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Patients Rights Council

# Update

## Care or suicide? It's all available at Washington's "full-service" cancer center

**W**hat was once unthinkable is now laudable, according to a study in the *New England Journal of Medicine* (NEJM). And what's more, the previously unthinkable—a one-stop cancer center that not only fights and treats patients' cancers but also intentionally ends patients' lives—is being offered as a helpful model for use in other states that may opt to legalize doctor-assisted suicide sometime in the future.

### Death with Dignity Program

Washington State enacted its assisted-suicide law, the Death with Dignity Act (DWDA), in 2009. That same year, administrators at the Seattle Cancer Care Alliance (SCCA)—the care site for the Fred Hutchinson/University of

Washington/Seattle Children's Hospital Cancer Consortium that serves five Pacific Northwest states—conducted an institution-wide training program on the DWDA as well as town hall-style meetings with doctors and other staff members to discuss implementing the new law.

According to the study's researchers, all of whom are affiliated with SCCA, there was "considerable internal debate" over implementation. Then a confidential survey was sent to 200 SCCA doctors asking whether they would be willing to be a lethally prescribing physician or a consulting doctor, who just verifies the patient's terminal diagnosis. Of the 81 doctors who responded, 29 said they would be will-

ing to prescribe a lethal drug, 21 would be willing to be a consulting doctor, and 31 were unwilling to participate or were undecided. "The small cadre of willing physicians was thought to be sufficient to support implementation," the researchers explained.

SCCA's new Death with Dignity Program is geared to making doctors and staff comfortable with the assisted-suicide process. Physicians and others employed by SCCA are not compelled to participate, and new patients who are solely seeking suicide assistance are not accepted in the program. (They are referred directly to the prescribed-suicide advocacy group Compassion & Choices of Washington.)

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## State legislatures deal with doctor-assisted suicide measures

**S**o far this year, lawmakers in seven states have had to deal with prescribed-suicide bills—some more than others. Here is an overview.

### Connecticut

It was a defeat that Compassion & Choices (C&C) fought hard to avoid, but on April 5, 2013, the Connecticut General Assembly's Public Health Committee chose not to vote on the C&C supported bill HB 6645, effectively killing it for the 2013 legislative session. "[T]here wasn't enough support in the committee for the vote," said committee vice-chairwoman Senator Gayle Slossberg (D-Milford). "It wasn't even close." [The Register Citizen, 4/5/13] After the bill's defeat, C&C president Barbara Coombs Lee said assisted-suicide activists would work in Connecticut "for the remainder of the year to be in a strong position at the start of next year's leg-

islative session to advance" the bill. [C&C Press Release, 4/4/13]

### Montana

Perhaps the most hotly contested battle occurred in Montana when two bills—one to formally legalize doctor-prescribed suicide (SB 220) and the other to explicitly prohibit it (HB 505)—were defeated in the legislature this session. The tabling of SB 220 last February was a huge defeat for C&C and its supporters, who had waged an intense lobbying and public relation effort in the state. When the assisted-suicide opponents' bill, HB 505, subsequently passed in the House by a vote of 51-46, an alarmed C&C stepped up its lobbying efforts once again in hopes of defeating the measure. Those efforts succeeded on April 15, 2013, when the Senate failed to pass the bill by a vote of 23-27.

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## New developments in Minnesota's case against the Final Exit Network

The Minnesota case against the assisted-suicide facilitating group Final Exit Network (FEN) has become very complicated due to a ruling by Dakota County Judge Karen Asphaug. She found that part of the state's law banning assisted suicide is overly broad and unconstitutional.

The case involves the 2007 death of Apple Valley resident Doreen Dunn, 57, who was not terminally ill, but suffered with chronic pain, insomnia, and depression. Originally, her death was ruled the result of natural causes. She actually died as a result of placing a plastic bag filled with helium over her head—FEN's suicide method of choice. Authorities in Georgia, who had been investigating FEN in another felony case, came across Dunn's name in confiscated FEN documents. They alerted Apple Valley police, and, in May 2012, the Dakota County Grand Jury issued a 17-count indictment against FEN and four of its "exit guides."

In Minnesota, anyone who "intentionally advises, encourages, or assists another in taking the other's own life" can face 15 years in prison. [MN Statute §609.215(1)] FEN's lawyer, Robert Rivas, argued that the state can prohibit "assisting" a suicide, but it is unconstitutional for the law to make "advising" or "encouraging" a suicide illegal, since those are simply acts of speech.

On March 22, 2013, Judge Asphaug ruled that only the term "advises" unconstitutionally infringes on the right to free speech,

and she limited the meaning of the term "encourages" to include only physical acts or language "promoting or urging" a person to commit suicide.

The judge dismissed all charges against Thomas Goodwin, who was charged simply because he was FEN's president at the time of Dunn's death. She also dismissed the "assisting a suicide" charge and the "aiding and abetting interference with a death scene" charge against FEN case coordinator Roberta Massey. (FEN teaches its exit guides to remove evidence in order to fool authorities into thinking the deceased died of natural causes.) Massey, who lives in Delaware, talked with Dunn by phone but had not traveled to Minnesota to see her. She remains charged with aiding and abetting others to assist a suicide.

All charges against FEN (the corporation) and the two exit guides who were present when Dunn died—former FEN medical director Lawrence Egbert and FEN president Jerry Dincin—were not dismissed. However, just days after the judge issued her ruling, Dincin died, and his charges were subsequently dismissed.

Both sides in the case are appealing the judge's ruling. The Dakota County Attorney's Office is challenging the judge's determination that part of the law is unconstitutional, and FEN is appealing the judge's refusal to dismiss all charges in the case. [Dakota County News Release, 4/4/13; FEN News Release, 3/26/13; AP, 3/23/13; *Star Tribune* (MN), 3/23/13] ■

### State legislatures deal with doctor-assisted suicide measures, continued from page 1

#### Vermont

Prescribed-suicide advocates have targeted Vermont nine times for bills to legalize the practice. Up until now, all measures failed. The current bill (S 77), however, may not meet the same fate. In February, the Senate drastically amended the 22-page, Oregon-style bill down to one page that simply granted immunity to doctors and family members if a patient opts to overdose on drugs that were properly prescribed by the doctor. When the bill was referred to the House Human Services Committee, committee members reinstated the Oregon language, and, on April 23, passed the measure along party lines by a vote of 7-4. It then went to the House Judiciary Committee where it was amended again and passed by a margin of 8-3 on April 26. The full House is expected to vote on the measure sometime during the week of April 29.

Interestingly, a poll conducted in March by the Vermont Alliance for Ethical Healthcare found that 67% of Vermonters do not support Oregon-style doctor-assisted suicide and 60% think that it should not be a priority issue for the legislature. [SmithJohnson Research, 3/5-7/13]

#### New Jersey

Two identical bills to legalize physician-assisted suicide were introduced late last year. The Assembly bill (A 3328) was heard in the Health & Senior Services Committee on February

7, 2013, and passed by a vote of 7-2. The Senate bill (S 2259) was referred to the Health, Human Services and Senior Citizens Committee on October 15, 2012. To date, no further action has been taken on either bill.

#### Massachusetts

On January 16, just two months after voters rejected a November 2012 ballot measure to allowed doctor-assisted suicide, a bill to legalize the practice was introduced in the Massachusetts Legislature. HB 1998 was referred to the Joint Committee on Public Health, but, as yet, no action has been taken.

#### Kansas

The Kansas assisted-suicide bill, HB 2068, was introduced on January 23 and referred the next day to the Committee on Health & Human Services where it has been languishing. The committee has taken no action on the measure.

#### Hawaii

Hawaii is the state most often targeted by assisted-suicide activists. This is the twelfth year since 1998 that a prescribed-suicide bill has been introduced. The 2013 bill (HB 606) was referred to the Health, Judicial and Financial Committees on January 22, but the measure died when those committees failed to move the bill before the deadline for House bills to be passed and sent to the Senate. ■



## Texas Struggles with Its Futile Care Beast

By Wesley J. Smith

**F**or years, bioethicists touted “autonomy” as the be all and end all in health care. You don’t want to be hooked up to machines when you become very ill? You have a right to just say no. You don’t want to live with a terminal illness or serious disability? Doctors should be able to write a lethal prescription so you can kill yourself “non violently.”

Okay, but what if you *want* life-sustaining treatment when seriously ill? Sorry. That’s not up to you. *Autonomy has its limits!* Doctors and bioethics committees should have the final say. Welcome to the surrealistic world of Futile Care Theory (AKA medical futility) where “futilitarians” are busily redefining the role of doctors, the ethics of health care, the perceived moral worth of sick and disabled people, and the power of patients over their own bodies.

Futile Care Theory goes something like this: When a patient reaches a certain stage of age, illness, or injury, any further treatment other than comfort care is “futile” and should be withheld or withdrawn. That the patient may want the treatment anyway, because of deeply held values or a desire to live longer or take a chance on medical improvement, is not decisive; the doctors and hospitals involved have the right to refuse treatment as an exercise in *their* autonomy. So much for patient rights.

Texas has the most egregious futile care law in the United States. Under the Texas Health and Safety Code, if the physician disagrees with a patient’s decision to receive life-sustaining treatment, he or she can take it to the hospital bioethics committee for adjudication. A hearing is convened at which all interested parties explain why they want or don’t want treatment to continue.

Committee decisions to refuse treatment are determinative. Even if the family finds another doctor willing to provide the treatment, it can’t be provided in that hospital. Not only that, but the only remedy for the patient/family is to transfer care to another hospital—which must be done in a mere *ten days*, after which, according to the statute, “the physician and health care facility are not obligated to provide life-sustaining treatment.”

In practical terms, that’s often a death sentence. The economics of medicine have changed. Today, extended care in ICUs is usually a money loser for hospitals, meaning that families find it almost impossible to find a facility willing to accept the transfer of expensive patients whose care has been declared to be “futile.” There are even reported cases of desperate families looking *out of state* for a facility willing to provide treatment for a loved one about to be pushed out of the lifeboat by a Texas hospital.

For the last decade, opponents have made several efforts to repeal the law—without success. Meanwhile, supporters have acknowledged that the law is flawed. But rather than repeal it, they have attempted to “reform” the law, often going further in the wrong direction than making it better.

Futile care “reformers” are at it again this legislative session with SB 303. As originally drafted, the bill would have explicitly permitted doctors to impose a do not resuscitate order (DNR) on a patient’s chart *without consent*, and sometimes, without notice! (A DNR means that no resuscitation will be attempted if the patient has a cardiac arrest.) The only remedy for the patient or family was to appeal the decision to a hospital

ethics committee, and during the appeal the DNR remained on the chart! Talk about a bum’s rush to death.

I was asked by alarmed opponents to testify against the bill, and soon found myself in the Texas Senate Chamber face-to-face with the bill’s well-meaning author, Senator Bob Duell, a physician, who insisted to the committee that his bill provided better protection to patients than the status quo. And to be fair, by the time I sat down at the witness table, SB 303 had been revised to usually require notification of the DNR to a competent patient or family member. Moreover, upon a “written” appeal being filed by the patient, the order would be removed from the chart pending determination by the committee. Of course that was still not good enough. I testified:

Senators, many of the people who will fall afoul of this provision if it is enacted into law will be poor or uninsured. They may not have the money to pay for a second opinion. They may not speak English. They may not understand medical nomenclature. And what if the second opinion physician concludes that the DNR was misapplied? That doesn’t settle the matter! The family then has to convene a bioethics committee meeting to present their “case” for the DNR to be removed...

And please consider what this will mean to the people—your constituents—who will have to work within the law and whatever procedures the hospitals may establish. These will be people in crisis: A loved one is lying in a hospital bed away from home—seriously, perhaps deathly, ill. We have all experienced the stressful and emotionally draining

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## Study finds diagnostic errors common in primary care

**A** study, published in *JAMA Internal Medicine* (formerly *Archives of Internal Medicine*), found that diagnostic errors commonly occur in the primary care setting and usually involve a broad array of medical conditions. Diseases most often misdiagnosed include cancer, pneumonia, congestive heart failure, acute renal failure, and urinary tract infections.

Researchers examined the medical records of 212,165 patients from the ambulatory-care sites of two urban hospital systems to find cases where, within two weeks after being seen by a primary care doctor, patients had to be hospitalized or needed to be seen again by their doctors or in an emergency/urgent care setting. Researchers found 190 cases of missed, incorrect, or delayed diagnoses involving 68 different conditions. In 87 percent of the cases, errors had the potential for moderately to severely harming patients.

Almost 80 percent of the errors occurred because of "process breakdowns in the patient-practitioner clinical encounter"—in other words, during office or clinic visits—with other errors occurring as a result of referrals to other providers, pa-

tient-related factors, follow-up and tracking of diagnostic information, and the performance and interpretation of diagnostic tests. [Singh et al., "Types & Origins of Diagnostic Errors in Primary Care Settings," *JAMA Internal Medicine*, 2/25/13]

Dr. Hardeep Singh, the study's lead author, blames office visit time pressures on doctors as a major reason for diagnostic errors. "In general, we're talking less to patients, and those skill sets and techniques of getting the history and the examination of the patient are going a bit downward."

Johns Hopkins neurologist Dr. David Newman-Toker, who wrote the accompanying commentary for the published study, agreed. "The real time with the patient has shrunk, and that definitely contributes to error," he explained. "There's no question that the visit is so truncated that you couldn't hope to get the right diagnosis all the time just based on the patient's appearance and chief complaint. The patient who presents with a headache, you say it's a migraine and you're right about 98% of the time. The other 2% of the time, it's a stroke." [American Medical News, 3/11/13] ■

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experience of having a loved one's life hanging in the balance. Adding such an additional and onerous burden upon people who are in such demanding, perhaps even, traumatic circumstances—to, in essence, *require them to fight for their loved one's life against their own doctor*—is simply beyond the pale.

The bill had another extraordinary provision that would accord absolute protection against liability to doctors and hospitals that imposed a DNR order, safe harbor not available to doctors who respected patient autonomy by only placing DNRs into charts with consent. I testified:

Even if the physicians are negligent in placing the DNR on the chart, so long as they follow the procedure, they are home free. This would mean that there would be *no checks and balances in an issue of life and death!* More ironically, a doctor who did not place a DNR on the chart could face greater legal scrutiny for that decision in the event of a later dispute than if he did issue the order.

During the question and answer session, Senator Duell defended his belief that SB 303 is fair, saying to me, "But we give notice!" To which I responded, "Senator, notice is not the same as consent!" For some reason, that simple logic fails to sink in.

Since my time in Texas, SB 303 has been further amended to accommodate a concurrent bill—SB 675—that would prohibit discrimination in futile care decisions based on age, health, disability, and the like from being the basis of a futile care imposition.

While that effort is laudable, once again, the reformers are missing the point. Indeed, the entire futile (if I may) effort to make Texas's poisonous law somehow palatable casts a bright klieg light on all that is wrong with futile care: A doctor could be required by law to be Hippocrates, the head of an ethics committee to think like St. Francis of Assisi, and it would all be for naught because there *are no enforcement mechanisms*. The ethics committees keep no records of their deliberations. The decisions about withdrawing wanted life-sustaining treatment are *imposed by*

*strangers to the patient*. The meetings that decide who receives and who is denied treatment are *held in secret*. The *committee members cannot be questioned* as to their reasoning or thought processes. And there is no appeal.

Here's the bottom line: Texas's entire system—which literally involves issues of life and death—denies patients and families due process of law. The only just and equitable answer to Texas's current deeply flawed ad hoc rationing approach to resolving disputes over difficult questions of life and death is to remove the futile care law from the books entirely and thereby restore hospital ethics committees to their proper role as mediators between the sometimes unreasonable or unwise patient/family demands and the contrary recommendations of caring and well-intentioned doctors. Anything less simply will not do. ■

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## Researchers develop test to see if older patients will be alive in 10 years

**A** new test, developed by researchers at the University of California in San Francisco (UCSF), can reportedly shed light on whether a patient will likely be alive in ten years. The test, referred to as the "mortality index," is expected to help doctors to decide whether expensive disease screening tests and medical procedures are worth the risks for patients age 50 and over who are not likely to be around in ten years.

According to lead author Dr. Marisa Cruz, the index "wasn't meant as a guidance about how to alter your lifestyle." Instead, it is a tool doctors can use to educate patients on the risks and benefits of procedures such as intensive diabetes treatments, colon cancer screening, or cervical cancer tests. Cancer screenings may not be safe or appropriate for sick or elderly patients who are likely to die before the cancer even develops.

The index's one-page test form contains 12 questions. The answer "yes" for each question is assigned a point score:

- All men automatically receive 2 points.
- Men and women are given points according to their ages: 60-64 = 1 point, 65-69 = 2 points, 70-74 = 3 points, 75-79 = 4 points, 80-84 = 5 points, and 85 & older = 7 points. (There is no 6-point score for age.)
- 2 points are given for each of the following conditions: a previous or current cancer diagnosis, lung disease that limits activity or necessitates the provision of oxygen at home, congestive heart failure, smoking, difficulty bathing, difficulty managing money due to health or memory problems, and difficulty walking several blocks.
- 1 point is given for diabetes or high blood sugar, difficulty pulling or pushing large objects, and being thin or normal weight.

The smaller the point tally, the better chance the patient has to live ten or more years.

When Dr. Cruz was asked why being thin or normal weight scores 1 point while being overweight carries no score and is not even

mentioned on the test form, she said that being thin could be a sign of illness in elderly patients.

Researchers developed the index after analyzing data provided by nearly 20,000 Americans over 50 who were part of a 1998 national health survey. Researchers then tracked these individuals for ten years. [Cruz et al., "Predicting 10-Year Mortality for Older Adults," *JAMA*, 3/6/13; UCSF News, 3/5/13]

But the mortality index has its critics. Dr. Stephan Fihn, a University of Washington medical professor and health quality measurement specialist for Seattle's Veterans Affairs Health Services, said that, even though the index appears to be "methodologically sound," it would probably be most accurate for very elderly patients, who don't need a scientific

crystal ball to figure out their days are numbered. [AP, 3/6/13]

TV medical commentator Dr. Manny Alvarez questioned the purpose of this new mortality tool. "[T]he way I read this is that doctors using this point system will decide what patients may or may not get in terms of their future medical treatment—and that's not right," he wrote. "Are these doctors going to be physicians employed by the insurance industry or perhaps federal medical boards like Medicaid and Medicare?" "[C]reating a mortality index is not the answer," he added. "Patients have to be treated with respect and be given opportunities when there is the slightest sign of hope.... Ultimately, using a score card makes us less human and disrespects the sanctity of life." [Fox News, 3/6/13] ■

## Social isolation is deadly for older men & women

**A** British study has found that older people who are socially isolated are more likely to die early, regardless of their health status.

The study, published in the *Proceedings of the National Academy of Sciences (PNAS)*, assessed social isolation in 6,500 men and women aged 52 and older who took part in the English Longitudinal Study of Aging in 2004 to 2005 and followed them for seven years. Researchers found that isolation from family and friends accounted for a 26 percent higher risk of death over the course of the study.

While both social isolation and loneliness have been associated with increased mortality, researchers wanted to assess "the extent to which the association between social isolation and mortality is mediated by loneliness." They found that the effect of the subjective feeling of loneliness diminished after they adjusted the statistical data for demographical and health factors. It was social isolation that remained significantly associated with mortality, not

loneliness. "Although both isolation and loneliness impair quality of life and well-being," researcher wrote, "efforts to reduce isolation are likely to be more relevant to mortality." [Steptoe et al., "Social isolation, loneliness, and all-cause mortality in older men and women," *PNAS*, 3/25/13]

The British study as well as studies in the US reinforce the need to make sure the elderly have strong social support. A US study of 2,000 cardiac patients found that having a trusted confidant was more significant than social connections alone. According to the study's author, Redford Williams, director of behavioral medical research at Duke University, the study revealed that mortality tripled among those patients who had neither a partner or a confidant. "There is something about not having social support—that is not acting through loneliness, nor through other health problems—that is contributing to mortality," Williams concluded.

In the US, more than 25 percent of households consist of people living alone. [LA Times, 3/26/13] ■

## Bioethicist says donor's death is insignificant in harvesting organs

In the April 1, 2013, issue of the *Cambridge Quarterly of Healthcare Ethics*, Canadian bioethicist Walter Glannon argues that the dead donor rule—the safeguard that requires organ donors to die before their vital organs can be harvested—is morally insignificant and can actually harm donors if their organs become unusable as a result of waiting for death to be declared.

There is an “alternative model” of organ donation, Glannon writes, one “based on patient autonomy and nonmaleficence,” where death doesn’t matter. What is important is that other conditions are met: the donor or surrogate consents to the or-

gan procurement, the donor has “an irreversible condition with no hope of [a] meaningful recovery,” the organ harvesting does not cause the donor pain or suffering, and the “donor’s intention is realized in a successful transplant.” Furthermore, he points out, donors are not required to be “permanently unconscious or imminently dying.” As long as they make a “voluntary and rational decision,” harvesting their organs would not harm them, and the “idea of organ donation euthanasia would support this position.” [Glannon, “The Moral Insignificance of Death in Organ Donation,” *Cambridge Quarterly of Healthcare Ethics*, 4/1/13] ■

### Care or suicide? It's all available at Washington's "full service" cancer center, continued from page 1

Also, SCCA makes sure that information on the suicide program and the DWDA is not posted in public spaces so doctors and staff are not constantly reminded of the program. According to the study's authors, by not publicly posting such information, patients are forced to be the ones who initiate suicide requests. However, their doctors are free to “raise the topic” as well.

As soon as patients are referred to the program, they are assigned a “patient advocate,” a licensed social worker employed by SCCA. The advocates are key to the whole process. They are the ones who grease the way to avoid problems. They assist patients, family members, pharmacists, and physicians and make sure that every one acts in compliance with the law. Their duties include selecting prescribing and consulting doctors for patients, verifying that patients are Washington residents and have a terminal condition, educating patients and their families about the process and the law, and helping patients and doctors to fill out the required state DWDA forms.

Perhaps the advocate's most significant duty is to assess the patient's mental status, specifically whether the individual is depressed or lacks decision-making capacity. If either is the case, the advocate is supposed to refer the patient to SCCA's Psychiatry and Psychology Service.

#### SCCA's statistics

Between March 5, 2009, and December 31, 2011, 114 SCCA patients inquired about the Death with Dignity Program.

Among those, 44 (39%) opted not to participate, and 30 (26%) started the suicide process but chose not to continue or died before completing it. Of the remaining 40 participants—all of whom received a prescription for a lethal dose of secobarbital—24 (60%) died after taking the drug. Presumably, the remaining 16 patients (40%) died of other causes.

Eleven participants outlived their doctors’ “6-month or less to live” prognosis—meaning, at the time the prescription was issued, they were really not legally eligible for assisted suicide. Commenting on this finding, the study authors wrote:

[W]e have purposefully not informed prescribing and consulting physicians when Death with Dignity participants live longer than 6 months, because of the concern that such feedback may unintentionally delay prognostic conversations until clinicians are certain of the timing, thereby reinforcing the more persistent and likely problem of communicating the prognosis (too) late in the course of the illness.

Most of the participants were “white, male, and college educated” and the majority cited “loss of autonomy” (97%), “inability to engage in enjoyable activities” (89%), and “loss of dignity” (75%) as reasons for their suicides. Uncontrolled pain or fear of it was a concern for only eight participants. The study further explained, however, that SCCA’s “specialized care for pain and palliative care services” are infrequently invoked

by participants “perhaps because the participants typically do not have symptoms at the time of the [death] request.”

Not one of the participants was deemed by social workers and doctors to have “current or previous depression or decisional incapacity,” so there were no referrals made for a psychological evaluation. Also, no reported complications occurred for those who took the prescription—other than one patient who took a whole day to die, causing family members and clinicians “distress.”

It should be noted, however, that no SCCA prescribing or consulting doctor or other clinician was present when participants took their lethal drugs, so any data regarding drug ingestion and the subsequent death is based on second-hand accounts from family members or others who were with the participant. Another problem with the study is that it was not an outside, independent assessment of SCCA’s DWDA implementation. Five of the six authors of the study actually work for SCCA.

Not surprisingly, the authors conclude that their program is “well accepted” by grateful patients and families. They dismiss assisted-suicide opponents’ concerns about the risks to vulnerable patients, and offer the finding that their 40 DWDA deaths account for only 0.02% of SCCA’s total annual death rate—as if a “low” death rate invalidates those real concerns. [Loggers et al., “Implementing a Death with Dignity Program at a Comprehensive Cancer Center,” *New England Journal of Medicine*, 4/11/13] ■



## News briefs from home & abroad . . .

● **Canada:** The battle over assisted suicide continues to wage in Canada. In March, the British Columbia (BC) Court of Appeals conducted a week-long hearing on the federal and provincial governments' appeal of BC Supreme Court Judge Lynn Smith's June 2012 ruling that struck down Canada's longstanding law banning assisted suicide. According to her decision in *Carter v. Canada*, Judge Smith found that the law was both discriminatory and unconstitutional, but she suspended her ruling for one year and ordered the Canadian Parliament to use that time to write and pass a new law that would be in line with her recommendations. (Parliament has not done so because the federal government is challenging the ruling.) The judge also granted Gloria Taylor, the only patient plaintiff in the case, a year-long exemption from the current law to get a doctor's help to die, if that was her choice. The patient, however, died naturally four months later of an infection.

The lawyer for the surviving plaintiffs in the case told the Court of Appeals that the country's ban on assisted suicide is "tantamount to torture." The lead lawyer for the federal government, on the other hand, argued that both the Supreme Court of Canada and the Canadian Parliament have previously considered assisted-suicide legalization and rejected it because the rights of vulnerable patients who could be harmed outweigh the rights of those who want a doctor to help bring about their deaths. The Court of Appeal's decision is pending. The case is expected to go all the way to the Canadian Supreme Court. [Toronto Star, 3/18/13; CTV News, 3/18/13; Winsor Star, 3/20/13]

**Other Canadian news:** Earlier this year, the Canadian Medical Association conducted an on-line survey of over 2,000 doctors and found that only 20% would be willing to engage in euthanasia if it was legal. More than twice as many (42%) said they would refuse to do so, while 23% weren't sure. Fifteen percent (15%) simply didn't respond. Almost half

(44%) said they would refuse requests for physician-assisted suicide. [*Montreal Gazette*, 2/8/13]

● **Ireland:** The Irish Supreme Court has upheld a lower court ruling that the country's absolute ban on assisted suicide is both justified and proportionate under the constitution, and anyone who assists in another's suicide is committing a "free-standing criminal offense" punishable by up to 14 years in prison. The case before the court was brought by Marie Fleming, 59, who has advanced multiple sclerosis. Since she is no longer physically able to kill herself, she petitioned the court to declare that she has a constitutional right to end her life with help. She also sought guarantees that Tom Curran, her partner and full-time caregiver, would not face criminal charges if he helped her die. After the Supreme Court rejected her appeal, Curran said he is willing to do whatever she wants. Fleming was reportedly too ill to attend the hearing. [*Irish Independent*, 4/29/13; *Belfast Telegraph*, 4/29/13, 4/28/13; *Irish Times*, 4/29/13, 3/5/13]

● **Australia:** According to a report issued by the non-profit think tank Australia21, the country's state governments, including Australia's territories, should pass laws now to allow and regulate euthanasia and assisted suicide in limited circumstances. The report is the result of a January 2013 roundtable meeting in Brisbane, where invited participants voiced a "diversity of views" on the question, "How should Australia regulate voluntary euthanasia and assisted suicide?" (Note that the question didn't ask *If* Australia should regulate the death-inducing practice—just how it should be done. Legalization was already presumed.) As *Bioedge* editor Michael Cook observed, many of the roundtable participants "were well-known euthanasia activists." [Australia21, "The Right to Choose an Assisted Death: Time for Legislation," 4/13; *Bioedge*, 4/27/13]

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## News briefs from home and abroad, continued from page 7

- **Belgium:** Belgium continues to be proof positive that euthanasia's "slippery slope" truly exists. Between 2011 and 2012, the number of reported euthanasia cases skyrocketed a whopping 25%, bringing the number of deaths *just for that year* to a record 1,432. [World Federation of Right to Die Societies News, 3/24/13]

An article by Belgian university professor Tom Mortier, entitled "How my mother died," gives some indication why the number of euthanasia deaths are dramatically increasing. While it is often thought that the Belgian law limits euthanasia eligibility to those who are suffering unbearable *physical* suffering, many of those who are given lethal injections now have *mental* illnesses like chronic depression, chronic anorexia nervosa, schizophrenia, and borderline personality disor-

der. Mortier's mother suffered from chronic depression. "Two years ago, she broke off all contact with me," he wrote. "In April 2012 she was euthanized.... I was not involved in the decision-making process and the doctor who gave her the injection never contacted me," he explained. "I am still trying to understand how it is possible for euthanasia to be performed on physically healthy people without even contacting their children."

According to Mortier, Belgian doctors are now discussing euthanasia for people with autism and suicidal children. "I believe," he wrote, "that the appeal to 'free choice' is becoming a dogma of convenience. We are rapidly changing into a society of absolute loneliness where we don't want to take care of each other any more." [Mercatornet.com, 2/4/13] ■

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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