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Patients Rights Council

# Update

## Colorado voters favor death control over protecting vulnerable patients

**O**n November 8—while most of the country was fixated on who would be the next US president—voters in Colorado were approving a doctor-prescribed suicide ballot initiative that will profoundly affect the state’s most at-risk patients: the poor, the elderly, the depressed, and the disabled. Voters passed Proposition 106, the Colorado End of Life Options Act, by a 65% to 35% margin.

Supporters of the initiative plied voters with personal tales of terminally ill patients who feared future suffering and the loss of their dignity and autonomy. They said these patients needed a lethal drug prescription from their doctors so they could be in control of the timing and the manner of their deaths.

Coloradans Against Assisted Suicide, a broad-based coalition of disability rights, legal, healthcare, faith-based, and patient advocacy groups opposed to the ballot measure, argued that

Proposition 106 threatened vulnerable patients and susceptible teens. The measure, they said, lacked effective safeguards against abuse, conveyed the message to the young that suicide was the answer to seemingly unbearable physical and mental suffering, and encouraged insurance companies to deny coverage for costly medical treatments while covering inexpensive assisted suicides. The editorial boards of both the *Denver Post* and the *Colorado Springs Gazette* opposed the measure, arguing that it lacked proper safeguards and posed a danger to many patients. [*Denver Post*, 10/11/16; *Colorado Springs Gazette*, 10/22/16]

But, despite the opponent’s best efforts, Colorado voters opted for personal death control over protecting at-risk patients.

Well-funded assisted-suicide activists had decided to go directly to voters after the legislature had rejected pre-

scribed-suicide bills in 1995, 1996, 2015, and 2016. They essentially took the failed 2016 bill and turned it into a successful ballot measure.

The initiative effort was ramrodded by Compassion & Choices (C&C), the main activist group behind state legalization efforts, including the California law that took effect this year.

According to Kim Callinan, C&C’s chief program officer, the “senior leadership and staff” of both C&C and the C&C Action Network knew that, after California, they needed a “win in another state within one year to replicate the model that was successfully used in the marriage-equality movement of creating a domino effect.” C&C analyzed the “movement and the political landscape,” Callinan wrote, and “put our talents and resources toward launching a citizen-led initiative campaign in Colorado.” [compassionandchoices.org, “The Key to Victory...,” 11/8/16] ■

### Also in this Update

Insurer denied treatment coverage but would pay for assisted suicide ..... 2

DC Council passes doctor-prescribed suicide bill ..... 2

CA: Assisted suicide for the institutionalized mentally ill  
*Wesley J. Smith* ..... 3

News briefs from home and abroad ..... 4

## Indiana Medical Association officially opposes assisted suicide

**T**he Indiana State Medical Association (ISMA) voted to oppose doctor-prescribed suicide and any attempt to legalize the practice in the state. The ISMA vote was taken during its October annual convention in Indianapolis.

Members argued that doctor-assisted suicide would create a culture that encourages the elderly, disabled, and depressed to end their lives and make it easier for caregivers to abuse their patients. Moreover, in its press release, the ISMA posed the question, “Will the government and insurance companies do the right thing—pay for treatment costing thousands of dollars—or the cheap thing—pay for lethal drugs costing hundreds of dollars?” [*Fort Wayne News-Sentinel*, 10/11/16]

Gary Wiggins, spokesman for the Indiana chapter of Compassion & Choices (formerly the Hemlock Society), objected to ISMA’s argument that assisted-suicide laws make it easier for depressed people to kill themselves instead of getting treatment. “[Patients] have to be mentally competent, they cannot be suffering from depression,” Wiggins countered. The claim, he said, that “depressed people can just get this medicine, that’s not true.” [*Indiana Public Media*, 10/3/16]

But Wiggins is mistaken. In states where prescribed suicide is legal, depressed patients can qualify for lethal drugs as long as doctors think that the depression does not cause the patient to have “impaired judgment.” ■

## Insurer denied treatment coverage but would pay for mom's assisted suicide

At the age of 29, Stephanie Packer, a California resident, was diagnosed with a terminal form of scleroderma, an autoimmune disease that can cause the hardening and scarring of tissue in the lungs and other internal organs. Her doctor said she had three years to live.

Packer is now 33 years-old and has outlived her doctor's prognosis. As a wife and mother of four young children, she wants to live as long as she can so she can be with her family and teach her children that death is just a natural part of life.

Recently, Packer has been in the news, both nationally and internationally, as a result of a video produced by the Center for Bioethics and Culture Network in which she tells about her struggle with her health insurer to obtain a needed chemotherapy drug prescribed by her doctor.

"For a while, five months or so, we've been trying to get me on a different chemotherapy drug for the infusions, because my doctor felt that it would be less toxic than some of the other drugs that we were going to be using," she explained in the video. "And I was going back and forth, and finally I had heard back from [the insurance company], and they said, 'Yes, we're going to get it covered, we just have to fix a couple of things.'"

But then California's doctor-prescribed suicide law went into effect in June 2016, and her insurance company reversed its decision. "[I]t was a week later I received a letter in the mail saying they were going to deny coverage for the chemotherapy that we were asking for," Packer said.

Packer then called the insurance company to find out why they were not going to cover the needed drug. She also asked if assisted-suicide drugs would be covered under her plan, and was told, "Yes, we do provide that to our patients, and you would only have to pay \$1.20 for the medication."

"As soon as this law was passed—and you see it everywhere when these laws are passed—patients fighting for a longer life end up getting denied treatment, because [prescribed suicide] will always be the cheapest option," Packer said.

Terminally ill patients are "so tired and don't have the strength to deal with the fight," she added. "Instead, they'll take the assisted suicide option because it's easier." [Packer, "Compassion and Choice DENIED," 10/17/16 (on youtube.com)]

Packer is correct when she says that other terminally ill patients have been denied coverage for needed treatment once assisted suicide was legalized. In 2008, Oregon residents Barbara Wagner and Randy Stroup, both with terminal cancer, were sent letters from their insurer, the Oregon Health Plan (OHP), that said the drugs their doctors prescribed would not be covered, but assisted-suicide drugs and services would. Both Wagner and Stroup could not afford to pay for the expensive cancer drugs, so, for them, the OHP letter meant that prescribed suicide was their most realistic treatment option.

The medication both had been prescribed would not have saved their lives, but would have eased their pain and might have extended their lives.

As a result of both patients going public with their OHP denial letters and the resulting media coverage, OHP apologized for the "insensitive" letters and said, in the future, they would call patients to discuss coverage instead of sending letters.

Wagner's doctor asked the company who makes the drug he prescribed for her to provide it free of charge. Surprisingly, the company agreed. [ABC News, 8/6/08; Fox News, 7/28/08]

When the sponsors of the doctor-prescribed suicide bill that eventually became law in California were struggling to get it passed in the legislature, they added a "safeguard" that they said would prevent what happened to Wagner and Stroup from ever happening in California. It states that any communication from an insurance carrier "shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage." [California End-of-Life Option Act, §443.13(c)]

As is the case with most, if not all, assisted-suicide law safeguards, this insurance "safeguard" is totally meaningless. Packer's insurance company complied with



*The Packer Family, courtesy of stephaniesjourney.org*

the law's provision by not mentioning assisted-suicide coverage when they denied payment for her chemotherapy, but the outcome for her was still the same as what happened to Wagner and Stroup: denial of a needed treatment when a much cheaper option was available. ■

### DC Council passes doctor-prescribed suicide bill

On November 15, 2016, the Council of the District of Columbia passed an assisted-suicide bill by a vote of 11-2. The Council had passed the bill by the same margin in a preliminary vote two weeks earlier. DC is the only predominantly African-American jurisdiction to pass such a measure, despite opposition from black residents and the disability community, who said the bill would target the elderly and disabled in their communities. [Washington Post, 11/15/16]

The bill, called the Death with Dignity Act, now awaits the signature of Washington DC Mayor Muriel Bowser, who has indicated that she will not veto it. The measure then goes to the US Congress, which has 30 days to either approve or reject the measure. If the 30 days expire without any determination by Congress, the bill becomes law.

Among other dangers, the measure does not require that patients "self-administer" the lethal drugs. Instead, the bill uses the term "ingest" (defined in Webster's dictionary as "swallowing" or "absorbing"). [Bill 21-38, Amendment #1, 10/18/16] As a result, the bill would allow other persons to place the drugs in the patient's mouth or administer them through an IV tube. ■

# California: Assisted suicide for the institutionalized mentally ill

by Wesley J. Smith

Assisted suicide proponents always promise that facilitated death will be offered solely and strictly to the mentally competent. But once a society accepts the premise of doctor-prescribed suicide—that it is acceptable to eliminate suffering by eliminating the *sufferer*—there is no way to restrict the putative “right to die” to the mentally healthy.

Mental illness often causes greater anguish than any physical disease and, indeed, for a far longer time. Thus, no one should be surprised that euthanasia of the mentally ill is a growing phenomenon in the Netherlands, where the practice has even been boosted by psychiatric journals, and in Belgium. In the latter country, doctors now condone the medicalized killing of mentally ill people with consensual organ harvesting!

Whenever I warn that the same progression will eventually happen here if assisted suicide becomes normalized, supporters of doctor-facilitated death sniff that America is different. But that assurance has already proved empty. California’s End of Life Option Act, which went into effect last June, legalized assisted suicide for the terminally ill who have the “capacity to make medical decisions.” (Please note that having this capacity is *not* the same as being mentally “competent.” That implied conflation is a ruse often deployed in assisted-suicide legalization schemes.) If the death-prescribing doctor suspects a condition causing impaired judgment, he or she “shall refer the individual for a mental health specialist assessment.” Thereafter, a lethal prescription should be written only “if the patient is not suffering from impaired judgment due to a mental disorder.”

Those provisions would seem to preclude access to assisted suicide for patients who are involuntarily hospitalized in state psychiatric institutions. After all, these are people with severe psychosis or emotional disturbance. But apparently state bureaucrats don’t see it that way. Soon after the California law went into effect, a regulation was quietly promulgated guaranteeing institutionalized mentally ill patients access to assisted suicide if they have been diagnosed with a terminal illness. Not only that, but the rule permits such people to receive a court-ordered release from institutionalization—not because their underlying condition has been successfully treated, *but for the specific purpose of killing themselves* with drugs prescribed by a doctor. From 9 California Code of Regulations § 4601 (my emphasis):

A terminally ill patient, as defined by the End of Life Option Act, may petition the superior court for access to participate in activities under the End of Life Option Act by *requesting release from the custody of the Department of State Hospitals* from the court. If the court orders release from the custody of the Department of State Hospitals, the Department of State Hospitals shall release the patient to the ordered entity or person.

Think about this: These are people denied their very freedom due to diagnosed severe mental disease! They are un-

doubtedly being treated with powerful psychotropic medications. In what universe could they possibly be deemed “not to be suffering from impaired judgment due to a mental disorder”?

The ironies are disturbing. For example, if a patient is hospitalized because he is acutely suicidal from deep depression, no court would free him for the purpose of committing suicide. Indeed, in such a circumstance, preventing that lethal act is the very point of the institutionalization! But if that *same* suicidal patient can show that he has been diagnosed with terminal cancer, he can be freed for that same purpose—even if the reason he wants to die is the depression and not the terminal diagnosis.

And what if a court decides that the patient is too dangerous to be let out, or if it can’t find an outpatient setting in which the death may take place? The state must then take action to ensure that the institutionalized mentally ill patient has access to assisted suicide:

If a court orders that the patient meets the qualifications under the End of Life Option Act, and that the Department of State Hospitals *shall facilitate the patient’s access to participate in activities under the End of Life Option Act*, the Department of State Hospitals will facilitate the patient’s access to an off-site facility that allows the patient the ability to participate in activities under the End of Life Option Act....

If the court orders that the patient meets the qualifications under the End of Life Option Act, and the Department of State Hospitals is unable to find an off-site facility for the patient to participate in activities under the End of Life Option Act, *the Department of State Hospitals will facilitate the patient’s ability to participate in activities under the End of Life Option Act on-site.*

This boggles the mind. The regulation puts the state in the business of *directly causing* the deaths of mentally ill patients under court-ordered custodial care. It goes beyond merely legalizing assisted suicide; it elevates euthanasia access for the institutionalized mentally ill into a court-enforceable *right*—all without public debate, passage through the usual legislative process, or so much as a news story to alert the people of California that the scope of their new assisted-suicide law has been radically extended.

The state is abandoning the institutionalized terminally ill to their darkest impulses. This isn’t compassion. The so-called “death with dignity” movement is driving us out of our collective minds. ■

*Wesley J. Smith, JD, is a consultant to the Patients Rights Council and a senior fellow at the Discovery Institute’s Center on Human Exceptionalism. His new book, Culture of Death: The Age of “Do Harm” Medicine, is published by Encounter Books.*





## News briefs from home & abroad . . .

- **United States:** In the last issue of the *PRC Update*, we reported on the assisted-suicide death of Betsy Davis, a 41-year-old artist with advanced ALS. Her death was widely reported in the media because it was one of the first under California's new doctor-prescribed suicide law, and she had thrown herself a farewell weekend party culminating in her planned death. (See *Update*, 2016, No. 4, p. 2 .) Now new information on Davis' death has emerged as a result of an investigation conducted by the *Des Moines Register* into the circumstances of her prescribed suicide.

According to the newspaper, Davis' death was a "team effort by necessity." Her ALS had advanced to the point that she was unable to hold the cup containing the lethal cocktail of drugs and drink it quickly enough to ensure death. California's law requires that patients "self-administer" the drugs, defined as the "physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death." [CA End-of-Life Option Act, §443.1(p)] A spokeswoman for the Medical Board of California said that a third party can prepare the lethal drug but cannot assist in the administering or ingesting of it.

When it was apparent that Davis's self-administering and ingesting was taking too long—risking unconsciousness before the lethal amount had been ingested—Davis' caregivers supported her as she sat and held the cup for her to drink, then leaned her back so the drug would go down. Davis' doctor, who was observing the drug administration, told the caregivers, "Go ahead and hold it for her." It took her nine minutes to successfully drink the deadly concoction with help. [*Des Moines Register*, 11/25/16]

- **The Netherlands:** The Dutch keep finding new ways to expand the eligibility for death under its supposedly "strict" euthanasia law. Patients deemed alcoholic can now be eu-

thanized under the law's "hopeless and unbearable suffering" criterion.

In an excerpt from his forthcoming book on his brother's death, published in the Dutch magazine *LINDA.*, journalist Marcel Langedijk recounts the story of his brother, Mark, who for eight years was in and out of 21 hospitals and rehab facilities in the hope of stopping his excessive drinking, but without success. Mark had two children, but his wife left him as a result of the alcoholism. Even though his parents and siblings supported him, he told his doctor, "I want to die, enough is enough." He claimed that his life of suffering was unbearable, a hopeless combination of pain, loneliness, and sorrow. A doctor specializing in euthanasia support and consultation ultimately approved Mark's induced death application. His life was terminated shortly thereafter. [*LINDA.*, 11/15/16; *BioEdge*, 11/25/16]

- **Australia:**
  - The South Australian Parliament has narrowly defeated a euthanasia bill by a vote of 24 to 23. The bill, the Death with Dignity Bill 2016, was hotly debated during a marathon overnight session that culminated with the Speaker of the Assembly casting the final vote to kill the measure at 4:00 am on November 15. The majority said the bill posed too many dangers for patients. It was the 15th time that a euthanasia bill was defeated in that parliament. [ABC News, 11/16/16]
  - The Australian Medical Association reaffirmed its opposition to euthanasia and assisted suicide in a new position statement stating, "...doctors should not be involved in interventions that have as their primary intention the ending of a person's life." [AMA Position Statement on Euthanasia & Physician-Assisted Suicide, 2016] The British Medical Association did likewise earlier this year. ■

### PRC ALERT

The American Medical Association (AMA) is considering changing its decades-long opposition to doctors participating in the intentionally induced deaths of patients. There is an effort within the AMA for the group to take a neutral stand on doctor-assisted suicide in 2017. Anyone who is concerned about this possible policy change should express those concerns to:

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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.

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

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