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Patients Rights Council

Update

New year brings dangerous doctor-prescribed suicide bills to targeted states

The new year is here, and with it came an unprecedented number of new assisted-suicide bills that proponents introduced in the 2017 legislative sessions of targeted states. Normally, all state bills to legalize doctor-prescribed suicide are modelled after the Oregon Death with Dignity Act, the first assisted-suicide measure to become law in the US. But this year is different.

As of February 21, prescribed-suicide bills have been introduced in 21 states: Alaska, Arizona, Connecticut, Hawaii, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Jersey (bills carried over from 2016), New Mexico, New York, Oklahoma (referendum bill), Pennsylvania, Tennessee, Utah, and Wyoming.

In some of those states two or more bills have been introduced. Hawaii leads the bill count with five; New York follows with three—two of which are "companion" bills (virtually identical bills in each legislative house). Indiana, Iowa, Maryland, Massachusetts, New Mexico, and New Jersey also have companion bills. Connecticut has two "proposed bills" that are being drafted.

Oregon model

The majority of the 2017 measures are patterned after Oregon's doctor-assisted suicide law that went into effect in 1997. Oregon-style bills are open to abuse largely because of illusory "safeguards" that give the impression of patient protection, but, in reality, are meaningless—resulting in a flawed reporting system, unenforceable state oversight, no public access to all state-obtained data, no protections for patients after the time the lethal drug prescription is filled, and no real protection from greedy heirs or others with a vested interest in the patient's death.

Standard of care bill

This year, Hawaii and New Mexico have a new type of bill for lawmakers to consider. Unlike the Oregon model measures, these new bills represent the next stage in assisted-suicide advocates' strategy to normalize prescribed suicide within the practice of medicine, making assisted suicide subject only to the "standard of care" criteria. Standard of care means the level at which the average, prudent health care provider in a given community would practice medicine. It is how similarly qualified practitioners would manage the patient's care under the same or similar circumstances.

(continued on page 2)

Also in this *Update*

How legal assisted suicide harms patients who want care

This statement is by Dr. Brian Callister, a practicing physician and associate professor at the University of Nevada Reno School of Medicine. Assisted suicide is not legal in Nevada, but it is in neighboring Oregon and California.

I am Dr. Brian Callister, a practicing physician in Reno, Nevada. Because we are a tourist destination and because of our proximity to California, some of our patients go out of state for treatment that is either not available in Northern Nevada or is closer to their homes.

During the summer of 2016, I worked with two different patients who I felt would benefit from bone marrow transplants for their cancers. Since we no longer perform this procedure here in Reno, the patients would have to go to a center in Northern California or Oregon to receive the treatment.

When I spoke with the insurance medical directors of the patients' insurance companies by telephone on separate occasions (these were appeals to try to get the patients approved for transfer/treatment), both of the insurance medical directors said they would cover hospice or assisted suicide but would not approve the bone marrow transplants.

Neither the patients nor I had requested the lethal drugs for an assisted suicide, yet it was offered presumably as a less expensive "treatment." It is now my experience and opinion that since assisted suicide became legal in California and Oregon, the practice of medicine across the West has been irreparably harmed for patients who still want their diseases treated but are now simply offered the cheaper option of a quick death. ■

New year brings dangerous doctor-prescribed suicide bills to states, ***continued from page 1***

2017 State Assisted-Suicide Bills
(as of February 21)

State	Bill	Introduced	Type of Bill
AK	HB 54	1/18/17	Oregon Model
AZ	HB 2336	1/24/17	Oregon Model
CT	HB 6024 & HB 6238	1/19/17 1/20/17	Text is Pending (bill type unknown)
HI	HB 150	1/19/17	Oregon Model
	HB 201	1/19/17	Standard of Care
	SB 357	1/20/17	Standard of Care
	HB 550	1/25/17	Oregon Model
	SB 1129	1/25/17	Oregon Model
IN	HB 1561 SB 273	1/23/17 1/9/17	Oregon Model
IA	HF 299 SF 215	2/14/17 2/7/17	Oregon Model
KS	HB 2120	1/20/17	Oregon Model
ME	LD 347	2/2/17	Oregon Model
MD	HB 370 & SB 354	1/25/17	Oregon Model
MA	HD 950 & SD 744	1/18/17 1/26/17	Oregon Model
MS	SB 2283	1/13/17 (Failed 1/31/17)	Oregon Model
MO	HB 524	1/9/17	Oregon Model
NE	LB 450	1/17/17	Oregon Model
NJ	A 2451 & S 2474	2/4/16 7/29/16	Oregon Model
NM	HB 171 & SB 252	1/20/17 1/30/17	Standard of Care
NY	A 2383 & S 3151	1/19/17 1/20/17	Oregon Model
	A 3598	1/27/17	Oregon Model
OK	HJR 1009	1/18/17	Oregon Model (Referendum)
PA	SB 238	1/26/17	Oregon Model
TN	SB 1378	2/9/17	Oregon Model
UT	HB 76	12/21/16 (Failed 2/9/17)	Oregon Model
WY	HB 122	1/12/17	Oregon Model

Since state oversight is no longer mandated, standard of care bills dispense with the usual Oregon model requirements, such as mandatory state reporting, second doctors' opinions, multiple patient death requests, waiting periods between requests, and other elements which assisted-suicide activists had formerly claimed were necessary safeguards.

If the Hawaii and New Mexico standard of care bills—as introduced— were to pass:

- A single physician or non-physician licensed to prescribe drugs (i.e., an advanced practice nurse) could give a patient a terminal diagnosis, deem that patient eligible for assisted suicide, inform the patient of the availability of assisted suicide, and write the prescription for lethal drugs *all on the same day*—without the patient ever recovering from the initial shock of being told he or she is terminally ill .
- There is no specific procedure required for a patient's death request. What the bills allow is no more stringent than a person's request for a flu shot.
- Since "terminally ill" is so broadly defined as the final stage of an incurable and/or irreversible disease or "condition," even a person with an incurable and irreversible spinal cord injury could qualify as terminally ill—even though, with intervention and rehabilitation, the person could live many years. Insulin-dependent diabetic patients could qualify if they stop using insulin. Patients with certain types of leukemia could also be deemed terminally ill.
- Both Hawaii and New Mexico could easily become national suicide destinations, since there is no requirement that a "qualified" assisted-suicide patient be a resident of the state.
- Health care facilities would not be allowed to opt out of providing assisted-suicide services. Only individuals would be allowed to opt out.

Latest bill update

New Mexico's bill, HB 171, had its first hearing in the House Health and Human Services Committee on 2/3/17 and was passed by a vote of 4-3. Hawaii's SB 1129 was unanimously passed on 2/15/17 by the Senate Committee on Commerce, Consumer Protection, and Health. Those bills now go to their respective chamber's Judiciary Committee for consideration.

Mississippi's SB 2283 died in committee on 1/31/17, and Utah's HB 76 failed to pass at its first hearing and was tabled on 2/9/17. ■

Editor's note: *The Patients Rights Council has compiled analyses of many of the new state bills. They are available on the PRC website: www.patientsrightscouncil.org.*

Congress runs out of time to overturn Washington, D.C.'s, assisted-suicide law

Congressional efforts to overturn the Washington, D.C., doctor-prescribed suicide measure, signed into law last December, have failed due to a lack of action on a joint resolution of disapproval within the limited time allowed by law.

Both the U.S. Constitution and the D.C. Home Rule Act gives Congress jurisdiction over the District of Columbia and the power to overturn its laws as long as Congress takes action within 30 working days after receiving the newly passed law. If Congress takes no action or fails to get a disapproval resolution passed by both the House and Senate and obtain the president's signature on the resolution before the deadline, then the D.C. law goes into effect. Congress's deadline for the assisted-suicide measure expired on February 20, 2017.

The joint resolution of disapproval, H.J. RES. 27, was referred to the House of Representatives Committee on Oversight and Government on January 12. The committee debated the resolution on February 13 and voted (22 to 14) to send it to the full House for approval. But it was never sent—despite Committee Chairman Jason Chaffetz's (R-UT) pledge to overturn the D.C. law and his statements that it had "serious flaws" and that he worried that it would "create a marketplace for death." [*Washington Post,* 2/8/17, 2/13/17; Reuters, 2/13/17]

With the resolution dead, House Republicans are looking at a new tack: drying up the new law's funding by using Congress' appropriation process. [*Washington Post,* 2/15/17]

While the D.C. law is modeled after Oregon's, it does not require patients to "self-administer" the lethal drugs. As such, it could be interpreted to allow persons other than the patient to place the drugs in the patient's mouth or administer them through an IV tube. Like the Oregon law, the D.C. measure has no provisions protecting patients at the time the fatal overdose is ingested. There is no way of knowing if the patient took the drugs voluntarily or if they were forced to ingest them. ■

Claims of "no abuse " not substantiated in latest Oregon assisted-suicide report

It's become the mantra of advocates pushing doctor-prescribed suicide in targeted states: "There's been absolutely no instance of abuse under Oregon's Death with Dignity law." Their claim, they say, is based on annual assisted-suicide reports compiled by the Oregon Public Health Division (OPHD). But the newly released 2016 report, like previous reports, contains a significant amount of "unknown" data that discredits the advocates' claim.

According to the new report, there were 133 reported assisted-suicide deaths in 2016 and 1,127 such deaths since the assisted-suicide law took effect in 1997. [OHPD, "Oregon Death with Dignity Act - Data Summary 2016," 2/10/17 (posted on OPHD's website on 2/21/17), p. 5]

Included in the 2016 death total are 19 people who received lethal drug prescriptions in "prior years" but didn't take the drugs and die until 2016. [p. 3] The OPHD doesn't specify how many "prior years" had elapsed after doctors judged those patients to have six months or less to live and prescribed the fatal drugs. Data from previous years showed some patients lived two years or more beyond the six-month prognosis.

In 2016, 102 doctors wrote 204 lethal drug prescriptions. The number per doctor ranged from 1 to 25 prescriptions. Of the 204 patients prescribed fatal drugs, 114 took them and died. Thirty-six (36) did not ingest the drugs, but died from other causes. In 54 cases, the OPHD does not know whether the lethal drugs were ingested. [p. 5] Three patients had difficulty ingesting and/or regurgitated the drugs, but it's "unknown" whether 106 other patients (80%) experienced any complications. [p. 10]

The OPHD only uses ingestion data from prescribing doctors and other providers who were present when patients took the drugs. In 2016, doctors and other providers, respectively, were present in only 14 cases. In 100 of the 133 deaths, data relative to ingestion is "unknown." [p. 10] In 75% of the 2016 deaths, the OPHD has no clue what happened at this most critical time in the assisted-suicide process.

How can advocates' "no abuses" claim be credible when there's no data on issues like whether 75% of the patients took the drugs voluntarily or were forced to do so? ■

Reported Assisted-Suicide Deaths in Oregon 1998-2016

Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates.[1]
Figures are those reported by the state in the 2016 report.

Categories	1998 - 2013	2014	2015	2016	TOTAL
No. of reported assisted-suicide deaths	754[2]	105	135	133	**1,127**[2]
No. of unreported assisted-suicide deaths	Unknown[1]	Unknown[1]	Unknown[1]	Unknown[1]	**Unknown**[1]
No. of reported lethal prescriptions written	1,172	155	218	204	**1,749**
No. of doctors who wrote lethal prescriptions in a given year	?[3]	83	106	102	**?**[3]
No. of cases where prescribing doctor was present when lethal drugs were ingested:	→	→	149[4]	14	**163**
Other care provider present:	→	→	256[4]	14	**270**
No provider present:	→	→	86[4]	5	**91**
Unknown:	→	→	*433*[4]	*100*	***533***
No. of cases where prescribing doctor was present at the time of death:	→	→	136[4]	13	**149**
Other care provider present:	→	→	281[4]	14	**295**
No provider present:	→	→	489[4]	102	**591**
Unknown:	→	→	*18*[4]	*4*	***22***
No. of patients referred for psychiatric evaluation	→	→	52 [5.3%]	5 [3.8%]	**57 [5.1%]**
Patients' reasons for requesting assisted suicide:					
Loss of autonomy	→	→	906 [92%][4]	119 [90%]	**1,025 [91%]**
Inability to do enjoyable activities	→	→	888 [90%][4]	119 [90%]	**1,007 [90%]**
Loss of dignity	→	→	680 [79%][4]	87 [65%]	**767 [77%]**
Lost control of bodily functions	→	→	475 [48%][4]	49 [37%]	**524 [47%]**
Being a burden	→	→	408 [41%][4]	65 [49%]	**473 [42%]**
Inadequate pain control or concern about it	→	→	249 [25%][4]	47 [25%]	**296 [26%]**
Financial implications of treatment	→	→	31 [3%][4]	7 [5%]	**38 [3%]**
Complications after lethal drugs were ingested:					
Difficulty ingesting/regurgitated	→	→	27[4]	3	**30**
Patient regained consciousness	→	→	6[4]	Not Reported[5]	**6**
Other	→	→	3	Not Reported[5]	**3**
Unknown	→	→	*437*[4]	*106*	***543***
Reported incidents of physician non-compliance with the assisted-suicide law[5]	22[5]	0	0	0	**22**[5]
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 information provided by prescribing doctors is 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. Also, the total number of deaths reported for specific years since 1998 are increased retrospectively when OPHD receives data on an assisted-suicide death that was not previously included in that year's annual report.**
2. **The 2016 Report reflects the official totals from 1998 to 2016. However, some of the previous years' totals, as listed in each year's individual report when issued, were changed in subsequent years with no explanation given.**
3. **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.**
4. **In the 2016 Report, this is the combined total for 1998 through 2015. In some categories, the totals may differ from figures reported in previous years. No explanation for the change was given.**
5. **Category is not included in the 2016 Report's tables. (Regarding doctor compliance, the text 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 ever been penalized for non-compliance.)**

Source:

Oregon Public Health Division, "Oregon Death with Dignity Act - Data Summary 2016," released *2/21/17*.

All 19 annual reports are available online at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

News briefs from home & abroad . . .

- **Ohio:** Last December, Ohio Governor John Kasich signed into law HB 470, a bill—unanimously passed by the Ohio House of Representatives—that makes assisted suicide a third-degree felony punishable by up to five years in prison. Ohio is the fifth state in recent years to strengthen its law banning assisted suicide. The other states are Arizona, Georgia, Idaho, and Louisiana. Previously, Ohio law only allowed a court to issue an injunction barring a person from aiding another's suicide. Now the law explicitly makes "providing the physical means" for or "participating in the physical act" of another's suicide or attempted suicide a punishable crime. [cleveland.com, 12/8/16; WMFD, 12/20/16]

- **Colorado:** Prescribed-suicide activists are not happy about how the new assisted-suicide law is *not* working in Colorado. Approximately one-third of the of the state's hospitals and affiliated clinics are refusing to assist in the suicides of their patients. According to the *Denver Post* and the *Boston Globe's* publication *Stat News*, Colorado's three major health care systems—Centura Health, SCL Health, and HealthOne—have opted out (in whole or in part) of the state's End of Life Options Act, which was passed by voters last November and took effect in December. Most of the opting-out hospitals are affiliated with the Catholic or Adventist churches, but not all. "It has a chilling effect," explained Holly Armstrong, a consultant for Compassion & Choices (C&C), the activist group behind the assisted-suicide legalization campaign in Colorado and other states. C&C argues that, while the new law allows hospitals and other health care facilities to prohibit patients from ending their lives on the facility's premises, it does not permit these facilities to bar doctors from writing lethal drug prescriptions that patients can take at home. C&C spokespersons have said a lawsuit challenging opting-out facilities is likely. [*Stat News,* 1/19/17; *Denver Post*, 1/26/17]

- **American Psychiatric Association:** With countries like Belgium and the Netherlands euthanizing patients with psychiatric conditions like depression and anxiety disorders, the American Psychiatric Association (APA) has approved an historic position statement against psychiatrist-prescribed suicide and euthanasia. It states: "The American Psychiatric Association, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death." [APA Statement on Medical Euthanasia, 12/16]

- **The Netherlands:** While she was still lucid, an 80-year-old dementia patient stipulated in her will that she didn't want to end up in a nursing home for dementia patients and she wanted euthanasia "when I myself find it the right time." Because her dementia had advanced to the point that her husband could no longer care for her, she was admitted to a nursing home apparently against her stated wish. After seven weeks in the home, her doctor decided to euthanize the woman since she was "suffering unbearably"—manifested by her seeming angry and wandering around the facility at night. When the doctor approached the woman to give her a sedative injection, she became agitated, so the doctor slipped the sedative into a cup of coffee and followed up with another injection. The drugs seemed to put the woman to sleep, but when the doctor tried to inject the fatal drug, the woman began to struggle and tried to get up. The doctor then asked her family members to hold the woman down while the last injection was given. The woman died shortly thereafter. The official Euthanasia Review Committee looked at the case and found that the doctor had acted in "good faith," and simply rebuked her for deceptively putting the drug in coffee and for not stopping the euthanasia when the patient struggled. [*Netherlands Times,* 1/26/17] ■

PRC ALERT

The America 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. We urge readers who are concerned about this possible policy change to 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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