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Update

Belgium does the unthinkable, then shocked at the world's reaction

Belgium's 2002 permissive euthanasia law has so altered the country's collective mind-set that many Belgians can no longer distinguish the unthinkable from the thinkable when it comes to end-of-life issues. The unthinkable in this case is the medicalized killing of sick children.

On February 13, 2014, the Belgian Parliament's House of Representatives voted overwhelmingly (86-44, with 12 abstentions) to remove all age limits from the existing law so that children could be euthanized along with adults. The Senate had passed the measure last December by a 50 to 17 majority.

Supporters of the law's expansion justified it by saying there are strict guidelines regulating the termination of children's lives. A qualified child

must request an induced death and have a terminal and incurable illness with death expected "within a brief period." Also, just like with adults, the child must have "constant and unbearable" suffering. But, unlike adults, the child would have to undergo an evaluation by a psychiatrist or psychologist to verify that the child is capable of discernment and understands what death means. Lastly, the child's parents and doctors must agree to his or her life being terminated. Senator Philippe Mahoux, a doctor and author of the 2002 euthanasia law, called the addition of children "the ultimate gesture of humanity." [Expat.com, 2/13/14; AP, 2/13/14]

But Belgium's history with actual adult euthanasia practice reveals just how easily "strict guidelines" are ig-

nored in the name of compassion. Three recent cases attest to that fact: the deaf Verbessen twins, 45, who were given lethal injections to avoid suffering the likelihood of blindness; Nathan Verhelst, 44, who was euthanized because he was not happy with the results of his sex change surgery; and an anorexic woman, known only as Ann G., who was euthanized because she was distraught after her doctor sexually abused her and got away with it. (See *Update* 2013-4 for more on these cases.)

While it was expected that the overly elastic euthanasia law would be expanded to include minors, there were some who strongly opposed it. Lawmaker Els van Hoof argued, "[Children's] brains aren't as developed" (continued on page 6)

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Election call kills Quebec's dangerous euthanasia bill

It was a shoo-in to pass. Bill 52, Quebec's euthanasia bill patterned after Belgium's law, was on the fast track to being passed overwhelmingly by Quebec's National Assembly before it recessed on February 20, 2014. But surprisingly, that's not what happened.

Instead, opposition Liberals, led by Philippe Couillard, decided that the bill's final debate should wait until after the two week recess so they would have more time to express their individual views on the bill. Members of other parties were stunned, some outright angry. [CBC, 2/10/14; Global News, 2/23/14]

But Bill 52's actual demise came during the recess when Quebec Premier Pauline Marois called for a new election in April in the hopes of getting enough votes to make her minority government a majority power. As a result, the

National Assembly was dissolved, killing all pending bills including Bill 52. [National Post, 3/5/14; Wall Street Journal, 3/5/14]

Bill 52 would have legalized both euthanasia and assisted suicide without ever including those terms in the body of the bill. Rather, the euphemism "medical aid in dying" was used for both practices so that the deliberate ending of a patient's life could be defined as a medical treatment. That was how Bill 52's drafters had planned to circumvent the Canadian government's law prohibiting both euthanasia and assisted suicide. In Canada, health care practice is under the jurisdiction of the provinces, not the federal government.

The fate of the bill will depend on the election results, but more than likely it will be resurrected in a future legislative session. ■

New Mexico district judge declares assisted suicide a fundamental right

New Mexico Second District Court Judge Nan Nash has ruled that competent, terminally ill patients have a “fundamental right” under New Mexico’s constitution to have a doctor provide them with the means to kill themselves. She issued her ruling on January 13, 2014, after conducting a two-day hearing the month before.

The case, *Morris v. New Mexico*, was filed in March 2012 by the national assisted-suicide activist group Compassion & Choices (C&C) and the New Mexico chapter of the ACLU on behalf of two doctors and a cancer patient currently in remission. One of the doctors, oncologist Katherine Morris, previously practiced in Oregon where she legally provided two patients with prescriptions for lethal drugs.

In their complaint, the plaintiffs alleged what has become C&C’s mantra, that what the doctors would practice in New Mexico is “aid in dying,” not assisted suicide. If the court were not to agree with that, they further argued that New Mexico’s assisted-suicide law violates multiple provisions of the state’s constitution. The Assisting Suicide Statute, passed by the legislature in 1963, makes “deliberately aiding another in the taking of his own life” a fourth degree felony. [*Morris v. New Mexico*, Verified Complaint for Declaratory & Injunctive Relief, 3/15/12]

Since Judge Nash’s written decision reads like a list of C&C’s talking points, it’s surprising that she ruled against their

argument that doctor aid in dying is not the same thing as assisting a suicide. The “plain language” of the statute, she wrote, “prohibits aid in dying.” “Distinguishing aid in dying from suicide does not remove aid in dying from the definition of assisting a suicide found in [the statute].” [Decision, *Morris v. New Mexico*, 2nd. Dist. Ct., D-202-CV 2012-02909, 1/13/14, p. 9. Hereafter cited as Decision.]

While the judge acknowledged that the legislature had considered assisted suicide when it passed two recent health care bills—both clearly stating that assisted suicide is not authorized—she was not deterred from carving out a big hole in the law the legislature passed in 1963 prohibiting all forms of assisted suicide.

Judge Nash explained that New Mexico’s constitution goes beyond the federal due process guarantees by not only guaranteeing life and liberty but also the “seeking and obtaining safety and happiness.” Then, she wrote:

This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one’s imminent death regarding how they and their loved one will face that death are not fundamental and at the core of these constitutional guarantees, then what decisions are?...

The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution....

[The Assisting Suicide Statute] therefore violates our State constitution when applied to aid in dying. [Decision, p. 13]

Judge Nash’s ruling currently affects only Bernalillo County where the state’s assisted-suicide law applies to everyone *except* doctors who prescribe lethal drugs for their terminally ill patients. To guarantee doctors legal immunity, she “permanently” prohibited the district attorney of Bernalillo County, the state attorney general, “and all those acting in concert with them” from “prosecuting any physician for providing aid in dying.” [Decision, p. 14] As of February 27, neither the county district attorney nor the state attorney general has filed an appeal in the case.

Disability rights advocate Marilyn Golden commented on the Nash decision. “With the stroke of a pen, a New Mexico judge unraveled some of the most basic protections people in our state have when facing serious illness or disability,” she wrote. “Nash’s ruling codifies the idea that some lives are not worth living and should have the option, if not the duty, to ‘choose’ a premature death via a doctor’s prescription pad.” [*Albuquerque Journal*, 1/17/14] ■

Current status of U.S. doctor-assisted suicide bills

- **Connecticut:** A bill to legalize doctor-prescribed suicide (HB 5326) is currently in the General Assembly’s Committee on Public Health awaiting a possible hearing in March. The bill is similar to one last year that never came to a vote due to a lack of support. Compassion & Choices (C&C) is pushing hard for passage.
- **Massachusetts:** C&C is pulling out the stops lobbying for the assisted-suicide bill HB 1998. The measure was introduced in January 2013—just two months after voters defeated a ballot measure to legalize the practice—and the bill is still alive in the Joint Public Health Committee. A hearing was conducted in December 2013, but no vote has yet been taken.
- **New Hampshire:** HB 1325, an Oregon-style, assisted-suicide bill that C&C was pushing, was overwhelmingly defeated in the New Hampshire House of Representatives on 3/6/14. The full House, bipartisan vote was 219 to 66. Two related bills, HB 1292 (to create a defense for suicide assisters), and HB 1216 (to decriminalize aiding a suicide) were both voted down on 3/5/14. It was a clean-sweep defeat for C&C.
- **New Jersey:** Last year, two companion assisted-suicide bills (A 3328 and S 2259) never came to a vote and died when the legislative session ended. The sponsors in both the Assembly and Senate have reintroduced the bills (A 2270 and S 382) in 2014 hoping that Vermont’s enactment of a similar bill last year will increase the New Jersey bills’ chances of becoming law. Gov. Chris Christie, however, has said that he opposes the measure, so it’s unlikely he would sign either bill into law.

Oregon's 2013 assisted-suicide report: Not a true picture

The Oregon Public Health Division (OPHD) has released its sixteenth annual statistical report on the statewide practice of doctor-assisted suicide. Entitled “Oregon’s Death with Dignity Act - 2013,” the new report remains true to a tradition—mandated by Oregon’s assisted-suicide law—of limited data, questionable reporting, and lots of unknowns.

The law, which compels secrecy under the guise of confidentiality, requires that the OPHD review only a “sample” of doctor-prescribed suicide cases and that all patient data be provided by the doctor who wrote the prescription for lethal drugs. The OPHD is also required to oversee doctor “compliance” with the law, which may be significantly compromised by the fact that doctors self-report their assisted-suicide cases to the state, creating a conflict of interest. [OR Death with Dignity Act (DWDA), §127.865 s.3.11] If a doctor did not comply with all the law’s provisions, it would not be in his or her best interest to report that to the state. The OPHD openly acknowledges that it is impossible for the agency to know how many cases go unreported.

According to the latest report, there were 71 reported assisted-suicide deaths in 2013, bringing the total number of such deaths since the law was enacted to 752. Of the 122 patients who received lethal drug prescriptions, 63 died after taking the drugs. An additional 8 patients also died in 2013, but they had received their prescriptions in 2011 and 2012. That statistic clearly indicates that at least some of those patients were not “terminally ill” (defined in the DWDA as having 6 months or less to live) when the doctor wrote them a prescription for lethal drugs—proving that doctors’ prognoses can be way off the mark.

Only two of the 71 patients who died last year were referred for a psychological evaluation, and the OPHD doesn’t know whether 31 of the patients who received prescriptions actually took the lethal drugs or not. [OPHD, “Oregon’s Death with Dignity Act - 2013,” 1/28/14] ■

Reported Assisted-Suicide Deaths in Oregon 1998-2013

Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates.¹

Figures are those reported by the state in the 2013 report.

Categories	1998 - 2010	2011	2012	2013	TOTAL
No. of reported assisted-suicide deaths	525	71	85	71	752
No. of unreported assisted-suicide deaths	Unknown ¹	Unknown ¹	Unknown ¹	Unknown ¹	Unknown ¹
No. of reported lethal prescriptions written	821	114	116	122	1173
No. of reporting doctors who wrote lethal prescriptions in a given year	? ²	62	61	62	? ²
No. of cases where prescribing doctor was present when lethal drugs were ingested:					
Other care provider present:	→	→	111 ³	8	119
No provider present:	→	→	235	3	238
Unknown:	→	→	73	3	76
Unknown:	→	→	192 ³	57	249
No. of cases where prescribing doctor was present at the time of death:					
Other care provider present:	→	→	99 ³	8	107
No provider present:	→	→	258	5	263
Unknown:	→	→	242 ³	57	299
Unknown:	→	→	12	1	13
No. of patients referred for psychiatric evaluation	39	1	2	2	44
Patients’ reasons for requesting assisted suicide:					
Loss of autonomy	→	→	618 [91%] ³	66 [93%]	684 [91%]
Inability to do enjoyable activities	→	→	602 [89%] ³	63 [89%]	665 [89%]
Loss of dignity	→	→	452 [82%] ³	52 [73%]	504 [81%]
Lost control of bodily functions	→	→	350 [52%] ³	26 [37%]	376 [50%]
Being a burden	→	→	264 [39%] ³	35 [49%]	299 [40%]
Inadequate pain control or concern about it	→	→	157 [23%] ³	20 [28%]	177 [24%]
Financial implications of treatment	→	→	18 [3%] ³	4 [6%]	22 [3%]
Complications after lethal drugs were ingested:					
Regurgitation	→	→	0	22	22
Other ⁴	→	→	0	1	1
Unknown	→	→	182 ³	59	241
Reported incidents of physician non-compliance with the assisted-suicide law ⁵	22	0	0	0	22
Penalties imposed for non-compliance with the assisted-suicide law ⁵	0	0	0	0	0

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 has no data on patient cases. Death certificates, by law, do not even indicate drug overdose as the true cause of death.
2. Since the OPHD reports do not identify the individual, lethally-prescribing doctors, there is no way to determine the total number of doctors who wrote prescriptions beyond a year at a time.
3. The 2013 Report combined the totals from 1998 to 2012. The previous totals for those years, as listed in each year’s individual report, were changed in the 2013 Report with no explanation given.
4. This is the first year “Other” was added under “Complications.” Nowhere in the 2013 Report is the 1 “Other” case described.
5. This category is not included in the 2013 Report’s statistical table. The text of the report, however, states, “no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.” The 22 cases of non-compliance listed above were cited in previous annual reports. No doctor has been penalized for non-compliance.

Source:

Oregon Public Health Division, “Oregon’s Death with Dignity Act - 2013,” released 1/28/14.

All 16 annual reports are available online at: <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>



Preventing (Some) Suicides

Wesley J. Smith

Since Jack Kevorkian first made headlines in 1990, the media have touted assisted suicide by the dying and severely disabled in positive, sometimes even glowing, terms.

Actually, “touted” may be too weak a word. For two decades, the media have repeatedly presented emotional narratives of very ill or disabled people who “just want to die,” along with sympathetic depictions of the doctors who “just want to help,” filtered through the ideological prism of issue advocates seeking to legalize doctor-prescribed death.

These deaths are usually described as a matter of the deceased “taking control,” or “dying on her own terms,” and other such laudatory language. In an unsettling bit of spectacle, actual assisted suicides—even acts of active euthanasia—have been aired on television with great fanfare on CBS’ *60 Minutes* and the BBC.

Even as we support suicide for some, we work hard to prevent it for others. But shouldn’t all receive the same kind of prevention services that can save lives? Indeed, isn’t promoting or applauding when someone ends their own life likely to increase the number of suicides?

That’s certainly the position of the World Health Organization, which has published media guidelines that strongly recommend *against* romanticizing or otherwise providing positive or detailed reportage about all suicides. For example, WHO urges media not to publish photographs or suicide notes, and to avoid reporting specific details of the method used, offering simplistic reasons for the act,

or glorifying or sensationalizing it in any way. Yet, all of these mistakes—and more—are ubiquitous in media reporting about assisted suicide.

Of course, the media also reports on suicide prevention—although rarely in the context of assisted suicide. Indeed, media outlets seem utterly oblivious that sympathetic reportage about assisted suicide works in direct opposition to suicide prevention. This dichotomy isn’t solely the fault of clueless journalists. The suicide-prevention community is at fault, as well.

This wasn’t always so. Back when Kevorkian began his campaign, suicide-prevention leaders spoke out forcefully against him. But that was a long time ago. These days, the suicide-prevention community is mostly silent about the political agenda that actively undermines the universal prevention meme.

Here’s a recent example: Quebec is on the verge of legalizing “aid in dying,” in which doctors would be authorized to lethally inject ill and disabled patients near “the end of life” (an undefined term) who ask to die. As this law moves ever closer to enactment, the Quebec Association for Suicide Prevention just launched its “You’re Important to Us” suicide awareness campaign, hoping to save the lives of suicidal people.

That’s laudable. But what about ill and disabled people whose suicides will be completed by doctors if Quebec’s euthanasia legislation is passed? Aren’t they also “important” to the Association? Apparently not: I searched the group’s website and

found not one statement opposing assisted suicide/euthanasia generally, or the legislation specifically.

Unfortunately, that’s par for the course. In the face of adamant and repeated advocacy to legalize assisted suicide—with three states now statutorily legalizing doctor-prescribed death—the prevention community has had little to say. To take another example, in 2012 the Surgeon General of the United States issued a new suicide prevention policy—which mostly got attention because it paid special heed to at-risk gay youth.

But the policy utterly failed to address the ubiquitous suicide promotion by euthanasia/assisted suicide activists. Thus, the Surgeon General’s “2012 National Strategy for Suicide Prevention” suggested “positive public dialogue” to “counter shame” and “build public support for suicide prevention.” It also urged the community to “address the needs of vulnerable groups” properly “tailored to the cultural and situational contexts in which they are offered to seek to eliminate disparities.”

Ironically, it also urged that suicide prevention, “Promote efforts to reduce access to lethal means among individuals with identified suicide risks.” Assisted suicide, of course, explicitly grants access to “lethal means among individuals with identified suicide risks.”

So, did the policy speak out against assisted suicide advocacy? Did it urge doctors not to write—and pharmacists not to fill—lethal prescriptions because that puts the means of

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A Place for Mom touted assisted suicide

Anyone who watches television has probably seen an ad featuring TV host and author Joan Lunden saying, “You can trust A Place for Mom to help you.” The product Lunden is selling is a free national service that helps “seniors and families like yours make informed decisions, save time, and feel less alone as they search for senior care and senior housing.” [www.aplaceformom.com]

But that is not the only “help” A Place for Mom (APFM) has been promoting lately. On February 26, APFM—which claims to be “the nation’s largest assisted living referral service”—posted an article on its official blog website promoting the assisted-suicide activist group Compassion & Choices (C&C), specifically the group’s Washington State chapter that successfully campaigned for legalized doctor-prescribed suicide in 2008.

Calling C&C “an advocacy organization for excellent, patient-centered, end-of-life care and expanded choice for the terminally ill,” APFM writer Jennifer Wegerer went on to talk about her interview with C&C of Washington Executive Director Robb Miller “about how the organization’s work helps empower the terminally ill and their families.” “Upon request,” Wegerer wrote, “[C&C] Client Support Volunteers are present at the time of death for their clients who elect to self-administer medication. Volunteers ensure that the medical protocol for taking the life-ending medication is followed so that family members can focus on their loved one.” “Having choices, even ones they will not use,” Wegerer explained, “can help terminally ill people regain a sense of control over their lives, improve their quality of life as life comes to an end, and feel peace of mind.” [APFM Blog, “The importance of End-of-Life Planning,” 2/26/14]

After people genuinely concerned about APFM’s obvious advocacy of C&C and its assisted-suicide agenda began calling APFM, Wegerer’s article was completely erased from the referral service’s website.

In his blog, Wesley J. Smith, a Patients Rights Council consultant, wrote, “In an age of terrible elder abuse, it is appalling that a business that seeks to earn the trust of seniors and their families would boost the ultimate abandonment of assisted suicide. If I ever need help caring for my 96-year-old mother, A Place for Mom is the last organization to which I would turn.” [Blog, *National Review Online*, 2/28/14] ■

New studies look at advance directives & surrogates

A recent study of doctors in French-speaking Switzerland, published in the *Journal of Pain & Symptom Management*, found that a patient’s advance health care directive and the decisions made by the patient’s designated proxy or surrogate influenced doctors’ decisions equally, but the influence was even greater if patients had both. Researchers also concluded that the “format of the advance directive and the identity of the proxy have little influence on decisions.” [*Journal of Pain & Symptom Management*, 1/1/14]

A separate U.S. study, this one published in *JAMA Internal Medicine*, found that surrogate decision making occurs in almost half of the cases of hospitalized older adults. That includes the decisions made by both the surrogate and the patient jointly. Most surrogates have to make decisions on patients’ “code status or other life-prolonging therapies,” and most of those decisions are made by patients’ daughters “without the help of living wills or previously appointed health care power of attorney forms.” Usually such decisions involve patients in need of “high-intensity care,” who consume “more resource utilization,” and are at serious risk of death.

Since surrogates are asked to make a broad array of health care decisions in both intensive care units and hospital wards, researchers concluded, “[h]ospital functions should be redesigned to account for the large and growing role of surrogates, supporting them as they make health care decisions.” [*JAMA Internal Medicine*, 1/20/14] Lead author Dr. Alexia Torke said, “Given the important role that family members play, they should be regarded as an integral part of the medical team.” [National Public Radio, Shots, Health News, 1/24/14] ■

Preventing (Some) Suicides, continued from page 4

self-killing intentionally in the hands of the suicidal? Is the pope Buddhist?

I am not saying that the suicide-prevention community is complicit in assisted suicide. But I do believe they are partially neglecting their calling. The lives of people with cancer, multiple sclerosis, Lou Gehrig’s disease and other serious and terminal illnesses are just as worthy of protection as those of suicidal people who may have other reasons for wanting to end their lives.

If suicide-prevention organizations want to play it safe by focusing on non-contentious issues such as youth suicide, or if they worry that their organizations might lose funding by engaging the emotionally charged assisted suicide controversy, perhaps the time has come to change the organizational names. “The Association for the Prevention of Some Suicides” might not be catchy, but at least it would have the virtue of honesty. ■

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Canadian court rules assisted spoon feeding is not a health care treatment

In a landmark court decision, British Columbia Supreme Court Judge Bruce Greuell found that providing patients with orally administered food and fluids is not a medical treatment but rather basic, ordinary, personal care that all human beings must have to survive. To deny an incapacitated patient in a health care facility oral nutrition and hydration would constitute neglect under the law. [*Bentley v. Maplewood Senior Care Society*, 2014 BCSC 165, 2/3/14. Hereafter cited as Decision.]

The ruling came as a result of a suit brought by the husband and daughter of Margo Bentley, an 82-year-old former nurse with late-stage Alzheimer's disease. The suit was also backed by the Canadian euthanasia advocacy group Dying with Dignity.

The family argued that Bentley's oral feeding should be stopped because a 1991 "Statement of Wishes" signed by Bentley said that, if she was ever in her current condition, she should be "allowed to die and not be kept alive by artificial means or 'heroic' measures." The statement also stipulated that "no nourishment or liquids" should be provided if she had no chance of recovering. When the care home where Bentley resides refused to comply with the family's orders, even though the husband and daughter were designated proxies, the family took their case to court. [*National Post*, 2/4/14]

In his very cogent decision, Judge Greuell found that, while Bentley has advance dementia, she is "capable of making the decision to accept oral nutrition and hydration and is providing her consent through her behavior." [Decision, p. 43] She will open her mouth when a spoon or glass touches her lower lip and will swallow. She won't open her mouth when full or doesn't want a certain food. The judge cited an incident when Bentley stopped accepting the entrée by not opening her month, but when the attendant said she was switching to dessert, Bentley opened her mouth right away. Adults can change their minds, the judge said, so Bentley's previously wishes "are not valid in the face of her current consent." [Decision, pp. 9 & 16]

Further, the judge ruled, "Withdrawing oral nutrition and hydration for an adult that is not capable of making that decision would constitute neglect within the meaning of the [law]." As far as the 1991 "Statement of Wishes" and a possible second one found in 2011 are concerned, neither "constitute a valid representation agreement or advance directive." He ordered that the feeding she currently receives "must continue." "The provision of oral nutrition and hydration by prompting with a glass or spoon," he wrote, "is a form of personal care, not health care..." and, therefore, cannot be withheld. [Decision, pp. 43-44] ■

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on an emotional, moral or cognitive level as an adult, and they are more depending on the influence of authority, and authority in this case would be doctors or parents." A 2010 functional MRI study at Washington University in St. Louis, Missouri, found that major changes in the area of the brain responsible for decision making and understanding the consequences of actions do not level off until a person's early 20s. [*USA Today*, 2/13/14; *New Scientist*, 2/13/14]

Sonja Develter, a Belgian palliative care nurse who has cared for more than 200 terminally-ill children, said, "I never had a child ask to end their life." Then she added, "But requests for euthanasia did often come from parents who were emotionally exhausted after seeing their children fight for their lives so long." She went on to say that children's euthanasia decisions would be based on what they thought their families wanted to hear, especially if they felt they were burdens to family members and caregivers.

An open letter signed by 175 Belgian pediatricians argued that changing the

law "responds to no real demand" on the part of sick children. According to the pediatricians, most medical teams treating terminally ill children will agree that these patients do not on their own voluntarily ask for euthanasia. [CNN, 1/13/14]

But child euthanasia is essentially a non-issue in Belgian society. A recent poll indicated that 75 percent of the public supported changing the law to include children. As the Belgian newspaper *De Morgen* opined, "For the first time since 1830 we have evolved to being ethically progressive leaders. We can be quite proud of that."

The rest of the world, however, did not see it that way. For example, the German newspaper *Die Welt* ran an article stating, "Belgium has allowed the killing on demand of terminally ill children and has headed for the ethical abyss. A state which allows something like this is a failing state." U.S. publisher Steve Forbes wrote, "We are on the malignant slippery slope to becoming a society like that envisioned by Nazi Germany." [Reuters, 2/14/14; *USA Today*, 2/13/14] Members

of Russia's parliament have asked the Foreign Ministry to ban the adoption of Russian children by Belgian citizens since "there is a danger for our kids to lose their lives in a foreign country." [rt.com, 2/17/14] And the American College of Pediatricians (AMCP) issued a statement that read in part, "The killing of infants and children can never be endorsed by the [AMCP] and should never be endorsed by any other ethical, medical or social entity." [AMCP Press Release, 2/18/14]

The world's reaction shocked Belgians, especially those in the media. The chief editor of the large Belgian newspaper *De Standaard* summed it up. "I'm annoyed at hearing 'you'll kill children' in the foreign media," he said. "We don't use that kind of language anymore. It's a very different debate on a different level." [Reuters, 2/14/14]

Apparently 12 years of killing adult patients has so numbed and blinded the Belgians that they no longer see what the rest of the world does—that the unthinkable is truly unthinkable. ■



News briefs from home & abroad . . .

- **Pennsylvania:** On February 11, Schuylkill County Court Judge Jacqueline Russell dismissed the criminal case against Barbara Mancini, a registered nurse who had been charged with assisting the suicide of her 93-year-old father. While visiting him in February 2013, her father had asked her to give him his prescribed bottle of morphine, which she handed to him. When a hospice nurse arrived at his home, she discovered that he had overdosed on the drug and called 911. A local police captain responded to the call and wrote in his report that the hospice nurse told him that the father had intended to commit suicide by overdosing on the morphine and that Mancini gave him the bottle to “end his suffering.” Subsequently, charges were filed against Mancini. [*Philadelphia Inquirer*, 8/1/13]

When Judge Russell dropped the charges, she ruled that the prosecution did not meet its burden of proof and instead relied on “speculation and guess serving as an inappropriate means to prove its case.” [*Commonwealth of Pennsylvania v. Barbara Joy Mancini*, No. 1305-13, 2/11/14, p. 46]

- **United Kingdom:** A new survey, commissioned by the British anti-euthanasia group ALERT, has found that there is significant public support for a change in the law to prevent patients from being left to die of dehydration. The online survey of 6,130 adults showed that 58% wanted the law changed “so patients cannot be left to die of dehydration if they had requested to be given water before they lost their ability to communicate.” Less than 17% did not want the law changed, and 25% had no opinion. When those 65 and older were surveyed, 62% said the law should be changed, and 61% of those with disabilities agreed as well.

Over the last several years, horror stories have emerged in the U.K. about patients being placed—without their or their families’ knowledge or consent—on a national end-of-life treatment protocol called the Liverpool Care Pathway.

These patients were then denied food and fluids. Baroness Campbell of Surbiton explained, “Food and water are basic human rights. They should never be withheld merely because a patient is mentally incapacitated or believed to be near to the end of life.” [ALERT Press Release, 1/30/14]

- **Switzerland:** A Swiss study on suicides facilitated by the country’s right-to-die groups found assisted suicide was more common in women and those living alone, divorced, and without religious affiliation. For younger people, assisted suicide was less likely for those with children than those without. Being well educated, living in urban areas, and having higher socio-economic status were also characteristic of assisted-suicide seekers. Researchers said the data was “relevant to the debate on a possibly disproportionate number of assisted suicides among vulnerable groups.” Social isolation and loneliness may also have a role in suicide requests.

Most of the people who died had cancer and nervous system diseases. There were 20 assisted-suicide cases where the person had mental or behavioral issues. Eighty percent (80%) had depression disorders, while 20% had dementia. [*International Journal of Epidemiology*, 2/18/14]

- **The Netherlands:** The Dutch Life-Ending Clinic, formed in 2012, has a mission: grant the euthanasia and assisted-suicide requests of those whose own doctors won’t. “We consider it self-evident that someone who is terminal can turn to euthanasia” said Clinic Director Steven Pleiter. “Now we are entering a phase in which there will be more debate about patients who are not terminally ill, among them psychiatric patients and those with dementia.” In 2013, the clinic euthanized people with dementia at a rate 18 times the national average and psychiatric patients five times the national rate.

(continued on page 8)

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These latest developments have at least one Dutch euthanasia pioneer concerned. Boudewijn Chabot—a psychiatrist who assisted the suicide of a seriously depressed, but physically healthy, woman in 1991—said on Dutch TV that the euthanasia law “has gone off the rails” and “things started happening that made me uncomfortable.” He explained that there are 100,000 Dutch psychiatric patients and of those “a large segment struggles with and against a death wish.” If the Life-Ending Clinic wants to take on these patients, he said, it better “get ready.”

Last year, the clinic euthanized a man with acute psychiatric issues. The 63-year-old man had claimed that he couldn’t cope with his forthcoming

retirement. The clinic’s psychiatrist said the man “managed to convince me that it was impossible for him to go on.” “He was all alone in the world,” the psychiatrist explained. “He did have family, but he was not in touch with them. It was almost like he never developed as a person. He felt like he didn’t have the right to live. His self-hatred was all consuming.”

According to the clinic’s director, “We are dealing with a group of patients that have no other place to go, that are also being ignored by psychiatry. We are looking at their [death] requests seriously, we treat them in all fairness,” he said. [Nadette De Visser, “The Dutch Debate Doctor-Assisted Suicide for Depression,” *The Daily Beast*, 2/3/14] ■

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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