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Patients Rights Council

Update

Vermont's Senate rejects assisted-suicide bill not once, but twice

If doctor-prescribed suicide advocates are anything, they are persistent—even in the face of defeat. That is especially true in Vermont where, prior to 2011, assisted-suicide activists introduced no less than ten bills since 1995, all of which failed.

But the 2011-2012 legislature—with its Democrat majority—was supposed to be more open to passing a prescribed-death bill. At least that's what polling and other research bankrolled by the national advocacy groups Compassion & Choices and the Death with Dignity National Center suggested.

With high expectations, two identical bills—H. 274 in the House and S. 103 in the Senate—were introduced in 2011. In spite of the strong support and lob-

bying efforts of Vermont's Governor Peter Shumlin, a Democrat, as well as national and local prescribed-suicide groups, neither bill received a hearing, and both ended up stalled in committees. They were, however, held over for the 2012 legislative session.

By February 2012, prospects for the bills had not improved. All eyes shifted to the Senate, since passage there was more doubtful than the House. If it wasn't going to pass in the Senate, it would be a waste of time for the House to conduct hearings and debates.

S. 103, titled "Patient Choice and Control at End of Life," had been assigned to the Senate Committee on the Judiciary, chaired by Senator Dick Sears, a Democrat who opposed the

measure. Since two other members of the five-member Judiciary Committee also opposed the bill, Sears said there would be no hearing on the measure, leaving it to languish and die. Then, under pressure from the governor, Sears scheduled a hearing for March 14. [VT Digger, 3/16/12]

Dick Waters, who heads the local assisted-suicide advocacy group Patient Choices Vermont (PCV), immediately sent out an email message to supporters stating, "This is the moment we've been waiting for. Please focus all your positive energy on our Senators." [PCV email message, 3/9/12]

As expected, the March 14 hearing—held in the largest meeting room in the

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US Supreme Court grapples with health care reform law

The fate of the Patient Protection & Affordable Care Act (PPACA)—also known as ObamaCare—is squarely in the hands of the US Supreme Court after an historic six hours of hearings over a three-day period in late March.

The key question before the court is whether the law's mandate that forces individuals to purchase health insurance or pay a fine is constitutional. If the high court rules it is not, then the next question is, can the rest of the PPACA survive? Younger, healthier people would need to buy health care insurance they don't use or need to provide

the essential funding needed to implement the law's other provisions. Moreover, the PPACA has no severability clause stating the law will still stand if one of its provisions is invalidated.

Those questions were addressed in January 2011 by Federal Judge Roger Vinson in Florida, who ruled, "Because the individual mandate is unconstitutional and not severable, the entire act must be declared void." [Florida v. HHS, No 3:10-cv-91-RV/EMT (D. Fla., 2011), at 76]

Some legal observers said several of the justices indicated by their tough questions

that the insurance mandate is in jeopardy. CNN's senior legal analyst Jeffrey Toobin told viewers, "I think the individual mandate is gone, based on the questioning." "It sure looks like there are at least five votes to get rid of [it]," he added.

White House spokesman Josh Earnest disagreed, saying that anyone who thinks he can predict how the justices will rule "is not a very good student of the Supreme Court." [CNN, 3/28/12]

But author Betsy McCaughey, who has written a book on the PPACA, observed that Justice Anthony Kennedy—often the

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Massachusetts legislature conducts hearing on “Death with Dignity” initiative

The Massachusetts “Death with Dignity” initiative (Initiative 11-12) has completed another hurdle in the state’s very winding road to the November statewide ballot. After prescribed-suicide backers were able to garner the initial number of voter signatures required, the measure to legalize doctor-assisted suicide was introduced as a bill in the legislature, where Massachusetts law required it to be heard in committee.

The hearing was conducted by the Joint Committee on the Judiciary on March 6. A handful of supporters argued for choice and control at the end of life. Among them was Rep. Louis Kafka, who sponsored a prior prescribed-suicide bill. “Everyone must be allowed to make their own choice with their own belief,” he declared. Another supporter, Rep. Cory Atkins, explained, “We are used to being in charge of our lives so it’s not unusual that we would want to be in charge of also the circumstances of our death.” [WWLP News, 3/7/12]

On the other side, more than 50 people testified against the measure. “The only thing worth killing is this bill,” argued Rep. John Rogers. “We define ourselves not by allowing our citizens to

die with dignity, but by empowering our citizens to live with dignity while they are dying.” Massachusetts Medical Society President Dr. Lynda Young spoke about her group’s recent vote to overwhelmingly oppose doctor-assisted suicide and called for compassionate care for patients.

Massachusetts attorney Patricia Stewart underscored the danger inherent in the initiative. “Facilitating ending human life in secret is a dangerous policy and that’s something that’s detrimental to the public welfare,” she said. Psychological counselor Karen Schneiderman, who was born with Spina bifida, testified on behalf of the disability rights group Second Thoughts. “As long as we devalue people with disabilities and other categories such as the elderly, we have constructed a hierarchy of human values, and we will have to live with that blood on our hands,” she said. [Sentinel & Enterprise, 3/7/12]

Legislators have until May 2 to pass the measure. If they don’t, which is likely, supporters will then have to garner another 11,485 voter signatures by July 3 to qualify the initiative for the state’s November ballot. [The Republican, 3/6/12] ■

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Statehouse—was standing room only. The testimony given was by invitation and represented both sides of the issue. Sears said he called the hearing so committee members could learn about the issue. [WPTC News, 3/14/12]

The committee had until March 16 to vote on the bill, but that vote never took place. Instead Sears and Senate President Pro Tem John Campbell, also a Democrat, announced that the bill would not be voted on because the vice chair of the committee, Senator Alice Nitka, had been hospitalized and was in intensive care. Sears explained that if Nitka had been present, the bill would have been defeated by a vote of 3-2. Without her vote, it would have been tied 2-2, which would have also killed the bill. A vote was pointless, he said, so the bill was tabled. [VT Digger, 3/16/12; Seven Days, 3/16/12]

Governor Shumlin was not pleased. Even though it was unlikely that there were enough votes in the full Senate to pass the measure, Shumlin pressured Sears to have the committee vote and advance the bill to the Senate floor with a recommendation to defeat it. Shumlin said, “I wanted it to get to the floor because I thought I could get the votes once

it got there.” Sears refused. [Bennington Banner, 3/21/12]

At this point most people figured that the assisted-suicide bill was officially dead—or so it seemed, that is, until April 10.

With absolutely no prior notification, no discussion, and no testimony given, the Senate Health and Welfare Committee voted 3-2 to take the tabled assisted-suicide bill from the Judiciary and attach it to a bill that banned minors from using tanning salons. Then the committee voted 3-2 to approve the measure with the new attachment, sending it to the floor for a full Senate vote in two days. [Vermont Press Bureau, 4/10/12]

But, in order for that to happen, the attached prescribed-suicide bill would have to be judged germane to the tanning bill. Senator Hinda Miller, who ramrodded the attachment ploy, argued that it was germane since both bills were related to cancer—one designed to prevent it, the other would be used by those dying from it. Lieutenant Governor Phil Scott, who had the power to rule on the issue, disagreed and declared the bills to be not germane to each other. Senate rules, he said, mandated that amendments cannot expand the subject matter of or relate to a

different topic than the host bill. Scott’s ruling was then challenged, resulting in a heated two-hour debate on the floor.

Those in favor of suspending the Senate’s rule on germane bills needed to get 3/4 majority vote to succeed. They not only didn’t get it, they didn’t even muster a simple majority. The vote (18 -11) effectively killed the assisted-suicide bill—for the second time. [Burlington Free Press, 4/12/12; WPTZ News, 4/12/12; Times Argus, 4/11/12]

That day, the *Burlington Free Press* published an editorial stating why the suicide bill should not have passed:

The legislation to allow assisted suicide and the practice itself—even with all its safeguards—still raises concerns, concerns grave enough to warrant keeping the bill from becoming law in this state....

Much meaningful information about assisted suicide would be withheld from the public in the name of privacy. Yet without sufficient information, there is no true public oversight. In its place, we would be asked to take the word of government officials that all is well... [Burlington Free Press, “Voice of the Free Press,” 4/12/12] ■

Oregon issues assisted-suicide report with record high deaths & unknowns

According to Oregon’s annual report on 2011 assisted-suicide deaths, a record 114 prescriptions for lethal drugs were written by 62 doctors in 2011, resulting in the reported deaths of a record high 71 patients—that’s 22.5 doctor-prescribed deaths per 10,000 total deaths in Oregon. This brings Oregon’s reported assisted-suicide body count to 596 since the Death with Dignity Act (DWDA) was enacted in 1997.

But the 2011 report may be more noteworthy for the high number of “unknowns” reported than for the record-high data compiled by the state.

The Oregon Public Health Division (OPHD), the state agency responsible for overseeing the DWDA and issuing the mandated yearly report, has previously acknowledged that it has no idea how many doctor-assisted suicides were not reported in any given year. Moreover, the OPHD has no authority whatsoever to investigate prescribed-suicide cases.

In the 2011 report, the OPHD admits that 25 patients fell through the cracks of the reporting system, and the state has no clue about their “ingestion status.” Three of the 25 died, but the OPHD doesn’t know if they ingested the lethal drugs or if they died of natural causes. The status of the remaining 22 patients is completely unknown—meaning the OPHD doesn’t know if they are alive or dead, let alone if they took the fatal drugs.

Other notable report “unknowns” include whether anyone was present when 57 patients ingested the lethal drugs, whether 59 patients had experienced complications after taking the drugs, and what the time interval between drug ingestion and death was for 63 patients out of the total 71 who died.

Only one of the suicide-requesting patients was referred for a psychological evaluation by his or her doctor. It was also not a surprise that no prescribing doctor reported themselves for not complying with the DWDA law. [OPHD, 2011 Report on Oregon’s Death with Dignity Act, 3/6/12] ■

Reported Assisted-Suicide Deaths in Oregon 1998-2011

Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates.¹
Figures and percentages are those reported by the state.

Categories	1998 - 2008	2009	2010	2011	TOTAL
No. of reported assisted-suicide deaths	401	59	65	71	596
No. of unreported assisted-suicide deaths	Unknown ¹	Unknown ¹	Unknown ¹	Unknown ¹	Unknown ¹
No. of reported lethal prescriptions written	629	95	96	114	934
No. of reporting doctors who wrote lethal prescriptions in a given year	? ²	55	59	62	? ²
No. of cases where prescribing doctor was present when lethal drugs were ingested	85	3	6	6	100
Other care provider present	180	38	10	3	231
No provider present	57	6	4	5	72
Unknown	9	12	45	57	123
No. of cases where prescribing doctor was present at the time of death	76	1	6	6	89
Other care provider present	186	47	19	2	254
No provider present	61	8	39	63	171
Unknown	8	3	1	0	12
No. of patients referred for psychiatric evaluation	38 [9.6%]	0 [0.0%]	1 [1.5%]	1 [1.4%]	40 [6.7%]
Patients’ reasons for requesting assisted suicide:					
Loss of autonomy	357 [89.9%]	57 [96.6%]	61 [93.8%]	63 [88.7%]	538 [90.9%]
Inability to do enjoyable activities	347 [87.4%]	51 [86.4%]	61 [93.8%]	64 [90.1%]	523 [88.3%]
Loss of dignity	228 [83.8%]	54 [91.5%]	51 [78.5%]	53 [74.6%]	386 [82.7%]
Lost control of bodily functions	233 [58.7%]	31 [52.5%]	30 [46.2%]	24 [33.8%]	318 [53.7%]
Being a burden	152 [38.3%]	15 [25.4%]	17 [26.2%]	30 [42.3%]	214 [36.1%]
Inadequate pain control or concern about it	95 [23.9%]	6 [10.2%]	10 [15.4%]	23 [32.4%]	134 [22.6%]
Financial implications of treatment	11 [2.8%]	1 [1.7%]	1 [1.5%]	2 [2.8%]	15 [2.5%]
Complications after lethal drugs were ingested:					
Regurgitation	19 [4.9%]	1 [1.7%]	1 [1.5%]	1 [1.4%]	22 [3.7%]
Patient awakened	13 [2.5%]	0 [0.0%]	2 ³ [3%]	2 ³ [2.8%]	5 ³ [8.4%]
Unknown	10 [2.5%]	1 [1.7%]	37 [57%]	59 [83%]	107 [18%]
Reported incidents of physician non-compliance with the assisted-suicide law	20	1	1	0	22
Penalties imposed for non-compliance with the assisted-suicide law	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 data provided by prescribing doctors are accurate or complete. The Pharmacy Dispensing Report simply asks for general information (ie., patient & physician names and drugs prescribed) but no data on patient cases. Death certificates, by law, do not even indicate drug overdose as the true cause of death.
2. Since the OPHD reports do not identify the lethally-prescribing doctors, there is no way to determine the total number of doctors who wrote prescriptions beyond a year at a time. The same doctor could have written multiple suicide prescriptions for multiple patients over the 14-year time span that assisted suicide has been legal.
3. The five patients (1 in 2005, 2 in 2010, 2 in 2011) did not die after ingesting the lethal drugs. They regained consciousness and eventually died of their underlying illnesses. Up until 2011, OPHD listed these cases under “Complications.” OPHD now lists them under “Other Outcomes,” and does not include them in the totals for assisted-suicide deaths.

Source:

Oregon Public Health Division, 2011 Report on Oregon’s Death with Dignity Act, released 3/6/12.

All 14 annual reports are available online at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>



First-Hand Report

Hospital Visit: A Death Sentence?

By Nancy De La Zerda

"I'm hungry! Pleeese, get me out of here," my mother pleaded. "They're trying to kill me!"

But Mother was in a hospital, and hospitals don't kill patients, we thought. Still, my siblings and I desperately consulted staff hospitalists, nurses, dieticians and even a "floor manager" regarding Mother's complaints of hunger, despite the fact she was being tube fed. They all assured us she was receiving enough nutrition.

The admitting hospitalist doctor then called in a psychiatric nurse to declare Mother "delirious." Soon, she was subdued with powerful psychotropic drugs, against our repeated objections.

Months after her death, I was finally able to obtain Mother's hospital records. The records supported what we had witnessed and suspected: We had been lied to consistently by hospitalists and staff. Our precious mother was systematically shepherded to a forced, horrifying and undignified death in a hospital, a place we trusted to help her. Perhaps the most unspeakable revelation was that she was, indeed, starved and dehydrated while she pleaded for her life! "Severe protein malnutrition" was noted on her medical record before the end of her first week hospitalized.

Each day, it seemed, she had to be treated for new complications created by what the hospitalist had ordered the day before. It felt like a diabolically orchestrated plan. Once it was in place, there was no escape. The admitting doctor saw to that. He used every power at his disposal to overrule our objections—from manipulating nurses

and staff, to repeatedly overruling Mother's appointed Durable Power of Attorney for Health Care (DPAHC) surrogate decision makers (calling in hospital security, city police and adult protective services to do so), and, finally, even to filing a legal detention to keep Mother in his hospital.

Meanwhile, she grew sicker each day until she was on life support. Even then, he ordered more surgeries and procedures, until he ran up a total of nearly half a million dollars in revenues for his hospital. Hospitalists, I understand, are paid according to how much they make for the hospital, not how many lives they save. Mother had been to the same hospital twice before with her primary care doctor as the admitting doctor. The tragedy this time was our allowing a hospitalist, that is, a doctor contracted by the hospital, to be her admitting doctor.

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She was weak and congested, so we'd taken her to the hospital's ER, where she was treated and released to their Telemetry Unit for what was supposed to be a "23 hour" observation period. That night—February 17, 2011—after a breathing treatment, Mother ate dinner and chatted with my sister and a lady who shared the semi-private room. My sister advised the hospital staff that Mother was highly sensitive to most medications

and asked them to hold off any more treatments for the rest of the night so Mother could sleep. My sister left the hospital at 2:30 a.m. to get some much-needed rest.

I arrived at approximately 9:00 a.m. the next morning to find Mother in full Code Blue status, surrounded by nurses and a hospitalist doctor insisting to my sister they hadn't given Mother "anything." Her blood pressure dropped dangerously low and she was unconscious. We agreed she be taken to the hospital's ICU to be resuscitated.

I'll never forget how the ICU nurse narrowed her eyes and asked, "Are you sure you want her resuscitated?" "Of course," I said. "She's just reacting to some medication, I'm sure." She shrugged and began her work.

Later, I realized she'd attempted to save us from the horror she knew awaited, or "business as usual" in that hospital. I thought about her warning look many times over the next three and a half hellish weeks as Mother was shepherded to a horrifying death.

When I reviewed the records, I quickly scrutinized every detail of Mother's first hours in that Telemetry Unit. What caused a woman—albeit a bit frail, congested and 87 years-old, but one who had gone to a Valentine's dance just days before—to go Code Blue? Had hospitalists administered medications that sent her blood pressure plummeting? Or were they truthful about not giving her "anything" as they insisted?

What an eye opener I had! Within Mother's first 24 hours in the hospital, five different hospitalists ordered medications, blood tests, EKGs and other procedures for her; yet other than the ER doctor, only one of them visited her.

At about 9:00 p.m. on the night she was admitted, the hospital scheduler denied a blood pressure lowering medication ordered by the admitting hospitalist. Records show that by 9:52 p.m. the same night, a different hospitalist ordered a similar medication to be administered the next morning. Despite the fact that Mother's blood pressure was not elevated, she was given an injection of the pressure lowering medication at approximately 8:30 a.m. the next morning. That explains the Code Blue situation I found her in.

We were lied to from the beginning. Records prove medications and procedures ordered by hospitalists indeed made Mother worse. I felt what happened to Mother must be an oft performed practice of milking patients' insurance while bringing about certain death. Unbelievable?

Not so. I researched the Internet directly after Mother's death. There it was. More evidence than I cared to face. But I learned that in our home state of Texas, where strict Tort "reform" laws were passed in 2003, there have only been two cases filed on behalf of anyone labeled "very elderly," i.e., those over age eighty-six. Mother had all the right stats for greedy hospitalists to see dollar signs. She was 87, fully insured and had a "full code" status; that is, she had no "do not resuscitate" (DNR) directives on file.

All along, the admitting hospitalist dehumanized my mother in many ways. He rarely visited her and never spoke to her directly. She recovered from the reaction to blood pressure lowering drugs, but several days on a ventilator with little or no nutrition left her weak. After she'd eaten soft foods for several days, she failed an informal bedside swallow test. My sister—Mother's primary DPAHC surrogate decision maker—was in the room at the time of said test, and strongly objected, claiming the dietician had "shoved the food into Mother's mouth while she was talking."

By now, the hospitalist had found my sister to be a thorn in his side for calling on hospital administrators to make the hospitalist "show himself" and discuss Mother's case with her. He'd

not visited Mother's room for several days. When my sister objected to the swallow test findings, he called hospital security, city police and adult protective services and claimed she'd tried to "manipulate test findings."

He asked that the entire family be banned for 24 hours. A community liaison person for the hospital stepped in

Mother had all the right stats for greedy hospitalists to see dollar signs.

and allowed my youngest sister to stay at Mother's side. The tube feeding began. The hospitalist called in an infection specialist who ordered three antibiotic drips for Mother, ostensibly as a precaution because another patient on the same floor had died of an infection.

Records show Mother never had an infection. Instead, the antibiotic drips she was given led to fluid collecting in her lungs. The admitting hospitalist then ordered all fluids cut off. Within five days, she went into shock and wound up on life support.

But the degradation continued with relentless doctor-ordered surgeries and invasive procedures until Mother appeared corpselike. While my siblings and I debated when to place a DNR order in our mother's medical records, we were told he objected because she was "too well." Meanwhile, he refused to speak to any of us. By then, he would only recognize the sole male offspring as mother's legal surrogate health care decision maker. He telephoned my brother for approval on procedures. Once, when my brother hesitated, he admonished, "Either she gets the CT tomorrow or you make funeral plans! It's up to you!"

The hospitalist ordered the breathing rate on Mother's respirator set higher than normal. I witnessed a most horrific sight: my mother, lying lifeless, her chest heaving, mouth opened wide, panting through a huge tube shoved down her throat.

Finally, even hospital medical technicians refused to conduct some of the procedures the hospitalist ordered. They sent her back from a third surgery to insert a PICC line (a line for injecting medications) because of blood clots. He ordered them to suture the line to the aorta instead. When he ordered a CT scan of her abdomen, the nurse protested because Mother had diarrhea. He ordered they insert a "balloon" in her anus in order to proceed.

I called the ICU in the wee hours of March 12th to demand to speak to the admitting hospitalist. "I want his phone number," I insisted to the nurse on call. "I wouldn't want to see a family pet the way I saw my mother panting tonight. I swear, I think he's trying to induce a heart attack."

She was gone for a while and returned with his number. "You have legitimate concerns," she confided.

Her words echoed in my head two hours later when I got the call from my brother that our beloved "Mamita" was dying. Records show that about an hour after I left a message at his answering service, the hospitalist ordered a lethal dose of morphine.

My siblings and I are left with a hollow feeling, a dread that our having trusted a hospital led directly to our mother's death. I struggle daily to push back memories of Mother pleading with us to take her out of the hospital. I know in my heart that we did all we could and realize we were up against a deadly routine that plays out in many hospitals. I hope that my sharing our experience may help others from getting caught up in similar snares of unscrupulous practices. ■

Nancy De La Zerda, Ph.D., is a native of San Antonio, Texas, and taught at both the university and high school levels for several years. Her mother's death and the family's experience with hospitalists were featured in a lengthy article published in the San Antonio Current on December 7, 2011.



Default death sentence for vulnerable PVS patients

A proposal, published in the journal *Bioethics*, would make the diagnosis—or misdiagnosis—of permanent vegetative state (PVS) a default death sentence.

Since all living beings will die without hydration, bioethicist Catherine Constable, MD, proposes that PVS patients should routinely have artificial nutrition and hydration (ANH) withheld or withdrawn, unless they have clearly stated wishes to the contrary to family members or in an earlier enacted advance directive.

The presumption to provide food and fluids to PVS patients is inconsistent with patient-centered healthcare and patient autonomy, she says. Citing two 2005 polls that indicated most people fear being PVS more than dying, Constable argues that a “worse violation of autonomy” is committed by “treating the patient than if we had not treated him against his wishes.”

Furthermore, the current “default position”—requiring clear justification for the withdrawal of ANH when the patient’s prior wishes are unknown or ambiguous—should be reversed. Instead, she says, “the burden of justification lies with those who would continue artificial nutri-

tion and hydration....” “To put the onus on a family to justify the decision to withdraw ANH,” she conjectures, “is to effectively treat them as would-be executioners who need to be checked.” “In the case of PVS, when in doubt as to a patient’s wishes, it is *better* to discontinue life-sustaining treatment.”

For Constable, “persons in PVS do not have an interest in being kept alive,” and holding out hope of a future recovery “does not serve the best interests of the patient, nor is it an economically fair or feasible position.” [Constable, “Withdrawal of Artificial Nutrition and Hydration for Patients in a Permanent Vegetative State: Changing Tack,” *Bioethics*, 3/12, pp. 157-163]

It would seem that Constable views dehydration as economical—less of a drain on the health care system—since patients will definitely die, and they will do so relatively quickly within 5 to 21 days.

Also, while she mentions the need for precise PVS diagnoses, Constable neglects to mention recent studies in the US and UK that show PVS is misdiagnosed 40% of the time. ■

Some surgeons don’t like advance directives

According to an article in the *American Journal of Nursing*, a study of US surgeons found that only half ask patients if they have an advance directive or discuss the provisions in those documents, such as restrictions on feeding tubes or ventilators that can sustain life after surgery.

A total of 912 vascular surgeons, cardiothoracic surgeons, and neurosurgeons completed the survey. All of them routinely perform high-risk operations.

Sixty-three percent of cardiothoracic surgeons said they would refuse to operate on patients if they had an advance directive that limited any after-surgery procedure the surgeon could perform to keep the patient alive. Half of the vascular surgeons and neurosurgeons also said they might refuse to operate because of an advance directive.

The study suggests that a significant number of surgeons regard an advance directive as a signal that the patient “isn’t truly committed or is unwilling to accept the invasive therapies that come with high-risk operations.” [*American Journal of Nursing*, 3/12] ■

Supreme Court hearings, continued from page 1

court’s swing vote—commented during the hearings that the mandate essentially changed the relationship between the government and the individual person. “He’s right,” McCaughey wrote. “ObamaCare does more than require you to enroll in a health plan—it also puts the federal government in charge of your doctor once you are in the plan. Sec. 1311 of the law says approved plans can pay only doctors and hospitals that follow whatever regulations the federal government imposes in the name of ‘quality,’” McCaughey explained. “That could mean everything—when your cardiologist recommends a stent, or your ob/gyn does a Cesarean.” [*New York Post*, 3/28/12]

It remains to be seen how the nine Supreme Court justices will vote on the issues. A ruling is expected in June and could profoundly affect the rights of each and every American patient. ■

Cancer diagnosis raises risk of suicide & heart attack

A study, published in the *New England Journal of Medicine*, has found that receiving a cancer diagnosis is a very traumatic experience that can immediately trigger both suicide and cardiovascular deaths.

Researchers studied over 6 million people in Sweden, all over 30 years-old, between January 1, 1991 and December 31, 2006. Since each person born in Sweden has an identification number, researchers were able to identify individuals who had received a cancer diagnosis by referring to the country’s Cancer Register. Since 1958, Swedish law has required the reporting of all cancers by doctors and pathologists. The “completeness” of the Register, researchers wrote, “approaches 100%.”

The study found that, within the first week after being diagnosed with cancer, patients were 12.6 times more likely to commit suicide than those without cancer. After one year, the suicide risk was 80% higher than for those cancer-free. Cardiovascular deaths were 5.6 times more likely within the first week, with the death risk 20% higher after one year.

The highest risk of suicide and cardiovascular deaths was associated with the more serious forms of cancer. [Fang et al., “Suicide & Cardiovascular Death after a Cancer Diagnosis,” *NEJM*, 4/5/12]

The psychological affect of a cancer diagnosis is greater than the study shows, said senior author Unnur Valdimarsdottir. That’s because the study deals only with deaths, and does not include unsuccessful suicide attempts. [*LA Times*, 4/4/12] ■



News briefs from home & abroad . . .

- **United States:** Massachusetts and Vermont aren't the only states that have dealt with the assisted suicide issue lately. Here's a brief rundown:
 - Georgia** – On March 29, 2012, the Georgia General Assembly passed HB 1114, a bill that makes it a felony for any person to “knowingly and willfully” help another person commit suicide. The new crime of assisted-suicide carries a penalty of up to 10 years in prison. Lawmakers felt it was necessary to pass the ban after the Georgia Supreme Court overturned a previous, ill-conceived assisted-suicide law. (See *Update*, 2012, No. 1.) HB 1114 had overwhelming support in both chambers and passed the House by a vote of 115-53 and the Senate by a 38-11 margin. The bill is currently awaiting the governor's signature. [www.legis.ga.gov]
 - Louisiana** – The Louisiana House unanimously passed a bill that will strengthen that state's criminal ban on euthanasia and assisted suicide. The vote, taken on April 23, 2012, was 97-0 for passage. HB 1086 clearly stipulates that anyone authorized to make medical decisions for another person cannot approve procedures considered to be assisted suicide or euthanasia. The bill's author said he wanted to insure that the ban was established in the state's medical consent law as well as criminal law. [www.legis.state.la.us; AP, 4/24/12]
 - New York** – AB 9360, a bill modeled after Oregon's law permitting doctor-prescribed suicide, was referred to the Assembly Health Committee on February 22. So far, there has been no further action taken on the bill. [www.assembly.state.ny.us]
 - New Mexico** – Two doctors in New Mexico have filed a lawsuit in state district court in Albuquerque challenging the state's law banning assisted suicide. The action was taken with the help of the national assisted-suicide advocacy group Compassion & Choices (C&C) and the ACLU of New Mexico. C&C's legal director Kathryn Tucker said they will argue that, while the state law bans assisted suicide, it does not expressly prohibit doctors from providing “aid-in-dying” to end the lives of terminally-ill patients. [AP, 3/15/12] In the 1990's, “aid-in-dying” was used by early right-to-die advocates as a euphemism for assisted suicide and euthanasia.
 - Hawaii** – Five doctors in Hawaii have formed the Physician Advisory Council for Aid-in-Dying in a bid to test that state's law. At C&C's instigation, these doctors are offering to write lethal drug prescriptions for terminally-ill patients who want to die—even though Hawaii's attorney general issued a legal opinion last December stating that doctors could be charged with manslaughter if they issue those prescriptions. [AMA News, 4/17/12]
- **Canada:** On March 22, the nine-member Quebec National Assembly Committee on Dying with Dignity issued a 180-page report recommending, among other things, that the law be changed “to recognize medical aid-in-dying as appropriate end-of-life care.” [*Dying with Dignity Report*, Recommendation 13, 3/22/12] Put another way, the committee wants to legalize euthanasia in Quebec without calling it euthanasia. Veronique Hivon, the committee co-chair, explained that they were not suggesting any form of euthanasia or assisted suicide, but rather the ultimate medical solution for the terminally ill. [*Globe & Mail*, 3/22/12] The committee also recommended the creation of an “advance directive for medical aid-in-dying” that adults could sign. It would become *legally binding* “in the event [the signer] becomes irreversibly unconscious.” [*Report*, Recommendation 17] Currently, euthanasia and assisted suicide are criminal offenses in Canada. Offenders could face up to 14 years in prison.
- **Germany:** A court in Berlin has lifted the Chamber of Physicians' ban on doctor-assisted suicide. The court ruled that the physician association's ban was “too general.” While euthanasia is presently illegal in Germany, the court ruling means that doctors can now engage in assisted suicide by providing terminally-ill patients with lethal doses of drugs if the doctors are sure those patients want to end

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their lives. Many believe the court's ruling takes Germany a step closer to having Swiss-style suicide clinics. Others say it will put a stop to Germans going to Switzerland to die. Still others say it opens the door to legalized euthanasia in a country where millions were euthanized during the 1930s and early 1940s. [The Local, 4/4/12; UPI, 4/4/12; German Herald, 4/5/12]

- **Switzerland:** Between 1998 and 2009, the number of Swiss residents who died with the help of assisted-suicide groups increased 700%. According to the first ever assisted-suicide report issued by the Swiss Federal Statistical Office, authorities recorded a total of 43 assisted deaths in 1998 and 297 in 2009. [Fed. Stat. Office, Press Release, 3/27/12] Exit, the Swiss assisted-suicide organization that accepts only Swiss residents as clients, earlier revealed that 416 people had died in 2011 with the group's help. Dignitas,

the clinic that also assists foreigners, helped 144 die in 2011. [swissInfo.ch, 2/20,12]

- **Belgium & The Netherlands:** This year marks the 10th anniversary of legalized euthanasia and doctor-prescribed suicide in both the Netherlands and Belgium. Official statistics indicate that combined these two countries terminate the lives of 4,000 people a year. The actual body count is likely to be higher since deaths sometimes go unreported. According to Dutch Health Ministry spokeswoman Inge Freriksen, "the [euthanasia] statute has remained unchanged, but what has changed is the way doctors interpret it." The result has been that more and more categories of patients now qualify for induced deaths. Those include advanced dementia patients who are incapable of making an informed death request. [Agence France-Presse, 3/30/12] ■

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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