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Patients Rights Council

Update

Hawaii's new law turns medical care into a deadly practice

A new law in Hawaii, titled the "Our Care, Our Choice Act" (OCOCA) took effect on January 1, 2019. The purpose of the law, as stated in the statute, is "to allow qualified patients... to determine their own medical care at the end of their lives." [OCOCA, Section 1, p. 4] That medical care now includes doctors' prescriptions for intentionally lethal drugs to end patients' lives.

It took nearly 20 years for the Hawaii legislature to pass a doctor-assisted suicide bill. Supporters introduced almost 40 bills during that time, with no success. Legislators were clearly reluctant to pass these measures because of real concerns about the abuse potential for vulnerable patients.

It became apparent that, if supporters were ever going to succeed, legislators would have to be convinced that

future prescribed-suicide bills were patient protective and abuse free. That meant more "safeguards."

The OCOCA's sponsors added several purported safeguards to the bill, including a mandatory psychological evaluation to determine the patient's competency, an increased 20-day waiting period between oral death requests, and increased criminal penalties for anyone who tampers with a patient's death request or coerces a patient to ask for lethal drugs. Supporters claimed that the bill's safeguards were stronger than those contained in any other state's prescribed-suicide law. Despite the fact that these new provisions were not at all as protective as they might seem, legislators passed the measure.

According to Compassion & Choices (C&C), the national assisted-suicide ac-

tivist group that lobbied heavily for OCOCA's passage, "Over the past several years we've explored a variety of legal and legislative strategies to expand end-of-life choice and authorize medical aid in dying [doctor-assisted suicide].... We worked closely with bill sponsors to review the legislation, filed a lawsuit to authorize medical aid in dying, gathered petitions, generated a constant drumbeat of media coverage and reached out to key health organizations. The Our Care, Our Choice bill was passed by veto-proof margins in both houses of the legislature." [C&C - Hawaii website]

But, like all state assisted-suicide laws, the OCOCA has major flaws that can adversely affect patients. For example, while the law mandates that the Hawaii Department of Health (DOH)

(continued on page 4)

Also in this Update

New & carried-over assisted-suicide bills being considered in 2019 2

Be careful what you write in emails and post on social media 3

AMA remains opposed to assisted suicide, but the battle over policy heats up 3

News briefs from home and abroad 4

Assisted-suicide activist wants patient protections dumped

The CEO of the national assisted-suicide advocacy group Compassion & Choices (C&C) has publicly stated that the "safeguards" that C&C supported in state doctor-prescribed suicide bills and laws are "unnecessary roadblocks" for terminally ill patients. According to CEO Kim Callinan,

If lawmakers want to improve medical aid in dying laws, then let's address the real problem: There are too many regulatory roadblocks already!... I am merely suggesting that we drop some of the regulations that put unnecessary roadblocks in place. [Mc Knight's Long Term Care News, 1/1/19]

The "most obvious" provision Callinan wants to eliminate is the mandated waiting period (usually 15 days, 20 days in Hawaii) designed to give patients time to reconsider

their death requests. She argues, "By the time a patient has navigated the entire process, they have waited plenty."

But that's not the only patient protection that Callinan would like to dump or change. She wants to eliminate "overly cumbersome reporting" meant to allow the state to oversee and regulate the death practice. She says it "deters doctors from practicing" assisted suicide. She also thinks lawmakers should extend lethal prescribing privileges to nurse practitioners, not just doctors, to make assisted suicide accessible to more patients.

Apparently, C&C—who helped write most of the state assisted-suicide bills and laws—backed touted safeguards simply to get the public and legislators to legalize the practice. It was a successful con job in the six states and D.C. that bought into the deception. ■

New and carried-over state assisted-suicide bills being considered in 2019

The new year usually brings with it a slew of new prescribed-suicide bills. So far this year, 11 states—Arizona, Connecticut, Indiana, Kansas, Massachusetts, New Mexico, New York, Oregon, Rhode Island, Utah, and Virginia—have had new bills introduced to legalize assisted suicide or expand an existing prescribed-suicide law (Oregon). In addition, New Jersey has a legalization bill that has been carried over from 2018, while Montana has a measure that would make prescribed suicide illegal and negate the 2009 Montana Supreme Court decision that a patient’s consent to doctor-assisted suicide is a defense the doctor could use against the charge of homicide.

While all measures to legalize prescribed suicide pose dangers for patients, the new bills introduced in New Mexico and Oregon are especially hazardous.

New Mexico

New Mexico has two identical new bills—one in the House (HB 90) and the other in the Senate (SB 153). They are both titled the “Elizabeth Whitfield End of Life Options Act.”

The bills increase risks to patients by allowing non-physicians—an advanced practice nurse or physician assistant—to diagnose a patient as being terminally ill and to prescribe lethal drugs to cause that patient’s death. These non-doctors lack the education and experience that doctors have in treating serious illnesses and disabilities or controlling a patient’s pain and symptoms.

Another huge concern is that the bills allow health care providers to diagnose and prescribe the lethal drugs using telemedicine technology without ever seeing the patient in person. Remote telemedicine can also be used by a mental health professional who is supposed to evaluate whether a patient has “a mental health disorder or an intellectual disability causing impaired judgment with regard to end of life medical decision making.” [HB 90, Sec. 4 (B.)] This psychological evaluation is a matter of life or death for the patient. That should be important enough to warrant several in-person consultations.

The categories of patients who could qualify for a prescribed death are greatly expanded because the definition of “terminal illness” is loosely written and completely elastic:

“‘terminal illness’ means a disease or condition that is incurable and irreversible and that, in accordance with reasonable medical judgment, will result in death within the foreseeable future.” [HB 90, Sec. 2 (K)]

If 50 people were asked what “foreseeable future” means, they would likely come up with many different answers. The term could mean virtually any length of time, well beyond the usual 6-month timeframe found in most assisted-suicide measures. Also, a “disease or condition” can be “incurable and irreversible” and still be *controllable with treatment*, allowing the patient to live for many years—such as in the case of an insulin-dependent diabetic.

In an attempt to streamline the death-inducing process, the New Mexico bills completely eliminate the usual 15-day waiting period (20 days in Hawaii) between the patient’s two oral death requests. That waiting period has been included in all previous doctor-prescribed suicide bills and laws to allow patients time to reassess their death request. The only waiting period mandated in the current measures is a 48-hour pause in the process between the writing of the lethal drug prescription and the dispensing of those drugs to the patient. [HB 90, Sec. 5 (A)] As PRC Consultant Wesley J. Smith, JD, explained, “This means that a patient could go to a nurse practitioner on Monday morning, be examined, have telemedicine consults, receive the prescription that day, have the poison dispensed on Wednesday, and be dead before Thursday begins.” [National Review, 12/27/18]

Oregon

In an op-ed published in the Eugene, OR, *Register Guard*, Bruce Yelle, director of the Hemlock Society related group in Oregon called End Choices, announced that there will be “bills, including one called Brittany’s Bill,” introduced in Oregon’s House and Senate in 2019 that will “expand” the boundaries of the state’s current Death with Dignity Act. He did not indicate the names or numbers of the pending bills except for Brittany’s Bill. [Register Guard, 1/15/19]

Three new bills, HB 2217, HB 2232, and SB 579, have been introduced, but, as of this writing, the one alleged to be named Brittany’s Bill has not. HB 2232 expands the definition of terminal disease even beyond the one in the New Mexico measures. HB 2232’s definition reads, “‘Terminal disease’ means a disease that will, within reasonable medical judgment, produce or *substantially*

(continued on page 3)

2019 Active State Assisted-Suicide Bills (As of January 28, 2019)

State	Bill	Introduced	In Committee
AZ	HB 2408	1/24/19	N/A
CT	HB 5898 SB 374	1/23/19 1/23/19	Joint Committee on Public Health Joint Committee on Public Health
IN	HB 1184 SB 300	1/8/19 1/7/19	Public Health Committee Health & Provider Services Committee
KS	HB 2089	1/28/19	N/A
MA	HD171 SD 395	1/8/19 1/14/19	N/A N/A
MT	HB 284*	1/24/19	House Judiciary Committee
NJ	A 1504** S 1072**	1/9/18 1/22/18	Passed Judiciary - 3/12/18 No action taken by HHS & Senior Citizens Com.
NM	HB 90 SB 153	12/18/18 12/21/18	Passed HHHS - 1/28/19; referred to Judiciary Public Affairs Committee
NY	A 2694	1/25/19	Health Committee
OR	HB 2217*** HB 2232*** SB 579***	1/14/19 1/14/19 1/14/19	House Health Care Committee House Health Care Committee Senate Judiciary Committee
RI	S 157	1/24/19	Senate Judiciary
UT	HB 121	1/9/19	N/A
VA	HB 2713	1/15/19	House Committee for Courts of Justice

* This MT bill would make doctor-prescribed suicide illegal.
 ** These NJ bills have been carried over from 2018.
 *** These OR bills would expand the existing assisted-suicide law.

Be careful what you write in emails and post on social media

It's a fairly common thing. People write things they don't really mean for effect or just to be funny. Things like, "If [such-and-such] happens, just shoot me and put me out of my misery!"

But, today, if such comments are posted online or in emails, they may prove fatal—especially if the writer lives in England or Wales.

Last December, the British Medical Association (BMA) issued a 93-page guidance for doctors to follow when they are assessing whether to start or continue the provision of nutrition and hydration for patients who lack the capacity to make their own medical decisions. According to the guidance, "anything relevant the patient wrote down—in a diary, letters, on social media, or in e-mails" can be used by doctors to determine whether life-sustaining treatment, including nutrition and hydration, should be withdrawn, resulting in the patient's death. [BMA, "Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent," p. 62]

The guidance is the result of an October 2017 court case in which a Court of Protection judge ruled that a comatose 74-year-old woman, referred to as Mrs. P, could be denied all food and fluids.

The judge based his ruling in large part on an email message Mrs. P sent to her daughter *four years earlier* in 2013. Mrs. P, who was known to be a heavy drinker, had just seen a TV documentary on dementia that troubled her and reminded her of the deaths of two family members. She emailed her daughter this message:

"Did you see that thing on dementia? Made me think of Dad and what a travesty of life his last years were and all the sadder as he had such incredible talent. You know I miss Mum everyday and still talk to her but it is a comfort that she went quickly and I am still haunted by how he ended up... Get the pillow ready if I get that way!... Love Mum" [Salford Royal NHS Foundation Trust v. Mrs. P, Approved Judgment, 10/30/17, at 35]

The judge wrote in his ruling that, while some consider the email to contain just "casual throw away remarks that we all make from time to time and are ultimately meaningless"—like "*Take me out and shoot me*"—he does not. "...I find the email to be reflective of her determination to preserve her independence, her privacy and her autonomy." [Salford v. Mrs. P, at 37] ■

AMA remains opposed to assisted suicide, but the battle over policy heats up

Since 2016, the American Medical Association (AMA) has been studying its long-held policy opposing physician-assisted suicide. That's because the AMA's Oregon delegation submitted a resolution to have the association go neutral on the issue. The AMA's Council on Ethical and Judicial Affairs (CEJA) undertook an intensive, 2-year study in light of the Oregon resolution and another resolution on the terms used to describe assisted suicide.

The CEJA issued its first report in early 2018, before the House of Delegates annual meeting in June. The report reaffirmed the AMA's opposition to the death practice and found that "physician-assisted suicide,"—not euphemistic terms like "aid-in-dying" or "death with dignity"—was the most precise term to describe the practice. But assisted-suicide supporters managed to get the House of Delegates to send the report back to the CEJA for more study.

The CEJA issued its second report quickly, just in time for another House of Delegates meeting in November. The new report, which reinforced the findings in the first one, resulted in a meeting that was both heated and divisive. Ultimately, the CEJA report was again not accepted, and, for the second time in 2018, was referred back to the CEJA for more study. Meanwhile, the AMA remains opposed to physician-assisted suicide. [Med Page Today, 11/12/18, 11/14/18, 12/21/18] ■

New & carried-over state assisted-suicide bills being considered in 2019, continued from p. 2

contribute to a patient's death." [HB 2232, Sec. 3 (13); emphasis added] Gone is the prognosis of 6 months or less, and in its place is the undefined phrase "substantially contribute" to death. High blood pressure is a condition that would likely "contribute" to a person's death. So would high cholesterol and any number of other conditions for which people are commonly treated, yet they still live long lives. If passed, HB 2232 would shatter even the illusion that patients must be near death to qualify for assisted suicide.

Another Oregon bill, SB 579, would create exemptions to the two waiting periods mandated in the state's existing assisted-suicide law. If the doctor says that the qualified prescribed-suicide patient will likely die before the 15-day waiting period between oral death requests expires, the patient can simply make the second request at any time after the first request and be exempt from the rest of the 15-day wait. The same type of exemption would apply to the later 48-hour wait after the written death request. Once an exception is given for either one of the

waiting periods, the fatal drug prescription can be written. [SB 579, Sec. 2 (2) and Sec. 3 (2)]

Other state measures

Even though assisted-suicide is not currently legal in Oklahoma, SB 108, "Death Certificate Accuracy Act," would make it a felony to lie on the death certificates of prescribed-suicide patients. In a preemptive move, SB 108 would require that the cause or manner of death be listed on these patients' death certificates as "suicide," not the patient's underlying illness as assisted-suicide laws require. A similar bill introduced in 2017 passed the House but stalled in the Senate.

In addition to state bills, Maine supporters are continuing their signature gathering effort to put an initiative (called the Maine Death with Dignity Act) on the state ballot in 2020. They need over 60,000 valid voter signatures, but currently have around 58,000 signatures that have not been validated. [DWD National Center, *Dignity Report*, Winter 2019] Supporters tried to qualify the measure for the 2018 and 2019 ballots but were not successful. ■



News briefs from home & abroad . . .

- **Belgium:** Three doctors from East Flanders—two medical doctors and a psychiatrist—have been ordered to stand trial for “poisoning” in relation to the euthanasia death of Tine Nys. The 38-year-old woman had two months earlier been diagnosed with Asperger’s syndrome, a mild form of autism. This is the first prosecution of any euthanasia doctor since the country legalized the practice in 2002. The indictments are the result of complaints filed by the Nys family, who questioned the autism diagnosis, saying Tine was simply depressed over a break-up with her boyfriend. After the family’s complaints became public, Dr. Lieve Thienpont, the psychiatrist who approved Nys’ request for euthanasia, wrote to her colleagues, “We must stop these people. It is a seriously dysfunctional, wounded, traumatized family with very little empathy and respect for others.” However, the committal hearing ruled that there was sufficient *prima facie* evidence of wrong-doing to bring the doctors to trial. [*Washington Post*, 11/29/18; *Brussels Times*, 11/23/18]

Another Belgian doctor is under investigation for the 2015 euthanasia death of an elderly woman who was distraught over the sudden death of her daughter. The woman had threatened to commit suicide. Marc Van Hoey, the doctor who ended her life, proudly admits that he has euthanized 140 patients. [*Daily Mail*, 12/1/18]

- **The Netherlands:** Like Belgium, the Netherlands is prosecuting its first death-inducing doctor since its euthanasia law took effect in 2002. The case involves a nursing home doctor (unnamed) who decided to euthanize a 74-year-old woman

HI’s new law turns medical care into a deadly practice, *cont. from p. 1*

implement and oversee the prescribed-suicide practice, it gives the DOH no legal authority over the practice. The OCOCA is a “strange piece of legislation,” said Lorrin Kim, chief of the DOH Office of Planning, Policy, and Program Development. “[I]t puts the department in charge of implementing the law, but the majority of the process occurs in the private sector and the DOH was not given any legal authority in the matter,” he explained. “The main idea is that this department believes this is a private matter between a patient and a doctor, like all medical care, and *we do not want to insert ourselves in any kind of regulatory manner.*” [*West Hawaii Today*, 10/22/18; emphasis added] With this lack of oversight and transparency, patients are at risk.

The DOH predicts that 40 to 70 patients will request an assisted-suicide death this year, but those patients may face initial problems. Currently, the drugs that are usually used to cause death are unavailable at local pharmacies, there is a statewide shortage of psychiatric professionals to conduct the mandatory mental competency exams on death-requesting patients, and many doctors are outright opposed to prescribed suicide or reluctant to engage in the practice. [*Civic Beat*, 1/2/19] ■

with dementia. In a will, the woman had said she wanted euthanasia but only when she thought the time was right. When the doctor tried to initiate the process, the patient became agitated, so the doctor secretly slipped a sedative into the patient’s cup of coffee. When the woman appeared to be asleep, the doctor tried to inject her with the fatal drug, but the patient began to struggle and tried to get up. The doctor then had the woman’s family members hold her down while the fatal injection was given. The woman died shortly thereafter. The prosecutor said the doctor’s actions were not in accord with legal standards. [*The Guardian*, 11/9/18]

- **Canada:** Doctors at Toronto’s Hospital for Sick Children, Canada’s largest pediatric hospital, have proposed a policy “with an eye to the future when MAID [medical assistance in dying, meaning euthanasia] may well become accessible to capable minors....” The doctors said the hospital developed the policy for managing MAID in their pediatric setting in the likelihood that the euthanasia law will eventually include minors.

In one of the most alarming sections of the policy, the doctors indicate that, if a minor does not want his or her parents to know about the planned MAID death, the child’s wish should be honored.

“Would we really allow a capable patient receiving care in our pediatric hospital to receive MAID *without the knowledge or consent of their parents?* In other circumstances in which capable young people make medical decisions that result in the end of life, the answer is ‘yes,’ although, again, clinicians would strongly encourage the patient to discuss this decision with their family. [DeMichelis et al., “Medical Assistance in Dying at a pediatric hospital,” *Journal of Medical Ethics*, 9/21/18; emphasis added] ■

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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