved prospects for the deaf-blind and others with disabilities. That these men wanted to die is tragic; that the state sanctioned and aided their suicide is frightening.” [NFB, Press Release, 1/15/13]

Stephen Drake of the disability rights group Not Dead Yet (NDY) blogged similar concerns and directed readers to a blog by Coco, a deaf-blind advocate and speaker. She wrote, “Makes me wonder if the doctors consulted with the only Flemish Deafblind organization, "Feviado," or if the twins were aware that there is another side to the Deafblind life—where there are accessible technologies, tactile lessons...This horrifies me.” [Drake, NDY News & Commentary, 1/14/13; Coco, Tactile the World blog, 1/14/13]

**More evidence of the slippery slope**

Just days after the twins’ deaths, the Socialist Party submitted new legislation to the Belgian parliament that would change the law to make minors and people with Alzheimer’s-like illnesses eligible for euthanasia. According to party chairman Thierry Giet, “The idea is to update the law to take better account of dramatic situations and extremely harrowing cases we must find a response to.” [Agence France-Presse, 12/18/12] But Belgian medical ethics professor Chris Gastmans disagrees: “Is this the only humane response that we can offer in such situations?” he asked. “Today it seems that euthanasia is the only right way to end life. And I think that’s not a good thing,” he explained. “In a society as wealthy as ours, we must find another, caring way to deal with human frailty.” [Daily Telegraph, 1/14/13]

Rita Marker, executive director of the Patients Rights Council (PRC), said Belgium should be a warning to any jurisdiction considering the legalization of doctor-prescribed death. “Belgium shows all of us where legalizing euthanasia or assisted suicide will take us.”
Like the constantly changing patterns of a kaleidoscope, attitudes shift ever so slightly, molding new patterns of thinking. Imperceptibly, what was once unthinkable transforms into the acceptable, on its way to becoming the appealing and, finally, the required.

Such a progression is currently underway regarding basic care and the right of patients to demand that health care providers act as enablers. An "enabler" is one who helps another carry out self-destructive behavior.

Not long ago, it would have seemed unbelievable that health care providers would be legally compelled to be enablers of a patient's death resulting from the patient's refusal of basic care.

That was then. This is now.

Refusal of basic care

At the end of November, an article titled, "You MUST Let My Bedsores Kill Me, You MUST," appeared on Medline (11/29/12). Its author, Arthur Caplan, PhD, who is the director of the Division of Medical Ethics at NYU Langone Medical Center in New York, described what he called an "interesting, and in some ways disturbing, ethics consultation" case.

The case involved a man in his eighties who had been living independently until a series of small strokes resulted in his hospitalization. He was told that, eventually, he would have to be moved to a nursing home and that his days of living on his own were over. He found that prospect to be totally unacceptable.

While still hospitalized, nurses caring for him explained that they needed to turn him since being in bed without repositioning raised a great risk of developing bad skin ulcers (bedsores). He not only refused to permit this but also rejected the suggestion that they provide him with a special air mattress to reduce the risk. He clearly stated, "I don't want you to turn me anymore: stop turning me."

His decision presented a dilemma for the hospital since it is a standard of care to turn patients who are immobilized.

Some of the doctors thought he must be depressed and unable to make rational decisions. However, a mental health evaluation indicated that he was competent. The hospital ultimately determined that, because of his refusal, he could not be turned.

As time went on, he did develop skin ulcers, some of which became infected. The hospital attempted to move him to a long-term care facility or to a hospice, but both refused to accept him as a patient. So, the man remained in the hospital until he died with large infected wounds.

Caplan described this, stating, "Basically, his body fell apart." After affirming the man's right to die in this manner, Caplan suggested that health care institutions may want to establish policies such as "We always turn people, and we do not shut off heat in a patient's room..." According to Caplan, "It may be important to think about this kind of dilemma in advance, and be ready to say as soon as a request comes that this is a patient's right, but is not something we can accept at this facility." (emphasis added)

Having such policies not only may be important, it is absolutely vital to do so.

Not an isolated case

Recent articles in medical journals, law journals and the popular press have promoted voluntarily stopping eating and drinking (VSED) as an "end-of-life option" available to any adult, anywhere, for any reason.

This "option" does not refer to stopping food and fluids provided by means of a feeding tube or to situations in which a patient has no appetite or is unable to eat or drink due to illness or disease. It is suggested for anyone who has decided to die. Death by dehydration will take place within 5 to 21 days. (See "Campaign for VSED" in Update, 2011, vol. 25, no. 3, p. 3)

Certainly, competent adults do have the legal right to stop eating and drinking. However, this does not mean that health care providers must be enablers by providing assistance supporting a patient's decision to reject basic care.

Medical treatment or basic care?

"Treatment" is defined as the application of remedies to relieve or cure a disease or disorder, and the right to refuse treatment is well established in law and practice. However, in recent years, the lines between what is care and what is treatment have blurred.

There are four major necessities of life that every person—whether old or young, independent or dependent—needs and, without which, the person would eventually die.

These four necessities are warmth, hygiene, food & fluids and repositioning. None of them cures any disease or disorder. Instead, they prevent life-threatening conditions.

Keeping in mind that what is legal is not always ethical, it is legal for competent adults to refuse even the most basic care. But, just as competent adults may refuse basic care, health care providers may refuse to become enablers of that self-destructive behavior—but only if they do so in a legally acceptable way.

Necessity of principles and policies

It is imperative that health care facilities and individual health care providers establish clear, written principles and policies regarding what is considered to be basic care and what they, as providers, will not do or enable.

Federal law as well as state laws permit this refusal, but only if patients and staff are informed of those principles and policies in a timely manner—generally at the time of admission.

Failure to formulate such principles and policies will force health care providers to be enablers of self-destructive behavior or face legal jeopardy.

Rita Marker is an attorney, author, and the executive director of the Patients Rights Council.
Some hospice policies present obstacles for patients

It’s often been said that terminally-ill patients are enrolled in hospices too late and miss out on weeks or even months of the hospice’s palliative care and support. At fault, we are told, are patients and families who are in denial regarding the prospect of the impending death and doctors who are reluctant to upset patients by referring them to hospice programs. But a new study, published in the journal *Health Affairs*, found that some of the blame belongs to hospices that have restrictive enrollment policies.

The study is the first national inquiry into hospice enrollment requirements. Researchers surveyed 591 US hospices and found that nearly 80 percent had at least one enrollment policy that could restrict access to care for patients with costly medical care needs. Over 60 percent had policies that prevent the admission of patients on chemotherapy, and half restricted hospice access for those needing intravenous nutrition. Many programs viewed patients receiving palliative radiation or blood transfusions as too costly. Smaller hospices, those in certain areas of the country, and for-profit hospices consistently reported more limiting policies.

“We observe that hospice providers’ own enrollment decisions may be an important contributor to previously observed underuse of hospice by patients and families,” researchers concluded. “Policy changes that should be considered include increasing the Medicare hospice per diem rate for patients with complex needs, which could enable more hospices to expand enrollment.” [*Health Affairs*, 12/12, pp. 2690-2698; *New York Times*, 1/3/13]

NY targets abuse of disabled

Data from just one New York agency showed that, since 2008, there were more than 60,000 alleged cases of abuse involving people with disabilities. But a new law will take effect on June 30, 2013, that will, hopefully, stop the escalation of abuse. The law puts into place a new prosecutor, inspector general, and an abuse hotline. It also establishes the Justice Center for the Protection of People with Special Needs, with over 400 staff members overseeing six state agencies and contractors for residential and day services for approximately one million New Yorkers with disabilities and special needs. When Gov. Andrew Cuomo proposed the new law in 2012, he said that, in 2010, there had been over 10,000 alleged abuse cases in state-funded facilities. [*Times Union*, 12/18/12]

AMA issues policy on “divided loyalty”

The American Medical Association (AMA) has issued a new policy statement on a problem many doctors face if they are employed by hospitals. The AMA’s House of Delegates adopted the policy at its Interim Meeting in December 2012.

More and more doctors are opting for hospital employment rather than face the rising costs and decreasing Medicare and private insurance reimbursements that comes with private practice. In addition, new federal health care mandates encourage physicians and hospitals to work together to coordinate patient care. But doctors employed by hospitals will likely encounter a number of conflicts of interest.

“In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority,” the policy states. “A physician’s paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to overtreat or undertreat patients.”

Since hospitals often try to discourage doctors from referring patients to health care providers or labs not affiliated with the hospital’s network, the policy states, “Physicians should always make treatment and referral decisions based on the best interests of their patients.” Furthermore, “patient advocacy is a fundamental element of the patient-physician relationship and should not be altered by the health care system or setting in which physicians practice.” [*AMA Principles for Physician Employment*, adopted December 2012]

“We never want patients to worry or wonder if a decision is being made in their best interest,” explained Dr. Ardis Dee Hoven, president-elect of the AMA. Cardiologist Dr. Jerry D. Kennett said he knew of cases where a hospital told its doctors not to insert defibrillators in Medicaid patients since “it’s a money-losing proposition.” [*New York Times*, 12/26/12]

Study identifies common elder abuse injuries

Researchers at the University Health Network in Toronto have begun to identify a pattern of injuries that could alert doctors to likely cases of elder abuse. Currently, only two percent of elder abuse cases are reported to authorities by doctors.

After analyzing over 1,100 cases, researchers found that the most frequent injuries among elder abuse patients were face and dental trauma, subdural hematoma (bleeding in the space between the outer and middle layers covering the brain), trauma to the eyes and larynx, rib fractures, and injuries to the upper extremities. The cause of death in a third of the cases was subdural hemorrhage.

In most cases of abuse, the elderly victim lives in a home setting and is cared for by non-professionals. According to lead researcher Dr. Kieran Murphy, “In the cases we reviewed, the abused elderly were often socially isolated, depressed and unkempt. The caregivers were not only financially dependent on the elderly person in their care, they were often dealing with their own substance abuse problems.” “More importantly,” he explained, “we need to integrate the physical and radiological findings with the social context of the patient to help identify those at risk.” [*Radiological Society of North America, News Release*, 11/27/12]
**Oregon:** As reported on page 3, the Oregon Public Health Division (OPHD) has released its annual physician-assisted suicide report for 2012. What is not in that report, or any previous year’s report, is something that was presented in testimony during a Vermont hearing on an Oregon-style, doctor-prescribed suicide bill (see p. 1). George Eighmey, former head of the assisted-suicide promotion group Compassion & Choices (C&C) of Oregon, told lawmakers at the hearing that C&C helps people who want a prescribed death to fill out the official death request forms and to find doctors who will write the deadly prescriptions. Later, Oregon physician Charles Bentz testified that C&C’s “help with the paperwork” includes filling out the forms that the suicide-prescribing doctors are supposed to fill out by law and submitting the forms to the OPHD. [True Dignity VT, Update, 1/31/13] The state agency then uses the data from those forms to compile their supposedly unbiased statistical reports—the same reports that assisted-suicide advocates have been using in other states to try to convince lawmakers and voters that they should adopt Oregon’s “abuse- and problem-free” law.

**Quebec:** On January 15, a panel of three legal experts issued a 435-page report stating that Quebec could legally circumvent Canada’s law banning euthanasia. The panel was convened in June 2012 by the Quebec government to find ways to implement an earlier Special Commission recommendation that euthanasia (called “aid-in-dying”) should be legalized as “appropriate end-of-life care.” [Dying with Dignity Report, Recommendation 13, 3/22/12] According to the legal panel’s report, “the Quebec legislature has the constitutional power to organize the required legal framework for care within the health-care system.” In other words, the province has jurisdiction over its health care system (including end-of-life care), not the federal government. As Quebec’s Junior Health Minister Veronique Hivon explained it, “We are really in a field of regulating end-of-life care and adding the possibility for somebody to have access to medical aid in dying.” [RT.com, 1/16/13] Hivon, who is now responsible for implementing the panel’s report, said she is planning to submit a bill outlining the rules for “medically assisted end-of-life procedures” for Quebec’s National Assembly to consider before it adjourns for the summer. [Montreal Gazette, 1/16/13]

Comment: The rationale being used by the Quebec government is straight out of Compassion & Choices’ strategy playbook for the US: transform the crimes of assisted suicide and euthanasia into medical treatments, and call them something appealing and ambiguous, like “aid-in-dying.”

**Great Britain:** The UK’s General Medical Council (GMC), the agency responsible for regulating doctors and ensuring good medical practice in Britain, has released an unambiguous policy statement (called a “guidance”) on how doctors should handle a patient’s assisted-death request since such assistance is illegal in the UK. The GMC guidance directs doctors to respect patient autonomy and the patient’s right to refuse unwanted treatment, but there is a limit to that autonomy. “Where patients raise the issue of assisting suicide, or ask for information that might encourage or assist them, the respect for a patient’s autonomy cannot justify illegal action,” the GMC wrote. Doctors should “be prepared to listen and discuss the reasons for the patient’s request” and “limit any advice or information about suicide to an explanation that it is a criminal offense to encourage or assist a person to commit or attempt suicide.” [GMC, “When a patient seeks advice or information about assistance to die,” 1/31/13]

**Japan:** In January, Taro Aso, Japan’s foreign minister and deputy prime minister, told those attending a meeting of the National Council on Social Security Reforms that the

(continued on page 8)
The Patients Rights Council is a human rights group formed to promote and defend the right of all patients to be treated with respect, dignity and compassion and to work with individuals and organizations to resist attitudes, programs and policies which threaten the lives of those who are medically vulnerable. To those ends, the PRC compiles well-documented and up-to-date information on a whole range of end-of-life issues, including health care advance directives, futile care policies, health care reform, and doctor-prescribed death.

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best way to solve the financial drain on the country’s social security program is to let the elderly die. “The problem won’t be solved unless you let them die,” he said. He also referred to elderly patients who can’t feed themselves as costly “tube people.” His statements caused quite a stir in Japan, where nearly a quarter of its 128 million population is 60 or older. Later, Aso attempted to apologize by calling his comments “inappropriate,” followed by, “I said what I personally believe, not what the end-of-life medical care system should be.”

But the minister has a history of “inappropriate” statements aimed at the elderly. In 2008, when he was Japan’s prime minister, he told a group of economists, “I see people aged 67 or 68 at class reunions who dodder around and are constantly going to the doctor. Why should I have to pay for people who just eat and drink and make no effort? I walk every day and do other things, but I’m paying more in taxes.” [Guardian, 1/22/13; Daily Mail, 1/22/13]

Commenting on Aso’s statements, Wesley J. Smith, PRC’s legal consultant, wrote:

Japan’s finance minister appears to be echoing former Colorado Governor Richard Lamm’s infamous assertion (he claims a distortion) that the elderly have a “duty to die and get out of the way.” Before we judge too harshly, we should look in a mirror as some express similar sentiments [in the US], for example, calling for health care rationing against the elderly. [National Review, 1/22/13] ■