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Update

Telehealth ushers in virtual doctor-assisted suicide practices

Since the 1960s, some have predicted that video visits with doctors would eventually become a common way that patients receive care. However, it took the Covid-19 pandemic to bring that prediction to reality.

Referred to by many as telehealth, remote access to medical care went mainstream in March 2020 when the Department of Health and Human Services declared that, because of the pandemic, Medicare would pay doctors and hospitals for a broad range of telehealth services. Those services would include care by physicians but also by nurse practitioners, clinical psychologists, social workers, and other health care providers.

It allows providers to use technology to diagnose and to provide care that, previously, had been only available through in-person visits.

It has been, and still can be, a welcome method for individuals. Rather

than driving long distances to medical appointments, sitting in a waiting room with other sick patients or even having to access an emergency room, diagnosis, treatment, and care can now be obtained from the comfort of one's own home.

But it also brings up the likelihood that assisted-suicide advocates will use it to further expand access to prescribed suicide.

Activists promote telehealth

As previously reported in the *Update*, Compassion & Choices (C&C), the former Hemlock Society, quickly adjusted the spin and direction of its assisted-suicide efforts in 2020 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 meet-

ings. 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]

In addition, the newly formed American Clinicians Academy on Medical Aid in Dying (ACAMAID) issued a policy statement calling for the use of telehealth 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

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UK court finds death by dehydration in man's "best interests"

A British Court of Protection judge has ruled that a 34-year-old man with a serious bowel condition that requires a stoma should be kept in a drug-induced coma while all nutrition and hydration is withheld causing the man's death.

The patient, who is identified in court documents as "MSP," is not terminally ill but has had gastrointestinal problems for ten years. After surgery in October 2019, a stoma was attached to his small intestine to allow feces to be collected into an external, disposable bag.

MSP found life with a stoma extremely distressing. He hid his condition from everyone except his mother, father, step-sister, and hospital staff to whom he made it clear that he simply could not live his life with a stoma. His

mother revealed that he told her, "How can I get a job? How can I get a woman?" [*The Telegraph*, 6/4/20] Even before his surgery, he made his rejection of a stoma explicitly clear in a carefully worded, but unwitnessed, advance directive.

On May 14, 2020, MSP requested that the stoma be reversed, but a few days after his release from the hospital he was readmitted with severe abdominal pain and sepsis. He was told that his condition was life-threatening and a stoma would have to be inserted immediately. While one of his doctors was very optimistic that the stoma would be reversible, the surgeon determined that was not the case. MSP's stoma would be permanent.

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Oklahoma passes law to prohibit discriminatory health care rationing

Earlier this year, as Covid-19 cases began to rise to a pandemic level, articles calling for health care rationing began to appear in bioethical journals as well as mainstream news publications. The general consensus was that rationing is inevitable given the probable shortage of ICU beds, ventilators, and other treatments. Bioethicists, such as Peter Singer (Princeton University), Ezekiel Emanuel (University of Pennsylvania School of Medicine), Julian Savulescu (Oxford University, UK), and others, offered a variety of utilitarian rationing protocols and recommendations, most of which were cold, calculating, and centered on a patient's quality of life and projected life expectancy rather than the patient as person. Often the protocols used "quality-adjusted-life-years" (QALYs) or "disability-adjusted-life-years" (DALYs), mathematical formulas that discriminate against older or disabled patients.

On May 22, 2020, in response to this utilitarian rationing mindset, Oklahoma Governor Kevin Stitt signed into law the "Nondiscrimination in Health Care Coverage Act" (HB 2587). The new law declares:

1. Physical and mental disabilities, age or chronic illness should in no way diminish a person's right to life, human dignity and equal access to medical care;
2. Historically, persons with disabilities, advanced age or chronic illness have faced discrimination in the health care system, including the denial of access to life-sustaining care;
3. Such discrimination is inconsistent with our society's commitment to human dignity and the full inclusion of persons with disabilities throughout society.

The law prohibits any agency from "developing or employing a dollars-per-quality adjusted life year, or similar measure that dis-

counts the value of a life because of an individual's disability, including age or chronic illness, as a threshold to establish what type of health care is cost-effective or recommended." The statute further states, "An agency shall be prohibited from utilizing such adjusted life year, or similar measure, as a threshold to determine coverage, reimbursement, incentive programs or utilization management decisions, whether it comes from within the agency or from any third party." [Enrolled HB 2587, 5/15/20] ■

Dutch Supreme Court approves euthanasia for advanced dementia

On April 21, 2020, the Dutch Supreme Court ruled that doctors can terminate the lives of advanced dementia patients who had written an advance directive requesting euthanasia when they were competent. If a doctor complied with the established euthanasia requirements, including determining that the patient was suffering unbearably without any possibility of improvement, then the court ruled, the doctor would not face prosecution.

The court's ruling also addressed a lower court decision that an unnamed nursing home doctor had acted with "due care," not criminally, when she euthanized a 74-year-old, female patient with advanced dementia who had resisted the lethal injection. The Supreme Court upheld the lower court's ruling and totally exonerated the doctor of any criminal charges and dismissed the disciplinary sanction imposed by the Central Disciplinary Committee for the Healthcare Sector. [rechtspraak.nl, 4/21/20 & 4/24/20]

While the high court found nothing legally or professionally wrong with the doctor's actions, the 2016 case caused outrage (Continued on page 3)

UK court finds death by dehydration in man's "best interests," continued from p. 1

Court Ruling

In his June 1, 2020, ruling on whether it was in MSP's best interests to be kept in a drug-induced coma while being starved and dehydrated to death, Mr. Justice Hayden wrote:

Many people require a stoma to be fitted and I have no doubt that the vast majority make the necessary accommodations to ensure that it does not unnecessarily inhibit their enjoyment of life or become an impediment to their personal and sexual relationships. However, this was simply not the case with MSP. There is powerful evidence that as a young man in his thirties who, as his sister has said, "knew he was good looking," MSP could never accept life with a stoma. No amount of

support, love or understanding could change MSP's mind. The stoma, it seems to me, ran entirely contrary to MSP's perception of who he is. Its existence was corrosive to his self-esteem. [*Barnsley Hospital NHS Foundation Trust v MSP* [2020] EWCOP 26 (01 June 2020), at 7]

The judge described MSP as being "6ft 3, handsome and meticulous in his appearance," and wrote that MSP's step-sister said he was "prone to more than a little male vanity." The judge also explained that, while MSP was a university student, he had gone through "a period of self-harming" and was "ultimately diagnosed as bi-polar." He has "remained on anti-depressant medication." [*Barnsley v. MSP*, at 15-16]

"There is no doubt, in my mind," the justice wrote, "that [MSP] had come to a clear and entirely settled decision that he was not prepared to contemplate life with a stoma or indeed any significant life changing disability." Furthermore, the judge added, "It is not for me, or indeed anybody else, to critique those views or beliefs, but merely to identify them. They are a facet of MSP's broader personality, the expression of which is integral to his own personal autonomy." [*Barnsley v. MSP*, at 17]

Justice Hayden concluded that the hospital's terminal sedation plan, and with it death by dehydration, was indeed in MSP's best interests.

A little more than a week after the judge issued his decision. MSP died—precisely according to plan. ■



Doctors Now Assist Suicides via Zoom

By Wesley J. Smith

We are always told that “strict guidelines will protect against abuse.”

It’s always been baloney. As sold, assisted suicide was supposed to only be engaged between doctors of long-standing and patients well known to the prescriber.

That was violated in the very first legal assisted suicide in Oregon. The doctor in that case—referred by an assisted-suicide advocacy organization—only met the patient two weeks before she received her poison pills.

Very quickly, death doctors began to assist the suicides of patients they have never treated. In California, a part-time ER doctor—who spent most recent years as a photojournalist—quickly set up a suicide practice after assisted suicide was legalized. There have also been many cases of oncologists assisting the suicides of ALS patients, and other similar out-of-specialty death facilitations.

Now, death doctors are assisting suicides of patients *they may never have met* via Zoom and other telehealth—talk about an oxymoron in this circumstance!—means of communication. From, “Dying Virtually,” published in *The Conversation* (6/2/20):

[Dr. Carol] Parrot says she sees 90% of her patients online, visually examining a patient’s symptoms, mobility, affect and breathing.

“I can get a great deal of information for how close a patient is to death from a Skype visit,” Parrot explained. “I don’t feel badly at all that I don’t have a stethoscope on their chest.”

After the initial visit, whether in person or online, aid-in-dying physicians carefully collate their prognosis with the patient’s prior medical records and lab tests. Some also consult the patient’s primary physician.

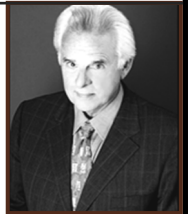
Did you catch the last bit there? Some “consult” the patient’s primary

physician. That also means some don’t. And that means *some people are assisted in suicide by doctors they have never met in the flesh and who have never examined them.*

This is a breach of all the assuring promises that were made when assisted suicide was legalized. But those promises were never meant to be kept. Only to give false assurance.

It is amazing to me how legalizing assisted suicide transforms peoples’ thinking. Making people dead quickly becomes the overriding imperative and suicide prevention for the seriously ill goes into total eclipse. The easier it is to get people dead, the better. ■

Wesley J. Smith is a consultant to the Patients Rights Council and a senior fellow at the Discovery Institute’s Center on Human Exceptionalism. His article, published in the National Review (6/2/20), is reprinted with the author’s permission.



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runs a clinic that provides only prescribed death. [ACAMAID, Telemedicine Policy Statement, 3/25/20]

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

Most assisted-suicide laws fail to require in-person terminal diagnosis

As of May 2020, eight of the nine jurisdictions where assisted suicide has been transformed from a crime into a “medical treatment” do **not** require that either the attending physician or the consulting physician diagnose the patient in person. (Those jurisdictions are Oregon, Washington, Colorado, California, Hawaii,

Maine, New Jersey, and the District of Columbia.)

Only Vermont requires that the diagnosis of a terminal condition be made in person by an attending physician and that it be confirmed, in person, by a consulting physician. ■

Editor’s Note: For more information on telehealth (also called telemedicine), please see the Patients Rights Council’s website: patientsrightscouncil.org.

The PRC website also allows you to access the previous issue of the Update (vol. 34, no. 2) that contains the article, “Along with state assisted-suicide laws, activists push remote ‘tele-death’ access.”

Dutch Supreme Court, continued from page 2

nationally and internationally as details were made public at the time. The patient had an advance directive that stipulated that she wanted euthanasia when *SHE decided the time was right* if she was in a nursing home for dementia. Instead, the doctor decided, with the family’s approval. The doctor slipped a sedative into the patient’s coffee and waited for the patient to fall asleep. When the patient awakened to find the doctor trying to give her a lethal injection, she resisted and tried to stand. The family then held the patient down, and the doctor gave the injection.

In a recent TV interview, the doctor revealed her name. Dr. Marinou Arends said she asked the patient three times if she wanted euthanasia and the patient said no, but she “didn’t understand.” Arends said she would do it all again. [Dutch News, 6/15/20] ■



News briefs from home & abroad . . .

- **Maine:** On March 18, 2020, Maine's Department of Health and Human Services (MDHHS) released its first statistical report on assisted-suicide deaths that reportedly occurred between September 19, 2019 (the day after the Maine Death with Dignity Act [MDWDA] took effect) and December 31, 2019. In terms of data provided, Maine's report is almost laughable. While the total report is 31 pages long, the statistics regarding the actual assisted-death practice is less than a quarter of one page long. The rest of the report consists of background information and three appendices containing the MDWDA statute, the MDWDA reporting rules, and all the state-mandated death request and doctor and pharmacist reporting forms. Here are the "General Statistics" as they appear in the report:

- There was one event [prescribed suicide] for this reporting period.
- The underlying diagnosis was prostate cancer.
- The individual was more than 65 years old, a longtime Maine resident, educated with a college degree.
- The mechanism for death was patient choice/self-administered medication. [MDHHS: *Patient-Directed Care at the End of Life Annual Report*, 3/18/20, p. 4]

Granted the report only covered about two months, so there wouldn't be a lot of deaths to report. But what about some of the important information other states with assisted-suicide laws provide—like how many prescriptions for lethal drugs were written in addition to the one patient who died, how many doctors wrote those prescriptions, how many patients were referred for a psychological exam, or what were the reasons the one patient gave for wanting assisted suicide? If Maine continues to compile such limited data in future annual reports, it certainly isn't adequately informing the public on how the law is working.

Canada: The small, 10-bed Irene Thomas Hospice in Ladner, British Columbia (BC), had a stellar reputation for excellent palliative care in line with the true hospice philosophy of never hastening death. Then, in 2016, Canada legalized euthanasia and pressure was placed upon the Delta Hospice Society, which operated the small hospice, to provide euthanasia, called medical assistance in dying (MAID), as part of its palliative care services. In 2019, Delta's newly elected board and its new president, Angelina Ireland, stood firm against the hospice offering MAID but would help patients transfer to the Delta Hospital next door or to their homes for MAID. However, that was not acceptable to either the Fraser Health Authority or BC Minister of Health Adrian Dix. Fraser Health announced it would be pulling its \$1.5 million in funding from the hospice on 2/25/21.

Since faith-based hospices are not compelled to offer MAID, the Delta board proposed amending its constitution to establish the hospice as a Christian facility since the authentic hospice philosophy is essentially Christian. A special meeting to vote on this change was scheduled for 6/15/20. But opponents to the move petitioned the BC Supreme Court to stop the meeting. They also claimed that the Delta board added like-minded people as Society members but rejected those who favored MAID. Justice Shelley Fitzpatrick not only stopped the meeting from happening, but she also ordered the Delta Hospice Society board to accept all those who were denied membership and to give the lawsuit's petitioners a list of those people. [Canadian Press, 6/15/20; CBC News, 6/9/20; *Delta-Optimist*, 6/4/20]

Ireland, the hospice board president, maintains that they are a private society concerned about protecting the palliative care philosophy and that the intent of Delta Hospice was never to be a euthanasia facility. [*Delta-Optimist*, 6/13/20] ■

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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