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Patients Rights Council

Update

Along with state assisted-suicide bills, activists push remote “tele-death” access

This year, doctor-prescribed suicide advocates have been extremely busy introducing bills to legalize assisted suicide in 17 states. As of April 6, nine of those states—Arizona, Florida, Georgia, Indiana, Iowa, Kentucky, New Hampshire, Utah, and Wisconsin—have already defeated their measures. Eight states—Connecticut, Delaware, Maryland, Massachusetts, Minnesota, New York, Pennsylvania, and Rhode Island—have bills that are still technically active. In addition, Virginia has a bill that was introduced in 2020 but is being held over for consideration in 2021.

Two states—Hawaii and Washington State—had bills to expand their existing laws permitting assisted suicide so more people would be aware of the legal, death-inducing practice and have access

to it. Hawaii defeated all four of its expansion bills, but Washington State passed both of its bills. They are currently awaiting the governor’s signature. (See Table on the bottom of p. 2.)

The coronavirus pandemic, however, has dealt a blow to lobbying efforts to pass the remaining active bills. Many state legislatures had to close up shop and adjourn their 2020 sessions. Even if some legislatures reconvene later this year, assisted-suicide measures may take a back seat to bills dealing with issues considered to be more of a priority. Most likely, this is not what assisted-suicide activists bargained for in 2020.

Activists promote telehealth access

Compassion & Choices (C&C), the former Hemlock Society, quickly adjust-

ed the spin and direction of its assisted-suicide efforts by using the pandemic lockdown to advance its goals. On March 20, President and CEO Kim Callinan sent out an email message pushing telehealth conferencing so patients and healthcare providers can have “office visits” online without face-to-face meetings. She wrote that the pandemic provides the opportunity “to make sure health systems and doctors are using telehealth... for patients to access end-of-life care options.” “These efforts,” she added, “should improve access to medical aid in dying [assisted suicide] in the short and *long term*.” [Kim Callinan, Email to supporters, 3/20/20; emphasis added]

Five days later, she wrote a letter to
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In a recent article, published in the journal *Clinical Ethics*, Dr. David Shaw, a bioethicist at the Universities of Basel and Maastricht, and Professor Alec Morton, a business management professor at the University of Strathclyde, proposed the unthinkable. They contend that there are “three economic arguments for permitting assisted dying” (which, they say, includes both euthanasia and assisted suicide).

The first argument uses “quality-adjusted-life-years” (QALYs), a discriminatory formula sometimes used to determine health care policy by numerically valuing the lives of healthy, able-bodied patients more than those with illnesses or disabilities. The researchers argue that “permitting assisted dying allows consenting patients to avoid negative quality-adjusted-life-years, enabling avoidance of suffering.”

The second argument holds that the resources used by patients who are denied assisted dying would be better used “to provide additional QALYs for patients elsewhere in the healthcare system who wish to continue living and to improve their quality of life.”

The researchers’ third proposal has already been adopted in the Netherlands, Belgium, and in some Canadian circles. The donation of organs by those deemed eligible for legal assisted dying, they argue, “may be an additional potential source of QALYs in this context.”

“Taken together,” the researchers conclude, “the cumulative avoidance of negative QALYs and gain in positive QALYs suggest that permitting assisted dying would substantially benefit both the small population that seeks assisted suicide or euthanasia, and the larger population.” “As such,” they added, “denying assisted

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Oregon releases 2019 statistics on the state’s reported assisted-suicide cases

According to official Oregon data released on March 6, 2020, the number of reported doctor-prescribed suicide deaths in 2019 was a record high 188—bringing the total body count since the assisted-suicide law, effective in 1997, to 1,657 induced deaths.

Oregon doctors wrote 290 lethal drug prescriptions in 2019, also a record high. Of the 112 lethally-prescribing doctors, one wrote 33 prescriptions, while 80% of the remaining doctors wrote one or two. The Oregon Health Authority (OHA), which oversees the assisted-suicide law, referred one doctor to the Oregon Medical Board in 2019 for failure to comply with the law’s requirements. The report does not say what the law violation was, nor does it reveal if the offending doctor was sanctioned in any way. Astonishingly, only *one patient* out of the 290 who were approved for death by doctors was referred for a psychiatric evaluation prior to receiving the fatal drugs. [OHA, *Oregon Death with Dignity Act - 2019 Data Summary*, 3/4/20, p. 7]

As has been the case with previous assisted-suicide reports, pain or fear of future pain was ranked very low on the list of why patients requested a prescribed death. In fact, it is number 6 after these concerns: unable to engage in enjoyable activities, loss of autonomy, loss of dignity, being a burden on family and caregivers, and losing control of bodily functions. [Report, p. 12] (See Table.)

While the majority of prescribed-suicide patients had cancer or neurological diseases as their underlying illnesses, the report also reveals that other illnesses, including diabetes, arthritis, complications from a fall, musculoskeletal system disorders, sclerosis, and stenosis, also qualified patients for an induced death—even if effective treatment was available. [Report, p. 11 & Footnote 3 on p.13]

Reported Oregon Assisted-Suicide Deaths			
Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates.			
Figures are those reported by the state in the 2019 report.			
Categories	2019	2018	TOTAL (since 1997)
Reported assisted-suicide deaths	188	178	1,657
Unreported assisted-suicide deaths	Unknown	Unknown	Unknown
Reported lethal prescriptions written	290	261	2,518
Doctors who wrote lethal prescriptions in a given year	112	103	Not Reported
Cases where prescribing doctor was present when lethal drugs were ingested:			
Other care provider present:	36	33	257
No provider present:	25	52	372
Unknown:	14	18	130
Unknown:	60	72	770
Cases where prescribing doctor was present at the time of death:			
Other care provider present:	34	28	235
No provider present:	28	39	382
Unknown:	80	91	881
Unknown:	1	1	23
Patients referred for psychiatric evaluation	1	3	66
Patients’ reasons for wanting assisted suicide:			
Less able to engage in enjoyable activities	170 (90%)	162 (91%)	1,480 (89%)
Loss of autonomy	163 (87%)	163 (92%)	1,494 (90%)
Loss of dignity	136 (72%)	118 (66%)	1,131 (74%)
Being a burden on family & caregivers	111 (59%)	99 (56%)	773 (47%)
Losing control of bodily functions	74 (39%)	69 (39%)	728 (44%)
Inadequate pain control or concern about it	62 (33%)	46 (26%)	440 (27%)
Financial implications of treatment	14 (7%)	9 (5%)	71 (4%)
Complications after lethal drugs were ingested:			
Difficulty ingesting/regurgitated	2	3	30
Patient regained consciousness	0	1	8
Seizures	0	0	2
Other	4	4	15
Unknown	127	113	903
Reported incidents of physician non-compliance with the assisted-suicide law	1	2	25
Penalties imposed for non-compliance with the assisted-suicide law	Not Reported	Not Reported	Not Reported

Source: *Oregon Death with Dignity Act – 2019 Data Summary*, March 6, 2020. All 22 Oregon annual reports are available online at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

Status of 2020 State Bills to Legalize or Expand Assisted Suicide								
State	Bill	Status	State	Bill	Status	State	Bill	Status
AZ	HB 2582 ¹ SB 1384 ¹	Defeated Defeated	IN	HB 1020 ¹	Defeated	NY	A30 ³ A 2694 ¹ S 3947 ¹	Active Active Active
CT	HB 5420 ¹	Active	IA	HF 2302 ¹ SF 175 ¹	Defeated Defeated	PA	HB 2033 ¹	Active
DE	HB 140 ¹	Active	KY	HB 224 ¹	Defeated	RI	H 7369 ¹	Active
FL	SB 1800 ¹	Defeated	MD	HB 643 ¹ SB 701 ¹	Active Active	UT	HB 93 ¹	Defeated
GA	SB 291 ¹	Defeated	MA	H 1926 ¹ S 1208 ¹	Active Active	VA	HB 1649 ¹	Cont. to 2021
HI	SB 542 ² HB 2451 ² SB 2582 ² SB 3047 ²	Defeated Defeated Defeated Defeated	MN	HF 2152 ¹ SF 2286 ¹ SF 2487 ¹	Active Active Active	WA	HB 2326 ² HB 2419 ²	Passed Passed
			NH	HB 1659 ¹	Defeated	WI	AB 522 ¹ SB499 ¹	Defeated Defeated

¹ Bill to legalize assisted suicide in the state.
² Bill to expand the implementation of the state’s existing assisted-suicide law.
³ Bill to establish a committee to study the assisted-suicide issue for possible future legalization.

State assisted-suicide bills & remote “tele-death” access, continued from p. 1

the Congressional leadership, strongly recommending that telehealth provisions for terminally ill and Medicare patients be specifically added to federal coronavirus legislation. [Kim Callinan, Letter, 3/25/20]

Subsequently, C&C announced on its website, “Compassion & Choices praised congressional leaders for including five provisions” in the “Coronavirus Aid, Relief, & Economic Security Act...” that C&C had recommended. [C&C website, 3/26/20]

Meanwhile, the newly formed American Clinicians Academy on Medical Aid in Dying (ACAMAID) issued a policy statement calling for the use of telemedicine by doctors to evaluate the assisted-suicide eligibility of death-requesting patients, conduct physical exams, and even be remotely present when the patient takes the lethal drugs. The six committee members who wrote the policy are all assisted-suicide proponents. One is Dr. Lonny Schavelson, who runs a clinic that provides only prescribed death. [ACAMAID, Telemedicine Policy Statement, 3/25/20]

Getting telehealth established as an essential mode of medical delivery certainly greases the skids for more access to assisted death without the doctor ever seeing the patient in person.



Federal Constitutional Court

Death on Demand Comes to Germany

By Wesley J. Smith

The 1973 dystopian film *Soylent Green* featured several shocking moments, including overpopulation riots and men calling women “the furniture” required for sex. But the most disturbing scene showed Edward G. Robinson entering a euthanasia clinic, choosing to be put down rather than live with his existential anguish. What was once fiction is becoming reality. Assisted suicide, unthinkable then, is popular now. Since the movie was released, many have come to view human existence as a relative, rather than absolute, good. The sanctity of life ethic has been replaced by the drive to eliminate suffering, even if this requires eliminating the sufferer. And the raw power of this logic has led directly to suicide clinics and a right to death on demand—since no one can judge what another person considers to be unbearable torment.

Assisted suicide activists insist that euthanasia is only for the seriously ill and offer vacuous promises of strict guidelines to protect the vulnerable. Such bromides have never made sense to me. If there is indeed a “right to die,” if the most important good is “choice” rather than “life,” how can the right to commit suicide remain limited to the seriously ill? After all, many people suffer more intensely and for a longer time than the sick. Once one accepts the moral propriety of euthanasia, the logic eventually leads to death on demand for anyone who desires to die.

Still, even I never expected full-bore death on demand to arrive in the West for another decade. I was too optimistic. A recent ruling from the Federal Constitutional Court, Germany’s highest court, has cast right-to-die incrementalism aside and conjured a fundamental right both to commit suicide and to receive assistance in doing it. Moreover, the decision has explicitly rejected limiting the right to people diagnosed with illnesses or disabilities. As a matter of protecting “the right of personality,” the court decreed that “self-determined death” is a virtually unlimited fundamental liberty that the government must guarantee to protect “autonomy.” In other words, the German people now have the right to kill themselves at any time and for any reason. From the decision (published English version, my emphasis):

The right to a self-determined death is not limited to situations defined by external causes like serious or incurable illnesses, nor does it only apply in certain stages of life or illness. Rather, this right is guaranteed in all stages of a person’s existence...The individual’s decision to end their own life, based on how they personally define quality of life and a meaningful existence, eludes any evaluation on the basis of general values, religious dogmas, societal norms for dealing with life and death, or consideration of objective rationality. It is thus not incumbent upon the individual to further explain or justify their decision; rather their decision must, in principle, be respected by state and society as an act of self-determination.

The court wasn’t done. The right to suicide also includes a right to assist suicide:

The right to take one’s own life also encompasses the freedom to seek and, if offered, utilize assistance provided by third parties for this purpose....Therefore, the constitutional guarantee of the right to suicide corresponds to equally far-reaching constitutional protection extended to the acts carried out by persons rendering suicide assistance.

The court also opined that Germany’s drug laws might have to be changed to facilitate the absolute right to die that “the state must guarantee”:

Sufficient space must remain in practice for the individual to exercise the right to depart this life and, based on their free will and with the support of third parties, to carry out this decision on their own terms. This not only requires legislative coherence in the design of the legal framework applicable to the medical profession and pharmacists but potentially also requires adjustments of the law on controlled substances.

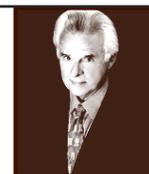
This is stunning and appalling: In Germany, autonomous people now have the absolute right to commit suicide and receive assistance in doing so for any reason or no identifiable reason at all. The court’s ruling is so encompassing that it seems to apply even to children capable of making autonomous decisions, since being underage is a “stage of existence.” While the court stated that minor restrictions such as waiting periods might pass legal muster—the government may also prohibit “particularly dangerous forms of suicide assistance” (whatever that means)—the German constitution now requires, literally, death on demand.

That will not be the end of it, either. One radical court ruling leads to another. The right to commit suicide could soon become a right to be killed outright. After all, everyone isn’t physically or emotionally capable of committing suicide, and homicide can achieve death more swiftly and with less discomfort than a do-it-yourself demise. Since Germany’s absolute right to assist in suicide is open-ended and not limited to doctors, why not permit friends to kill friends?

The ruling also opens the gates to social anarchy. How can the state now restrict the taking and selling of addicting drugs? Drugs may be harmful, but if an autonomous person chooses to spend their days high, how can the state gainsay that decision or inhibit the commercial providers who supply the fixes? How can the state restrict any surgical or chemical

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Researchers' utilitarian view of euthanasia is beyond chilling, cont. from p. 1

dying is a lose-lose situation for all patients." For example, they give the scenario of a cancer patient in great pain with a 2-year life expectancy. That patient will continue to need pain medication and clinical support for two more years if assisted dying is illegal. "For each such patient," they argue, "legalizing assisted dying would avoid this waste of resources." [Shaw & Morton, "Counting the cost of denying assisted death," *Clinical Ethics*, 3/10/20]

As frightening as the researchers' rationale for legalized assisted dying is, it isn't the first time that health care economics has been used to promote assisted suicide. In 1998, Derek Humphry—co-founder of the Hemlock Society (now Compassion & Choices) and all-around euthanasia guru at that time—co-authored the book *Freedom to Die*. In it, he wrote, "[I]n the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of accepted practice." [Derek Humphry & Mary Clement, *Freedom to Die*, 1998, p.313] ■

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sex changes? And on what basis can the state prohibit people who identify as "transabled" (people who have body identity integrity disorder) from amputating their healthy limbs or severing their healthy spinal cords? If suicide is no longer a harm the state has a duty to prevent, how can the state thwart a person's desire to destroy his bodily functions? Indeed, how can the state restrain any personal behavior or vice, so long as the desired autonomous act does not directly harm an unwilling other?

I am reminded of Canadian journalist Andrew Coyne's prophetic words more than twenty years ago. Reacting to his country's strong public support for a father who murdered his disabled daughter as a supposed act of compassion, he wrote: "A society that believes in nothing can offer no argument even against death. A culture that has lost its faith in life cannot comprehend why it should be endured." If we don't change our current cultural trajectory, we will become "Germany" too. ■

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.

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CDC: Suicide the leading cause of death among Oregon's youth in 2018

According to the Centers for Disease Control and Prevention (CDC), 2018 data indicate that suicide is the leading cause of death among young people in Oregon ages 10 to 24. In 2017, suicide was the second leading cause of death for that age group.

"Suicide continues to be a concerning problem in Oregon across all age groups, including youth, as this new data confirms," said Dana Hargunani, chief medical officer at the Oregon Health Authority. [oregon.gov/oha, Press Release, 3/4/20]

Since Oregon's assisted suicide law became effective in 1997, the state's suicide rate rose more than 40% over the national average. Three years ago, a study published in the *Southern Medical Journal* found that, between 1990 and 2013, "legalizing PAS [physician-assisted suicide] was associated with a 6.3% increase in total suicides." [*Southern Medical Journal*, 10/15]

Suicide contagion (a.k.a. Werther Effect) has been documented for years. It often happens when depressed, vulnerable youth read articles or see TV shows or movies glamorizing suicide. Until recently, the media followed guidelines to avoid hyping suicide cases, but the media now tends to glorify assisted-suicide cases—like that of Brittany Maynard, 29, who traveled to Oregon for an assisted death. Reportedly, one newspaper wrote that she "died...as she intended—peacefully in her bedroom, in the arms of her loved one." The article also quoted Maynard as saying, "My journey is easier because of this choice." [Mercator.com, 10/1/18] Presenting suicide as an easier journey and an accepted solution for suffering when young people are so emotionally vulnerable is a recipe for tragedy. ■

Things to think about

The Patients Rights Council deals a lot with end-of-life issues, and we encourage everyone to give thought to the decisions that matter – what sort of medical care you want, who will make your decisions for you, etc. We hope you have thought about these things, and we would like to also suggest that you think about making a planned gift.

Our work is truly a partnership. The Patients Rights Council operates completely on donations. Without YOUR support, our work protecting the vulnerable doesn't get done. Many tax-advantaged financial tools can be used to support the PRC and our fight against euthanasia and doctor-prescribed suicide. For instance, you can:

- make a tax-free gift from your IRA.
- gift appreciated securities to the PRC, which could cost you less than the tax deduction you would receive.
- make the PRC a beneficiary of your will, revocable trust, or retirement plan—costing you nothing during your lifetime.
- gift assets that you no longer need or want—perhaps a vacation home, land, or a life insurance policy.

For more information about these and other planned-giving vehicles, please contact your tax advisor and attorney. If you then decide to proceed and would like to discuss the possibility of a planned gift with us, please contact:

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