



2015
Vol. 29, No. 4

Patients Rights Council

Update

How California legislators strong-armed an assisted-suicide bill into law

The bill, the California “End of Life Option Act” (SB 128), had died in the Assembly Health Committee last July after the measure’s sponsors pulled it from two scheduled hearings. The sponsors had been unable to garner the support of some Democrats on the committee who argued that doctor-assisted suicide posed real dangers to their many constituents already marginalized by an inequitable health care system. According to legislative rules, the two-year bill could be heard again, but not until January 2016—or so most people thought.

But the sponsors of SB 128, Senators Lois Wolk and Bill Monning and Assemblywoman Susan Eggman, had another, rather underhanded, plan.

Because the state’s Medi-Cal (Medicaid) program is facing a \$1.1

billion shortfall, Governor Jerry Brown had called for a special legislative session specifically to pass legislation to fund the Medi-Cal program. The California Constitution requires that, during a special session, legislators can only pass bills on the subjects specified by the governor. [California Constitution, Article 4, Sec. 3 (b)]

But SB 128’s sponsors, who were backed by the assisted-suicide activist group Compassion & Choices (C&C), saw that the special session was their best chance to get what they wanted most: legalized doctor-prescribed suicide in California. It didn’t matter that the bill was not on the subject for which the special session was called.

On August 17, as the special session convened, Assemblywoman Eggman introduced the “End of Life Option

Act,” only this time it had a new number, ABX2-15. The next day, the bill’s sponsors and C&C (the former Hemlock Society) held a press conference to announce that the bill had been resurrected. “We have been committed the entire time that this [bill] be heard this year,” Eggman said. “Whatever means were available to us, we were determined to go forward.” [Ventura County Star, 8/18/15]

The special session was the perfect “means” for the bill’s advocates. It was much shorter time-wise and allowed sponsors to circumvent many of the regular session requirements. Most importantly for Eggman and her colleagues was that the special session Assembly Health Committee would be smaller and hand-picked, allowing for

(continued on page 2)

Also in this Update

Doctor-prescribed suicide is never the answer
Lindsay Baran & Anne Sommers..... 3

Washington State issues 2014 assisted-suicide death report 4

Canada prepares for euthanasia & assisted-suicide legalization 5

Belgian euthanasia & assisted-suicide practices beyond alarming 6

News briefs from home & abroad 7

British House of Commons puts California to shame

On September 11, the same day that California’s legislature passed its doctor-prescribed suicide bill, the British Parliament’s House of Commons overwhelmingly rejected a similar measure by a vote of 330 to 118.

Like California’s “End of Life Option Act,” the British bill was modeled after the Oregon law, with one major difference: a High Court judge, in addition to two doctors, would have to approve each case by ruling that the person’s death request is well-considered and freely chosen. Despite that added “safeguard,” a huge majority (212) of Parliament members (MPs) rejected the bill, in large part because it posed significant danger to patients, particularly those in situations that make them vulnerable to coercion and exploitation.

The bill, entitled the “Assisted Dying Bill,” was introduced by MP Rob Marris in June

2015. It was essentially the same bill that was debated last year in the House of Lords, but failed to pass before the country’s general election, which effectively killed the measure.

Marris argued that his bill provided dignity and choice with strong safeguards to allow terminally ill patients in England and Wales to die peacefully at home without having to go to a Swiss suicide clinic to die. But it was clear during the four-and-a-half hour debate that preceded the vote, most MPs had serious reservations regarding the effects of such a law.

“What sort of society do we want to create when we feel that we can solve problems by hastening death rather than promoting life?” asked MP Sir Edward Leigh from Gainsborough. “What sort of society are we creating if we say that we value people who are healthy,

(continued on page 2)

How California legislators strong-armed an assisted-suicide bill into law, *continued from page 1*

the removal of legislators who had opposed the measure weeks earlier during the regular session. According to Senator Wolk, the new committee would be more “favorable” towards the Oregon-style bill. [*Ventura County Star*, 8/18/15]

And so it was. On September 1, the now named Assembly Public Health & Developmental Services Committee passed the bill by a vote of 10 to 3—and the skids were greased. Just four days later, the Assembly Finance Committee followed suit, approving it 5 to 3. Five days after that, the full Assembly passed it 44 to 35 and sent it to the Senate.

The sponsors knew that the Senate posed no problem for passage. As the more liberal legislative house, the Senate had already passed SB 128 during the regular session. So the Senate leadership, of which Senators Monning and Wolk were members, waived the usual committee hearings and sent the bill straight to the floor for the final vote on September 11. As those opposing the measure expected, the doctor-prescribed suicide bill passed 23 to 15. It only took 11 days for ABX2-15 to pass both houses.

Assemblyman Scott Wilk, who voted against the bill, remarked, “In the last few weeks of the session, I witnessed the majority party undermine democratic principles and violate rules to implement personal agendas.” [*SCV News*, 9/21/15]

The governor

The fate of the bill was now in the hands of Governor Brown, who, like the bill’s sponsors, is a liberal democrat. He is also unpredictable, so no one could say

with any certainty what he would do. Opponents were guardedly hopeful that he would veto ABX2-15 because, when it was introduced, the governor communicated his displeasure that the sponsors were using the special session to advance the bill. He said, through his spokeswoman, that this session was not an appropriate venue for the measure, that the 2016 regular session was. [*AP*, 8/19/15]

But, on October 5, Governor Brown signed the bill into law anyway. He sent a letter to Assembly members stating, “ABX2-15 is not an ordinary bill because it deals with life and death.” He went on to say that he “read the thoughtful opposition materials presented by a number of doctors, religious leaders and those who champion disability rights” as well as letters and pleas from supporters. But, ultimately, he had to think about “what I would want in the face of my own death.” “I don’t know what I would do if I were dying in prolonged and excruciating pain.” he wrote. “I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn’t deny that right to others.” [Brown, Letter to the California State Assembly, 10/5/15] With Brown’s signature, the bill can become law in 2016.

Californians Against Assisted Suicide—a long-established coalition of healthcare providers, disability rights and patient rights advocates, religious groups, and advocates for the poor that opposes doctor-assisted suicide—immediately responded to the governor’s letter. “This is a dark day for California and for the Brown legacy,”

the group said. “Governor Brown was clear in his statement that [his signing of the bill] was based on his personal background. As someone of wealth and access to the world’s best medical care and doctors, the Governor’s background is very different than that of millions of Californians living in health care poverty without that same access—these are the people and families potentially hurt by giving doctors the power to prescribe lethal overdoses to patients.” [*CAAS*, 10/5/15]

The governor and legislators heard and read all kinds of testimony about the dangers ABX2-15 posed for the poor, elderly, and those with disabilities—including the fact that large segments of California’s highly diverse population would have fewer treatment choices when government health plans and other insurers could refuse coverage for costly care but pay for the cheapest treatment of all, prescribed-suicide drugs. Yet, it didn’t matter.

They heard from oncologists, palliative care specialists, and psychiatrists who said legalizing prescribed suicide would adversely change their profession and undermine equal protection for all patients. They heard ethnic group leaders and disability rights advocates talk about how vulnerable members of their communities are in a broken health care system, and how ABX2-15 would actually allow the abuse of patients by caregivers and greedy relatives.

But, in the end, none of it mattered.

Editor’s note: There will be more on the California law in the next Update. ■

British House of Commons puts California to shame, *continued from page 1*

fit, beautiful and young more than we value people who are poor, old, crippled, ill and dying?”

Prime Minister David Cameron also had concerns about the bill. “I think there are dangers and so I don’t support it,” he said.

Assisted-suicide advocates, armed with public polls and a list of celebrities supporting their cause, were outraged by the MPs’ vote. “The vote only goes to show just how ridiculously out of touch MPs are with the British public on the issue,” declared Sarah Wootton, head of the activist group Dignity in Dying. “Parliament has failed to act and if it fails to recognize its responsibility over the next five years,” she added, “the courts have no choice but to act instead, to

end this suffering and injustice.” [*MercatorNet*, 9/12/15; *Telegraph*, 9/11/15; *BBC*, 9/11/15; *Daily Mail*, 9/11/15]

But it appears that Wootton’s group isn’t going to wait five years after all. She recently told the press that Dignity in Dying is preparing a legal challenge to the UK’s assisted-suicide law.

So is the British Humanist Association. It is trying to raise over £500,000 to locate individuals who would be eligible for an assisted death to be plaintiffs and then bring the case before the British Supreme Court, the same court that, in a similar case last year, was not opposed to striking down the law, but felt it was a question Parliament should decide. [*The Guardian*, 10/17/15] ■

Doctor-prescribed suicide is never the answer

By Lindsay Baran & Anne Sommers

The disability community has been trying to have honest end-of-life conversations for years. After all, we're the real experts on the front lines of the health care system that serves (and, sadly, often underserves) dying people. But for the most part, the megaphone has remained firmly within the grasp of the assisted suicide lobby and its well-intended supporters, many of whom haven't been exposed to complete information about the construction, operation and consequence of such laws.

Last week, California became the fourth state to legalize assisted suicide, providing the state's imprimatur on the notion that some suicidal people warrant suicide prevention services and some warrant help getting the job done. Tragically, the only difference between those two groups is their health status or disability. Those already at increased vulnerability for depression and abuse because of their failing health are the ones who get state-sanctioned assistance with their suicidal ideations.

Soon after Brittany Maynard became the long-awaited face of the right-to-die movement, the assisted suicide lobby (Compassion & Choices) enjoyed a fresh crop of proposed bills in sixteen states, with twelve defeats, California passing last week, and three others still pending.

Although this whole ugly business seems far more palatable when such noble aims as pain mitigation are headlined, 17 years of available data do not bear out this claim. Oregon's annual report data demonstrate that it's social factors that propel assisted suicide requests. According to one study, "loss of autonomy" (92 percent), "less able to engage in activities" (89 percent), "loss of dignity" (80 percent), "loss of control of bodily functions" (50 percent), and "feelings of being a burden" (40 percent) were the main reasons patients said they wanted to commit suicide. Pain did not even break the top five.

It is dangerous business for public policy to tether dignity to independence. Functional loss and disability nearly always accompany a terminal diagnosis. Linking dignity to independence brands scores of people, including those who age into or acquire disabilities and who depend on others for personal care, as living undignified lives.

Legalizing assisted suicide sends the message that feeling like a burden is not only an acceptable reason for suicide, but a justification for our health care system to provide someone the lethal means. Assisted suicide laws reinforce the very societal prejudice that disability rights laws were meant to dismantle and shifts the focus from respecting and accommodating people with disabilities and illnesses to assisting them to die.

Perhaps the greatest disappointment to disability rights advocates in Governor Brown's signing the assisted suicide bill into law last week was his hook-line-and-sinker belief in the unsubstantiated safeguards these laws offer.

The truth is, the safeguards that have been put in place to prevent mistakes and abuse are tremendously ineffective. Coupled with problematic monitoring and data management, assisted suicide can easily take place outside of the legal framework with neither meaningful oversight nor investigation.

Professional peddlers of the "dignity" and "compassion" myths tell policymakers and the public that there hasn't been a single case of abuse in states where these laws have been on the

books. This is dangerous fiction. Truth is, the system wasn't set up to find any.

All reporting about doctor-assisted deaths is self-reported, which is like asking drivers to tell their states each year whether or not they ever rolled a stop sign or drove above the speed limit. Further, assisted suicide laws don't grant the department of public health investigatory authority and resources, foreclosing investigations of abuse or coercion. It all but ensures the record of these laws will appear above reproach.

After assisted suicide became legal in Oregon and concerns about abuses were raised, Dr. Katrina Hedberg of the Oregon Department of Human Services stated: "We are not given the resources to investigate," and "not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."

That means that as the abuse of elders and people with disabilities is on the rise nationwide, under these laws, an abusive caregiver could easily steer someone towards assisted suicide, witness the request, pick up the lethal dose and even administer the drug. Without witnesses required at death, who would know? And without the ability to investigate any reports, it wouldn't matter anyway.

The assisted suicide lobby also claims that assisted suicide is about choice and autonomy, which is far from reality. Every health insurance coverage decision is based largely on financial considerations, with insurance providers often overriding physician recommendations due to cost. When doctor-recommended treatments are denied, or even delayed, assisted suicide is no longer reflective of a patient's true choice. While asserting that insurance providers will choose their bottom line over patients may seem like hyperbole, that's exactly what we have seen happen in Oregon.

Proponents of legalized assisted suicide don't deny the financial influence of this legislation. Derek Humphrey, founder of the Hemlock Society (which has since become Compassion & Choices) acknowledged that the connection between assisted suicide and the "cost, value, and allocation of health care resources are part of the political debate, albeit frequently unspoken."

One thing is clear: Where assisted suicide is legal, there is no doubt that some people's lives will be ended by mistakes and coercion. We've already seen this happen under the assisted suicide law in Oregon. It's clear that the conversation is moving in the wrong direction. Instead of assisted suicide, we should be talking about providing adequate, affordable supports and services for people living with disabilities and illnesses, and making sure palliative and hospice care options are readily available.

Doctor-prescribed suicide is never the best medical treatment for anyone. People with disabilities and illnesses must be supported in living, not dying. ■

Lindsay Baran is a policy analyst with the National Council on Independent Living, a cross-disability, grassroots organization, and Anne Sommers is the chair of Not Dead Yet, a national, grassroots disability rights group. Their article appeared in the Washington Examiner on October 19, 2015. Reprinted with permission.

Washington State issues 2014 assisted-suicide death report

According to latest figures issued by the Washington State Department of Health (WSDH) on reported 2014 assisted-suicide cases, 176 people were given prescriptions for intentionally lethal drugs by 109 different doctors—prescriptions that were dispensed by 57 different pharmacists. Of those 176 patients, 126 died after taking the prescribed drug and 17 died without ingesting the drug. For the remaining 33 patients, the WSDH does not know whether 27 ingested the drug or if an additional 6 patients are dead or alive since they have no information at all on them. [WSDH, 2014 Death with Dignity Act Report, 8/6/15]

The data contained in the 2014 report is based on information from lethally-prescribing doctors' reports, dispensing pharmacists' reports, and patients' death certificates—all received by the WSDH on or before March 16, 2015. In addition, the WSDH reports that, as of that date, it still has no data on the status of 4 patients who received lethal prescriptions in 2013, 1 patient who got the prescription in 2011, 1 patient in 2010, and 1 in 2009 (the year the assisted-suicide law took effect.)

From the *known* reported assisted-suicide data since 2009, 725 patients have been given lethal drug prescriptions and 712 of those died as a result.

As in previous years, the number of death-requesting patients who were referred for a psychological evaluation in 2014 is extremely low—only 6 out of the 176 patients given lethal prescriptions. That statistic suggests that doctors are likely overlooking signs of depression in patients or judging depression as a normal response to terminal illness and, therefore, surmising that the patient's judgment is not adversely affected.

Cancer was the underlying illness for most of the assisted-suicide cases, followed by neurodegenerative disease (including ALS), respiratory disease (including COPD), heart disease, and "other illnesses." Unlike Oregon's 2014 assisted-suicide report, the Washington report does not list the specific "other illnesses." In Oregon's report, other illnesses included diabetes. [Oregon Public Health Division, Oregon Death with Dignity Act – 2014, Table 1, footnote 6, p. 5]

Reported Assisted-Suicide Deaths in Washington 2009-2014

Report data supplied by lethally-prescribing doctors, pharmacists, & death certificates.¹

Figures and percentages are those reported by the state, and can change from year to year.

Categories	TOTAL	2014	2013	2012	2009 - 2011
Number of reported assisted-suicides	712	170	169	121	252
Number of unreported assisted-suicide deaths	Unknown ¹				
Number of reported lethal prescriptions written	725	176	173	121	255
Number of reporting doctors who wrote lethal prescriptions in a given year	? ²	109	89	80	121
Number of cases where the patient's status (living or deceased & ingestion status) is reported as "unknown"	136	33	28	20	55
Number of cases where prescribing doctor was present at the time lethal drugs were ingested	21	7[6%]	2	5	7
Number of patients referred for psychiatric evaluation	25 [3.5%]	6 [4%]	6	3	10
Patients' reasons for requesting death: ³					
Loss of autonomy	536	127 [89%]	132	94	183
Inability to do enjoyable activities	533	135 [94%]	129	90	179
Loss of dignity	463	113 [79%]	115	84	151
Lost control of bodily functions	309	73 [51%]	75	56	105
Being a burden	314	85 [59%]	88	63	78
Pain or concern about it	215	59 [41%]	53	33	70
Financial implications of treatment	44	12 [8%]	19	5	8
Complications from lethal drugs:					
Regurgitation	7	2 [2%] ⁵	3	0	2
Seizures	1	1 [1%]	0	0	0
Patient awakened	2	0 [0%]	0	0	2
Other ⁴	1	0 [0%]	0	1	—
Cases unknown	29	2 [1%] ⁵	10	3	14
Reported cases of doctor non-compliance with the assisted-suicide law	Not Reported				
Penalties imposed for non-compliance with the law	Not Reported				

- The Washington State Department of Health (WSDH), the agency responsible for overseeing assisted-suicide practice, has no way of knowing if 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 contains no data on the patients who died by doctor-prescribed suicide. Death certificates, by law, are not permitted to indicate drug overdose as the true cause of death.
- Since the WSDH reports do not identify the lethally-prescribing doctors, there is no way to determine the total number of doctors who wrote prescriptions beyond a year at a time. The same doctor could have written multiple lethal drug prescriptions for multiple patients over the time span since assisted suicide was legalized.
- The Washington report states, "Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent."
- This category was not included in the 2009, 2010, and 2011 annual reports.
- There is a discrepancy between the percentages reported for the "Regurgitation" and "Cases Unknown" categories.

Source:

Washington State Department of Health, 2014 Death with Dignity Act Report, 8/6/15. All Washington's annual reports are available online at: <http://doh.wa.gov/dwdal>.

Canada prepares for court-ordered euthanasia & assisted-suicide legalization

Last February, when the Canadian Supreme Court decreed that the country's laws prohibiting assisted-suicide and euthanasia were unconstitutional, the court stayed its ruling for a year to allow the Federal Parliament and the provincial legislatures time to enact legislation establishing requirements, safeguards, and protocols for the implementation of these death-inducing practices. If the Federal Government does not pass such legislation before the February 2016 deadline, the court's ruling decriminalizing euthanasia and assisted suicide will take effect without any regulations or oversight.

In its ruling, the court did not limit these death practices to patients who are terminally ill or are experiencing excruciating physical pain or suffering. Instead, the high court justices said that a death-requesting, competent adult need only have "a grievous and irremediable medical condition that is intolerable to the individual in the circumstances of his or her condition." Consequently, existential or psychological suffering can qualify patients for a doctor-assisted death. [*Carter v. Canada*, 2/6/15, at 147]

Government's response

Currently, nine months after the court ruled, there has been no legislation introduced in the Federal Parliament or in any of the provincial legislatures. Many fear that there is not enough time to pass a bill before the court's February deadline.

The Federal Government did appoint a three-member panel to consult with medical authorities, the public, interveners in the case that precipitated the court's ruling, and with jurisdictions where prescribed death is legal to determine which regulations and provisions should be included in the law. But euthanasia advocates charged that two of the three-member panel were vocal opponents of the death practices. A second panel representing 11 provinces was also convened. This one has 10 members, most of whom favor the practices. To date, neither panel has issued a final report.

Doctors

The Supreme Court justices designated doctors to play the primary role in the death practices: to determine if a patient qualifies under the law and, if so, to bring about the patient's death either by directly administering lethal drugs to the patient or prescribing those drugs for the patient to self-administer. Unfortunately, the justices did not expressly rule that a doctor could opt out of the death-inducing business if such action goes against his or her conscience or religious beliefs. What they did say was that nothing in the ruling "would compel physicians to provide assistance in dying," adding that the "rights of patients and physicians will need to be reconciled." [*Carter v. Canada*, at 132]

There appears to be a growing consensus that the patient's right to obtain a legally induced death outweighs a doctor's right to refuse to participate *in any way* in such a death. For example, the Canadian Medical Association (CMA) recently issued guidelines for the implementation of the induced-death law that state, "In order to reconcile physicians' conscientious objection with patient's request for access to assisted death, physicians are ex-

pected to provide the patient with complete information on all options available to them, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service." [CMA, "Principles-based Recommendations for a Canadian Approach to Assisted Dying," 10/9/15, p. A2-6] Some provincial Physicians and Surgeons Colleges have already developed similar referral mandates.

But, for conscientious-objecting physicians, sending a patient to a death-facilitating doctor or service is as objectionable as doing the killing themselves. Dr. Philip Fitzpatrick, an ER and family doctor in Saskatoon said that assisting a death would be causing harm to a patient. "Definitely for me participating in an assisted suicide would be harming my patient—even a referral for that would make me culpable for that." [*Global News*, 2/13/15] Winnipeg physician Dr. Larry Rados said, "I will take the view that a referral to another doctor would be equivalent to a recommendation for the procedure. Why would I make a referral for assisted suicide if I don't think it is in the patient's best interest?" "I would subject myself to whatever discipline that is necessary to follow my conscience," he added. [CBC News, 10/6/15]

Doctors who practice medicine in the many huge, remote areas of Canada will feel the most pressure to end qualified patients' lives. Those are the areas that have the most pronounced doctor shortages. If there's one or two doctors in an area, and one or both refuse to induce death, then the requesting patient is being denied access to a legal "medical treatment." As former CMA president, Dr. Chris Simpson, told reporters in August, doctors "can't just simply disregard the patient's right to access a service they're eligible for." [*National Post*, 8/18/15]

Health care access

What should be of grave concern is the fact between 70 to 80 percent of Canadians have no access to palliative care or any quality end-of-life care or support. According to Dr. Harvey Max Chochinov, director of the Manitoba Palliative Care Research Unit at the University of Manitoba, "We are about to become a country that extends the right to a hastened death, but offers no legislative guarantees or assurances that [the patient] will be well looked after until they die." [Troy Media, 2/23/15]

Quebec's big problem with its law's enactment

Quebec is the only province not facing the Supreme Court's February deadline. That is because Quebec passed its own euthanasia law in 2014 prior to the court's ruling. But the province has a major problem because its law goes into effect on December 10, 2015, and large numbers of doctors and most palliative care programs are refusing to provide euthanasia and assisted-suicide services. According to Quebec Health Minister Gaetan Barrette, the law allows doctors to opt out based on conscience, but health facilities, palliative care units, and palliative care programs cannot. "It's the patient that will be the priority," he said. "Not the doctor, not the institutions." [Canadian Press, 9/2/15; CBC News, 9/2/15; *The Star*, 9/6/15] ■

Belgian euthanasia & assisted-suicide practices are beyond alarming

Even euthanasia supporters are calling developments in Belgium “worrisome” as a result of two, newly revealed cases that have been given formal approval for medically-induced death. Others see these cases as the tragic result of an ethical “slippery slope” that appears unstoppable in a country that has embraced euthanasia and assisted suicide as acceptable—even expected—ways to die.

The Australian TV news show *Dateline* followed two Belgians who had been approved by doctors for euthanasia. Simona de Moor, a 85-year-old, physically healthy, mentally sharp woman, decided five minutes after her daughter unexpectedly died from a heart attack that she wanted to have her life ended by a doctor. “The moment they broke the news to me, five minutes later I knew,” de Moor told *Dateline* reporter Brett Mason. “And nobody in the world will take it away from me.” “It’s driving me mad,” she explained, “and I don’t want to go to a mad house, I want to die here [in my home].”

De Moor and her 58-year-old daughter Vivienne had been very close after the death of de Moor’s husband several years ago. After Vivienne died, de Moor said, “I have no reason to live anymore, grief is unbearable pain.” According to Belgium’s euthanasia law, a person must be experiencing “unbearable” physical or mental suffering to qualify, but there is no consensus as to what constitutes “unbearable” suffering.

Mason was allowed to film the final minutes of de Moor’s life. “Are you really ready?” asked Dr. Marc Van Hoey, who is a vocal euthanasia advocate. “Absolutely, 100 percent,” de Moor replied. He then handed her a lethal drug cocktail that she drank.

Later Mason asked the doctor how many people he had euthanized. Van Hoey, who is also the president of the Right to Die Society in Flanders, replied, “To be frank, I don’t know, maybe hundreds, or over a hundred.” “A lot of elderly people are not really suffering in the narrow meaning of the word,” he added, “but one plus one plus one makes a whole. That in addition to their age gives them no future, there is nothing left any more, and so quite often they say, I’ve had it with my life.”

Mason later said that de Moor’s death was “the hardest story I’ve told.” “Most of all, I just feel sad to have said goodbye to someone who was physically healthy and sharp of mind, but believed the best treatment her doctor could offer her was death.” That was not the only thing that bothered him, however. “I was taken aback—not for the first time in recent weeks—by just how mundane and unremarkable euthanasia is to those who perform it,” he said. [sbs.com.au/news/dateline, 9/15/15]

Belgium’s Federal Euthanasia Review & Evaluation Committee has referred the de Moor case and Van Hoey’s handling of it to a public prosecutor for judicial review. It is the first time that a Belgian doctor has had to face such a review and possible criminal charges since the country legalized euthanasia in 2002. [sbs.com.au, 10/29/15]

At issue is the fact that Van Hoey did not consult with a psychiatrist as to whether de Moor was qualified for euthanasia, a requirement if a patient’s death is not imminent but the patient has unbearable mental suffering. Van Hoey said that the psychiatrist was unnecessary because of his own expertise. “It’s not, she wants to die because she’s depressed,” he explained. “She wants to die because she’s had it. See the difference?” [National Post, 10/29/15]

The second case *Dateline* followed was that of Peter Ketelslegers, a 32-year-old father of two who has severe cluster headaches that have left him unable to work or care for his family. “It’s like a knife being stuck in my head,” he told Mason. “It spreads through my whole head. I hit it to get rid of the pain.”

The headaches last up to three hours and can occur several times a day. Ketelslegers has tried different treatments, but nothing has worked. “I don’t want to be a burden to anyone.... I should take care of the children rather than them taking care of me, but I can’t,” he said.

The young father has requested euthanasia. Two doctors have already given their approval. He is waiting for a third doctor’s okay.

Ketelslegers’ wife, Conny, has said she supports his request for death, but “with

pain in my heart.” “You would be enormously selfish to keep your husband with you when you know that he’s in so much pain,” she explained. [sbs.com.au/news/dateline, 9/15/15; *Daily Mail*, 9/15/15; *Bio-edge*, 9/19/15]

An earlier case, reported in the last *Update*, involved a depressed 24-year-old woman, fictitiously referred to as Laura, who wants to be euthanized because she’s had suicidal thoughts since she was in kindergarten. “Life is not for me,” she claimed. Doctors have granted her euthanasia request. [Newsweek, 6/29/15; *Daily Mail*, 6/27/15]

A recent study, published online by *BMJ Open* (a *British Medical Journal* website), found that depression and personality disorders are the most common diagnoses in psychiatric patients who request euthanasia in Belgium. Ninety out of the 100 patients studied had multiple mental health issues, including schizophrenia, post-traumatic stress disorder, and anxiety disorders. After further testing, 12 were diagnosed with Asperger syndrome, an autism spectrum disorder. Euthanasia was approved for 48 of the patients. Researchers said there are no guidelines for how to handle psychiatric patients who request death. [BMJ Open, 7/27/15]

Some in Belgium want to expand its induced death eligibility even further by honoring pre-signed euthanasia advance directives for people with dementia. In a disturbing documentary, titled *End Credits*, an elderly man with dementia—who has definite lucid periods—emphatically tells doctors that he doesn’t want to be euthanized, even though he appeared to want it earlier. When asked about this case, bioethicist and euthanasia pioneer Etienne Vermeesch says, “He [the elderly man] no longer has an opinion. We should not ask him again. Some people have a problem with this. But they should recognize that an incompetent person is an incompetent person.” Vermeesch then offers his advice in the film: “Just give him his normal treatment and add a heavy narcotic. Then when he is asleep you administer an injection and the case is closed.” [End Credits, 2013; available at youtube.com; search for “End Credits euthanasia”] ■



News briefs from home & abroad . . .

- **Courts in four states** have rejected lawsuits brought by doctor-prescribed suicide advocates who claimed that state laws banning assisted suicide are unconstitutional.

California: On October 29, a division of the Fourth District Court of Appeals upheld a lower court ruling that California’s statute prohibiting assisted suicide is constitutional. The case was brought by Compassion & Choices (C&C) on behalf of a doctor and three cancer patients, one of whom was Christy O’Donnell, the mother, lawyer, and former Los Angeles police sergeant who has been featured in the national media promoting doctor-assisted suicide. The plaintiffs had argued that when a doctor writes a prescription for drugs that a terminally ill patient can take to end his or her life, the doctor is not violating the current assisted-suicide law, which states, “Every person who deliberately aids, or advises, or encourages another to commit suicide is guilty of a felony.” [CA Penal Code § 401] The Appeals Court rejected the plaintiffs’ claim. “A prescription for a lethal dose of drugs is ‘active and intentional participation in the events leading to the suicide,’” the court ruled. Since California’s new, permissive assisted-suicide law probably won’t take effect until March or April 2016 (maybe later), the plaintiffs likely to die before the law’s enactment also asked the court to expedite things and allow a doctor to write them a prescription if they requested the lethal drugs. The court refused. [O’Donnell v. Harris, Fourth Appellant District, Div. One, 10/29/15, at 12 and 29]

Another lawsuit, *Brody v. Harris*, also challenged the constitutionality of California’s Penal Code § 401. It was filed in Superior Court in San Francisco by Kathryn Tucker, former C&C legal director and now head of the Disability Rights Legal Center in Los Angeles, on behalf of three doctors, Christy O’Donnell, and three other terminally ill patients. Tucker argued that the law was ambiguous and didn’t apply to doctors who write lethal drug prescriptions

for dying patients. She also claimed that prescribed suicide was “an essential civil right” for dying patients. The suit sought a preliminary injunction to prohibit the prosecution of doctors who assist dying patients’ suicides. But Superior Court Judge Ernest Goldsmith rejected Tucker’s arguments and denied the injunction. [*San Jose Mercury News*, 8/13/15; *California Healthline*, 8/17/15]

New Mexico: On August 11, the New Mexico Court of Appeals overturned a 2014 decision by Second District Court Judge Nan Nash that competent, terminally-ill patients have a “fundamental right” under the state’s constitution to have a doctor provide them with the means to end their lives. The judge also permanently barred the state from prosecuting any physician in Bernalillo County who engaged in “aid in dying.” The case, *Morris v. Brandenburg*, was filed by C&C and the New Mexico chapter of the ACLU on behalf of two doctors and a patient whose cancer is in remission. Kathryn Tucker (see CA case) served as co-counsel. In overturning Judge Nash’s ruling, Court of Appeals Judge Tim Garcia, who authored the majority opinion, wrote, “We conclude that aid in dying is not a fundamental liberty interest under the New Mexico Constitution. Accordingly, we reverse the district court’s order permanently enjoining the State from enforcing Section 30-2-4 [the law banning assisted suicide].” [*Morris v. Brandenburg*, New Mexico Court of Appeals, No. 33,630, 8/11/15, at 1] The case was appealed to the New Mexico Supreme Court. Oral arguments were heard on October 26, and the high court’s ruling is pending.

New York: A state civil judge in Manhattan has dismissed a constitutional challenge by three patients, five doctors, and the group End of Life Choice New York (formerly named Compassion & Choices of New York). As was the case in New Mexico, the New York plaintiffs in *Myers v. Schneiderman* argued that the state’s statutes pertaining

(continued on page 8)

Want to keep more up-to-date?

It’s easy!

Just fill out this form and send it in ➔ or contact us on our website, patientsrightscouncil.org

We’ll email you periodic updates, news alerts, and keep you informed on the PRC’s work protecting patients’ rights.

And be assured that we will protect your privacy and will never sell or share your email address with other organizations or individuals.



Mail to: PRC, P.O. Box 760, Steubenville, OH 43952

Please add my email address to the PRC’s Email Alert List

Name: _____

Email Address: _____

News briefs from home and abroad, continued from page 7

to suicide violate their equal protection and due process constitutional rights. They wanted the court to declare that doctors who practice “aid in dying” are not criminally liable under the state’s laws prohibiting the acts of promoting, causing, or aiding another person’s suicide or suicide attempt. They also asked the court to issue an injunction prohibiting the prosecution of these lethally-prescribing doctors. On October 16, Judge Joan Kenney dismissed the case, saying that the U.S. Supreme Court had already ruled that New York’s assisted-suicide statutes are constitutional in the 1997 case *Vacco v. Quill* and that it exceeds her court’s jurisdiction to prohibit a district attorney from prosecuting a penal law violation. Kathryn Tucker, lead attorney for the plaintiffs, said the decision would be appealed. [*New York Law Journal*, 10/21/15; *NY Daily News*, 10/19/15]

Tennessee: The Chancery Court of Davidson County, Tennessee, has denied a case brought by two-time gubernatorial candidate, political activist, and lawyer John J. Hooker. Diagnosed with stage 4 cancer, Hooker had backed a 2015 bill that would have legalized doctor-prescribed suicide in Tennessee. When the bill failed to pass, Hooker and three doctors filed a lawsuit to challenge the constitutionality of the state’s current law and obtain legal immunity for doctors who provide patients with the means to kill themselves. On September 29, Chancellor Carol McCoy rejected their arguments. She found that “aid in dying” is a violation of the state’s penal code (TN Code Ann § 39-13-216), that the penal code statute does not violate the state’s constitution, and does not violate any of the plaintiffs’ fundamental rights to due process and equal protection. [*Hooker v. Slatery*, Chancery Court of Davidson County, 9/29/15, at 3]

- **Oregon & Washington suicide study:** A suicide study, published in the *Southern Medical Journal*, found an increase (6.3%) in total suicides, with a larger increase (14.5%) among individuals 65 or older, in Oregon and Washington after doctor-assisted suicide was legalized. Moreover, there was no decrease in nonassisted suicides, even for those over 65. The findings counter claims by prescribed-suicide advocates that legalizing the practice reduces the overall number of nonassisted suicides. Instead, according to the researchers, the introduction of doctor-assisted suicide “seemingly induces more self-inflicted deaths than it inhibits.” [Jones & Paton, “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?” *Southern Medical Journal*, 10/15, pp. 599-604]

In a commentary that accompanied the study, Dr. Aaron Kheriaty, a psychiatry professor at the University of California–Irvine School of Medicine, wrote that the study’s findings point to a phenomenon called suicide contagion,

when one suicide generates other copycat suicides. He suggests that the media attention given to doctor-prescribed suicides can encourage copycat suicides particularly for vulnerable individuals. Dr. Kheriaty described the widely-publicized assisted suicide of Brittany Maynard, the young, attractive newlywed with brain cancer who moved to Oregon to end her life using doctor-prescribed lethal drugs, as a case that could easily encourage copycat behavior. But suicides don’t need to be publicized to be “contagious,” Kheriaty wrote. “[R]esearch suggests that behaviors like suicide, whether assisted or nonassisted, influence the behaviors of not only one’s friends but also of one’s friends’ friends’ friends.” [*Southern Medical Journal*, 10/15, pp 605-606]

- **Misdiagnosis:** A report issued by the federal Institute of Medicine (IOM) said that most people will receive at least one wrong or delayed diagnosis in their lifetimes that could result in missed treatments or even death. “Diagnostic errors persist throughout all settings of care and continue to harm an unacceptable number of patients,” researchers wrote. These errors contribute to approximately 10% of patient deaths and are, according to the report, “the leading type of paid malpractice claims and are almost twice as likely to have resulted in the patient’s death compared to other claims.” What the report didn’t say, however, is that, in states where doctor-prescribed suicide is legal, a misdiagnosis of terminal illness can cause a patient to request and take legally prescribed lethal drugs and die, when the patient was not terminally ill in the first place. The IOM report said that improving the diagnostic process is imperative, otherwise “diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity.” [IOM, “Improving Diagnosis in Health Care,” 9/15] ■

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, POLST forms, futile care policies, health care reform, and doctor-prescribed death.

The *Update* is available to the general public; suggested minimum donation is \$25.00 [U.S.] a year. Add \$3.00 for foreign postage.

Executive Director: Rita Marker, J.D.
Assistant Director: Jason Negri, J.D.
Consultant: Wesley J. Smith, J.D.
Editor: Kathi Hamlon

Patients Rights Council

P.O. Box 760
Steubenville, OH 43952 USA
800-958-5678 or 740-282-3810
www.patientsrightscouncil.org

Copyright © 2015 Patients Rights Council