With the new year comes more dangerous doctor-assisted suicide bills

It’s becoming almost a tradition that the start of each new year brings with it a slew of new state measures to legalize doctor-prescribed suicide.

That was particularly the case last year—the result of assisted-suicide activist groups’ ramped-up lobbying efforts in targeted states. By the first week of February 2017, 25 states had new assisted-suicide bills introduced in their respective state legislatures. Another two states had measures introduced as the year progressed.

But not one of those states passed a prescribed-suicide bill. Most rejected their bills outright, while the others took no action and let their bills carry over to 2018, the second year of those states’ two-year legislative sessions.

So far, in 2018, the number of new assisted-suicide bills is far less than last year. The states with measures newly introduced are Arizona, Hawaii, Indiana, New Jersey, Ohio, Oklahoma, Rhode Island, and Utah. Incredibly, Hawaii had four new assisted-suicide bills introduced on one day, and New Jersey had two identical bills (called companion bills, meaning one introduced in each legislative chamber). All the rest of the states have single bills.

The states that had 2017 active bills carry over to 2018 are Alaska, Delaware, Hawaii, Iowa, Massachusetts, Michigan, Minnesota, Nebraska, New York, North Carolina, Pennsylvania, and Wisconsin. (See tables on page 2.)

Hawaii has a total of nine bills being considered by lawmakers: five carried over from 2017 plus the four new bills introduced in 2018. Oklahoma’s new bill would not directly legalize doctor-assisted suicide. Rather, it would authorize that a referendum on legalization be put on the 2018 ballot for voters to approve or reject.

In 2017, doctor-prescribed suicide activists in South Dakota attempted to place a “Death with Dignity” initiative on the 2018 state ballot, but they failed to collect the 14,000 voter signatures required to do so. Advocates in Maine are currently trying to garner 60,000 signatures in the hope of putting an assisted-suicide measure on that state’s 2018 ballot.

While all assisted-suicide measures pose real dangers to patients, several of the new measures are particularly worrisome.

Hawaii’s 2018 bill, HB 2218, not only allows doctor-assisted suicide (the patient self-administers lethal drugs), but also explicitly permits active euthanasia (a doctor physically administers the fatal drug overdose to the patient, i.e., lethal injection). [HI HB 2218, Part III A § 22 (3)]

When “terminal” does not mean six months left to live

For years, the Patients Rights Council (PRC) has said that U.S. doctor-prescribed suicide laws and proposed bills—claiming to limit assisted suicide to those with six months or less to live—actually allow the induced deaths of patients who have years, even decades, to live.

Why? Because the definitions of “terminal illness” contained in those laws and bills do not specify that death will occur within six months even with treatment.

For example, if an insulin-dependent diabetic—who would live for many years taking insulin—decided to stop that treatment after the sudden death of her husband left her depliant, she would likely die within six months, making her eligible for assisted suicide. Oregon’s official annual reports attest to this fact. Since 2003, all except the 2009 assisted-suicide report listed diabetes as an underlying condition for patients who died under the “Death with Dignity Act.”

Last December, Fabian Stahle, a Swedish investigator who questioned his government’s recent favorable report on Oregon’s assisted-suicide law, decided to pose his questions to the Oregon Health Authority (OHA), the agency responsible for overseeing the prescribed-suicide law. He asked if the law would apply if a patient refused available treatment. OHA Research Analyst Craig New responded, “The law is best seen as a permissive law, and states only that patients must have a terminal illness with six months or less to live. It does not com-

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Colorado & Vermont issue 1st assisted-suicide reports

There are several things that Colorado’s and Vermont’s doctor-prescribed suicide reports have in common. They are the first data reports each state has released—even though Vermont legalized assisted suicide three years before Colorado did in 2016. Vermont’s report covers deaths from May 2013 to June 2017; Colorado’s covers only 2017 deaths.

The amount of missing data in each report is staggering. In Colorado, that’s largely because official reporting forms, required by law, were never submitted to the state. The report shows that 69 patients received lethal drug prescriptions, but the state received only 60 prescribing-doctor reports, 47 patient’s written death requests, 1 mental health confirmation, and 27 consulting doctor reports. The state has only 56 death certificates related to patients who were prescribed overdoses, but, because the law mandates that prescribed-suicide doctors lie on patients’ death certificates by listing patients’ underlying illnesses as the cause of death, (continued on page 4)

Likewise, the wording in Ohio’s bill implies that the administration of the lethal drugs to the patient would be allowed if it is done with “the individual’s knowledge or consent.” [OH SB 249, Sec. 3792.22 (B) (3)]

An alarming, recent amendment to Delaware’s HB 160 expands prescribed death to those who have an “intellectual disability,” defined as “a disability, that originated before the age of 18, characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.” Such a patient could qualify for a lethal drug prescription if a “clinical social worker” says the patient truly understands the assisted-suicide information he or she has been given. [DE HB 160, Amendment 2, Lines 30-31 & Line 106, 1/18/18]

“These are people who can’t legally enter contracts! They can’t control where they live! They can’t make their own medical decisions! They also can’t vote, pursuant to the Delaware Constitution,” wrote PRC consultant Wesley J. Smith. “Yet, if they have a terminal illness, they are going to be able to commit assisted suicide if a social worker—who may be ideologically predisposed in favor—confirms they ‘understand’ that they are receiving a poison prescription!” [National Review, 1/22/18]

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Stahle also asked New if a patient’s insurance refused to pay for a life-sustaining treatment and the patient was unable to pay for that treatment would the patient qualify for assisted suicide. New answered, “If the patient does not receive treatment or medication (for whatever reason) and is left with a terminal illness, then s/he would qualify for the DWDA. I think you could also argue that even if the treatment/medication could actually cure the disease, and the patient cannot pay for the treatment, then the disease remains incurable.” [Fabian Stahle, “Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model,” 1/18; emphasis added by Stahle]

Dr. Charles Blanke, an oncologist and professor of medicine at Oregon Health and Science University, had a patient who was a young woman with a serious illness. She had a 90 percent chance of living for decades with treatment—but she refused the treatment. “That was a very challenging situation,” Blanke said. “You have to ask yourself, Why doesn’t that patient want to take a relatively non-toxic treatment and live for another seven decades?” Blanke ended up prescribing the deadly overdose for the woman anyway. [Bend Bulletin, 8/14/17]
Oregon releases 2017 prescribed-suicide report with high death count

O n February 9, 2018, the Oregon Health Authority’s Public Health Division released its annual data report on doctor-assisted suicide deaths that occurred in 2017. It is the 20th prescribed-suicide report that the state has published since the Death with Dignity Act (DWDA) took effect in 1997.

According to the 2017 report, a record high 143 patients ingested death-inducing drugs prescribed by their doctors. These are only the deaths that doctors reported to the state. Any deaths that were not reported by physicians remain unknown because the state has no authority to investigate individual DWDA cases.

Ninety-two (92) doctors wrote 218 prescriptions for lethal overdoses in 2017. The identity of those doctors is not reported, but the data shows that the number of prescriptions per doctor ranged from 1 to 29.

Of the 218 patients with drug prescriptions written in 2017, 130 ingested the drugs; 44 did not, but died of other causes; and, for the remaining 44 patients, their “ingestion status” is “unknown.” However, the state report indicates that 143 actually died from ingesting the drugs. That’s because an additional 14 patients, who had been prescribed the fatal drugs in “previous years,” took the drugs in 2017. The fact that patients had received the drugs in prior “years” indicates that, at least for some of those patients, their prescribing and consulting doctors were wrong when they determined that the patients had less than six months to live—a requirement for patients to be eligible for assisted suicide.

There were really 144 patients who took the drug overdose in 2017, but one didn’t die. That patient regained consciousness and later died of his or her underlying illness. This is not the first time that has happened. Two patients awoke in 2010, two in 2011, and one in 2012. Over the course of 20 years, seven patients have awakened after taking the drugs. Other complications reported include difficulty ingesting the drugs, regurgitation, and seizures.

Only five (3.5%) of the 143 patients who died had been referred for a psychiatric evaluation. [Oregon Health Authority, “Oregon Death with Dignity Act - 2017 Data Summary,” 2/9/18]
the state has no way of knowing if deceased patients took the drugs or died from other causes. [CO End-of Life Options Act, Year One—2017 Data Summary, p. 4, 2/1/18]

Vermont’s report is exceedingly sparse on data. During the 3-year reporting period, 52 patients qualified for assisted suicide. Of those, 48 obtained the lethal drugs and died. Of those, 29 died after ingesting the drugs, 17 died from their illness, 1 died from other causes, and 1 patient’s status is unknown. The remaining 4 patients “are assumed to still be living.” But the state then seemingly contradicts its own figures by stating that it has only been able to “positively identify 26 out of the 48 deceased” patients who filled their prescriptions. Out of the remaining 22 deceased patients, 7 “were likely prescribed” lethal drugs, but the state isn’t sure. What happened to the remaining 15 patients is anybody’s guess. [VT Report Concerning Patient Choice at the End of Life, p. 4, 1/15/18]