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Patients Rights Council

Update

Massachusetts assisted-suicide initiative up for vote on November 6

This November, it will be up to the voters in Massachusetts to decide whether or not their state transforms the crime of assisted suicide into a medical treatment.

Two national assisted-suicide advocacy groups, Compassion & Choices (C&C) and the Death with Dignity Political Action Fund (both spinoffs of the former national Hemlock Society), are behind the ballot measure to legalize doctor-prescribed suicide in the Bay State. Their strategy is to get one New England state to legalize death by prescription in the hope that other states in the region will follow suit—a strategy they used in the Pacific Northwest where the practice is now legal in Oregon and Washington State, and where a C&C instigated lawsuit in neighboring

Montana resulted in the state supreme court ruling that no Montana statute or policy expressly makes doctor-assisted suicide illegal.

But New England has historically been hostile territory for attempts to legalize prescribed suicide. In fact, legislatures in the six New England states—Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut—have together rejected nearly 30 assisted-suicide bills since 1995. In 2000, a ballot initiative in Maine, similar to the current one in Massachusetts, was also defeated by voters.

The Oregon model

Proponents of the initiative—listed on the official ballot as “Question 2” and titled “An Act Relative to Death with Dignity”—often point to Oregon’s

experience with legalized assisted suicide to support their claims that the Massachusetts initiative, which is modeled after the Oregon Death with Dignity law, will be transparent, safe, and abuse-free. As Dr. Marcia Angell, former editor of the *New England Journal of Medicine* and one of the initiative’s original petitioners, wrote in the *Boston Globe*, “The best answers come from Oregon, where the law has been used sparingly (most requests are refused) and exactly as intended....No law works absolutely perfectly, but this one seems to come about as close as possible.” [Boston Globe, 7/31/12]

Her claim, however, flies in the face of a little-known fact. In 2008, about a month before Washington voters were

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Proposal seeks to skirt doctors' opposition to assisted suicide

A proposal featured in the July 12, 2012 issue of the *New England Journal of Medicine* (NEJM) is yet another example of that journal’s long-standing advocacy for legalized assisted suicide.

The goal of the proposal, authored by Dr. Lisa Lehmann, director of Boston’s Center for Bioethics at Brigham and Women’s Hospital, and researcher Julian Prokopenko, is to make prescribed suicide available to many more patients by eliminating the overriding objections physicians have against their involvement in the induced-death practice. Strong opposition to legalized doctor-assisted suicide by the American Medical Association and numerous state and local medical groups has been key in blocking prescribed-suicide bills and initiatives (some proposed multiple times) in 25 states since 1992. Eliminate the reasons for that opposi-

tion, and, at least in theory, it will be far easier to pass such measures.

“Many medical professionals are uncomfortable with the idea of physicians playing an active role in ending patients’ lives,” the authors wrote. “[W]e propose a system that would remove the physician from direct involvement in the process.” Furthermore, they wrote, “We believe there is a compelling case for legalizing assisted dying, but assisted dying need not be physician-assisted.” [Prokopenko & Lehmann, “Redefining Physicians’ Role in Assisted Dying,” NEJM, 7/12/12, pp. 97 & 99]

Making a terminal diagnosis and prognosis are what doctors do as part of standard clinical care. It’s the writing of the prescription for lethal drugs that most doctors have a problem with. “So,” according to the authors, “if a physician certifies that [diagnosis and prognosis]

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Paralyzed man's campaign ends, but not as he wanted

Tony Nicklinson was a man determined to die. One of the last things he told his wife, Jane, before he died on August 22 was, "I'm already dead—don't mourn for me."

The 58-year-old, formerly athletic Nicklinson had "locked-in syndrome" (LIS), caused by a stroke in 2005. He was left paralyzed below the neck and unable to speak, yet he was fully conscious. Thanks to a computer that responds to eye blinks and a plastic alphabet board, he was able to communicate effectively. He even had his own Twitter account and was in the process of writing his memoirs. Able to swallow soft foods, he received fluids through a gastrostomy tube. He was not terminally ill. In fact, his life expectancy was 20 years or more.

Nicklinson described his life as a "living nightmare," and, with the support of his family, campaigned to have his life ended. He took his case to Britain's High Court as a co-plaintiff with an anonymous "locked-in" man, referred to as "Martin." Neither man attended the hearing in June, but, through his attorney, Nicklinson argued for the court to declare that, on the grounds of necessity, it would be lawful for a doctor to terminate his life. [BBC, 6/19/12]

But the three-judge panel hearing the case, while acknowledging both men's "deeply moving" circumstances, rejected their petitions for euthanasia. "A decision to allow their claims would have consequences far beyond the present cases," the judges wrote. In Nicklinson's case, "the court would be making a major change in the law." "It is not for the court to decide whether the law about assisted dying should be changed," they held, "and, if so, what safeguards should be put in place. Under our system of government, these are matters for Parliament to decide...." [*Nicklinson v. Ministry of Justice*, Judgment, High Court of Justice [2012] EWHC 2381, 8/16/12, at 150-152]

After the court's ruling was made public, a media frenzy erupted with very moving videos and pictures of Nicklinson weeping hysterically and saying, in a written statement, that the law had condemned him to a life of indignity and misery. He opted to stop taking food and liquids, but died just days later of untreated pneumonia. [BBC, 8/28/12]

Another "locked-in" man, Michael Cubiss, and his wife contacted the BBC shortly before Nicklinson's death because they wanted the public to know that life with LIS can be positive. Cubiss, a father of

Dutch death culture at work in prince's case

Six months ago, Prince Friso of Holland was buried in an avalanche while skiing in Austria. The 43-year-old son of Queen Beatrix was taken to a London hospital where he remains in a deep coma.

Now Dutch Parliament member Heleen Dupuis, a medical ethicist and head of the Dutch care organization for disabled people, is publicly questioning whether the prince's care should be continued. "Had the prince been sent to a Dutch hospital, doctors would probably have turned off the life support systems because there is such a slim possibility that he will ever recover," she said.

As reported in the *London Times*, the Netherlands has only 30 long-term coma patients and a euthanasia law that allows doctors to decide when to end treatment.

If the prince is brought to Holland as rumored, he would be the highest-profile patient to die under the country's death-inducing medical system. [*Times*, 8/31/12] ■

three who suffered a stroke at age 40, used an eye-blink computer to tell the BBC that he never thought about ending his life, only about how to keep living. His wife described him as "amazingly happy." [BBC, 8/22/12; voxxi.com, 8/23/12] ■

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information in writing, patients could conceivably go to an independent authority to obtain the prescription." [p. 99]

And who would that "independent authority" be? The answer: Government-facilitated, lethally-prescribing suicide clinics:

"We envision the development of a central state or federal mechanism to confirm the authenticity and eligibility of patients' requests, dispense medications, and monitor demand and use....Patients could also provide an independent authority with their medical record as proof of their prognosis." [p.99]

In an audio interview with *NEJM* Managing Editor Stephen Morrissey, which accompanied the online journal article, Dr. Lehmann further described her proposed "mechanism":

"It could be organized on either the state level or federal level partially by relying on physical centers to coordinate the dispensation of the medication or even through a mail order process the same way many people get medication today through a mail order system." (emphasis added)

She was quick to add this caveat, however: "In our case, we really didn't focus on the details of how that would work. [Dr. Lisa Lehmann Interview, *NEJM*, 7/12/12]

In an article published in *The Daily Caller*, Patients Rights Council's executive director, Rita Marker, and legal consultant, Wesley J. Smith, point out that the proposed government "mechanism" would significantly increase the number of assisted suicides and pose a very real danger for patients:

Let's consider this for a moment. Do we really think that a government that is constantly looking for ways to contain health care costs will be likely to deny death eligibility? Do we think that government death control officials will do the right thing—or the cheap thing?

Take this proposal, coupled with government-run health care, and you have "death panels on steroids." [Marker and Smith, "Death panels on steroids," *The Daily Caller*, 7/25/12] ■



Special Report

Obamacare ruled constitutional: What now?

By Rita L. Marker

On June 28, 2012, the U.S. Supreme Court released its long awaited decision on the Patient Protection and Affordable Care Act (ACA) [Public Law 111-148], also referred to as Obamacare.

Many court watchers expected that the most controversial part of the bill, the “individual mandate,” which requires that everyone must have health care coverage or pay a penalty, would be deemed unconstitutional. However, in its 5-4 decision, the court declared that the penalty for not having insurance was not really a penalty but was, instead, a “tax.” Thus, since the government has the right to levy taxes, the law passed constitutional muster.

One portion of the law, however, was not upheld. That was the portion of the ACA which required individual states to expand their Medicaid programs and provided that any state failing to do so would lose not only new federal Medicaid funding for that purpose, but also its entire Medicaid allotment. (The full text of the Court’s decision is available at the PRC website: www.patientsrightscouncil.org/site/health-care-reform)

Far from ending the national debate over the ACA, the decision added fuel to the electoral fire that is sweeping the country. Democrats are committed to preserving the law. Republicans have vowed to repeal and replace it. Without question, the ultimate fate of the law will depend upon the outcome of the November election. In the meantime, the law will continue taking effect.

Many people have assumed that, if the law remains in place, it will involve only those elements included in the hundreds of pages of the ACA. Unfortunately, this is not the case at all.

Rules and regulations

The law itself is essentially only a basic outline, with the details—the requirements for its implementation—taken care of through the ongoing proc-

ess of rulemaking and regulations. Already thousands of pages devoted to this task have been generated.

The result? A never-ending process of reporting requirements, changes, revisions, and additions is taking place. If people thought plowing through the original law was tedious and confusing, navigating the minutiae of rules and regulations is dizzying. In fact, entire programs, available by subscription and costing in the thousands of dollars, are available to track the process of announced rulemaking, public comments, and final regulations.

Even at this stage in the process, there are certain indications of how sweeping the additional requirements may become and how elements rejected in the bill as passed could eventually find their way back into the ACA.

Essential benefits

The ACA contains a bland sounding requirement that essential health benefits be included in all health care coverage, but what is meant by such benefits is extremely broad. Virtually unlimited power is given to the Secretary of Health and Human Services (a position currently held by HHS Secretary Kathleen Sebelius) to define them: “[T]he Secretary shall define the essential health benefits, except that such benefits shall include *at least* the following general categories and items and services covered within the categories.” [Sec. 1302, emphasis added]

The current general categories are:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance abuse treatment, including behavioral health treatment,
- prescription drugs,
- rehabilitation and habilitative services, and devices,

- laboratory services,
- preventative and wellness services and chronic disease management,
- pediatric services.

But note, the above categories are only those which *must* be available in every health insurance program. Additional categories can be added by the Secretary, and particulars within those categories will be determined by the Secretary.

Once the Secretary defines the specifics of a particular category, notice and an opportunity for public comments is provided before a final rule is issued. Public opposition during the comment period is to be taken into account, but nothing requires that the comments determine the final rule.

One such inclusion—one that has not escaped deep public outrage—is referred to as the birth control mandate. The mandate was included in the category of “preventative services.”

As the ACA continues to be implemented, the nebulous and ever-changing “essential benefits package” will, undoubtedly, contain other surprises and other added controversial requirements.

Shared decision making & patient decision aids

Decades ago, paternalism was the model for medical decision making. Under that model, the physician essentially made decisions. Patients were given information, doctors explained what should be done and, generally, the patient complied with the doctor’s decision. A “doctor knows best” mentality was the underpinning for this model (which still exists in many European countries).

In recent years, however, patient autonomy has provided the basis for health care decisions. Under such a model, doctors had the responsibility to provide patients with information about their condition, available treatments,

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potential side effects, risks, etc. Then, based upon that information, patients gave or withheld informed consent. Patients were in control.

Now, however, a shared decision-making model is gaining ground. Under such a model, patients and health care providers work collaboratively to arrive at a decision. Patients share specific information not only about symptoms and physical conditions but also about values and goals. Doctors, likewise, provide medical information and other value-laden concerns. A two-way knowledge exchange occurs to be followed by both the patient and health care provider having an equal role in the decision-making process.

This is a subtle, but significant, shift in patients' rights—not because of the open dialogue but because of what could be a stacked deck in the process.

A case in point is a section in the ACA that funds a program to facilitate shared decision making. [Sec. 3506]

Its purpose is “to facilitate collaborative processes between patients, caregivers or authorized representatives and clinicians” in decision making and to provide them with “information about trade-offs among treatment options....” The collaborative process will use “patient decision aids.” A “patient decision aid” is defined as “an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.” In other words, patients are to decide about their care *with* their health care providers.

The problematic part, however, is the requirement that the program will “contract with an entity to establish standards and certify patient decision aids.” That selected “entity” will convene a broad range of experts to develop and identify *consensus based standards* to evaluate the decision aids. The decision aids “shall address health care decisions across the age span, including those af-

flecting vulnerable populations including children.”

Shared decision-making centers will be a component of the program and funds for such centers “shall not be used to purchase or implement use of patient decision aids other than those certified.”

Provisions in this section are somewhat similar to the controversial “advance care planning” in an earlier version of Obamacare. In addition, the provision for an outside entity to establish standards and certify patient decision aids raises concern about how that entity will be selected. This is of particular concern since doctor-prescribed suicide advocacy groups have been positioning themselves to become the “go to” organizations regarding end-of-life decisions.

In short, the federal government will provide funding for a yet-to-be-named outside “entity” to determine, design and formulate decision aids. The government will establish shared decision-making centers that will only be permitted to use decision-making aids developed by the chosen entity.

Advance care planning: Temporarily gone but not forgotten

In early versions of the ACA, advance care planning received a great deal of attention leading some to refer to it with the emotionally charged (and erroneous) label, “death panels.” However, even though the language to describe advance care planning was over the top, concerns about abuse and coercion were well-founded.

In those initial bills, physicians and other providers would have been paid for discussing advance care planning about the “continuum of end-of-life services and supports” available. Because they would have been paid for those discussions, it was likely that health care providers would have routinely offered such consultations. And, because patients—particularly elderly patients or those who had just been diagnosed with a serious condition—are often reluctant to refuse to discuss something suggested by a doctor, they may have felt compelled to accept an advance care planning consultation. In states where doctor-prescribed

suicide is legal, health insurers and others could subtly nudge enrollees to consider all end-of-life options, including assisted suicide.

Oregon Congressman Earl Blumenauer, who works in cooperation with Compassion & Choices (the former Hemlock Society) wrote the advance care planning section of the early Obamacare bills. Because of the controversy that surrounded the advance care planning provision, it was deleted from the ACA, as passed.

Now, though, it appears there are several routes to get advance care planning back on the front burner.

Since passage of the ACA, Congressman Blumenauer proposed a bill called the “Personalize Your Care Act.” The proposal seeks to amend the ACA to include advance care planning that entails facilitation by health care providers or other professionals. The planning would be based on shared decision making and would include consideration of physicians orders for life-sustaining treatment (POLST) and various other end-of-life options. The measure does not allow encouragement or promotion of assisted suicide but would permit health care providers to present it as an end-of-life option.

Blumenauer, however, is not alone in promoting advance care planning on a federal level. While his is a direct attempt to amend the ACA, there’s more than one way to mandate advance care planning.

ABA calls for Congress to amend Patient Self-Determination Act

Recently, advance care planning was given a boost by the American Bar Association (ABA). It passed a resolution calling upon Congress to amend the 1991 Patient Self-Determination Act (PSDA) to “require the annual Medicare wellness examination, or other periodic doctor-patient interactions, to include both an opportunity to engage in and have resource options available relating to advance care planning for health decisions.” [ABA Resolution 106A]

Without question, the intent behind such a resolution is benevolent. But, also

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Canadian government appeals sweeping assisted-suicide ruling

The Canadian federal government is appealing the British Columbia (BC) Supreme Court's ruling that overturned Canada's assisted suicide law. Justice Lynn Smith declared the law unconstitutional in June, but stayed her ruling from taking effect for one year so that Parliament could pass a new law allowing the practice. She also granted ALS patient Gloria Taylor, a plaintiff in the case, a year-long exemption from the existing law so she could get a doctor to help her die if she so chooses.

Canadian Minister of Justice Rob Nicholson announced the government's appeal and said the law prohibiting assisted suicide is "constitutionally valid." He said the government is also seeking "a stay on all aspects of the lower court decision." [Justice Dept. News Release, 7/13/12]

But, on August 10, BC Court of Appeals Judge Jo-Ann Prowse shot down the government's request for a stay on Taylor's exemption, saying to deny her the death of her choosing would cause Taylor "irreparable harm." "She may be a symbol," the judge wrote, "but she is also a person, and I do not find that it is necessary for the individual to be sacrificed to a concept of the 'greater good' which may, or may not be fully informed." [Carter v. Canada, 2012 BCCA 336, 8/10/12, (paragraph 45)]

On August 17, Nicholson announced that the government will appeal Prowse's stay denial. The appeal of the BC Supreme Court ruling is expected to be heard next spring. [Justice Dept. News Release, 8/17/12] ■

Colombian committee OKs euthanasia rules

On August 9, a Colombian Senate committee passed a bill to regulate euthanasia practice. The vote was 11-5. [Colombia Reports, 8/9/12]

While euthanasia had been decriminalized in 1997 by a Colombian Supreme Court ruling, the court had not outlined any specific regulations, so the practice remained in limbo.

PRC director Rita Marker was asked in 1997 to debate the issue before legislators in Bogota. Her opponent was the court's chief justice, a euthanasia advocate. After the debate, legislators decided not to establish guidelines, so the practice was put on hold. But a couple of years ago, the chief justice was elected to the Senate, hence the bill. "It's heartening though," Marker said, "that it took 15 years to reach even this point." ■

Assisted-suicide debate rages in Germany

According to *The Local*, Germany's news in English source, "a row has blown up within the government about possible changes to German assisted-suicide laws."

The debate over assisted suicide escalated last April after a panel of judges in Berlin's Administrative Court struck down the absolute ban on assisted suicide imposed by the country's professional medical association as being "too general." Prior to the ruling, doctors who gave patients enough drugs to kill themselves could face fines up to €50,000 (\$62,000).

Court spokesperson Stephan Grosschurth explained that, if a doctor is prohibited from medically helping a suffering patient to die, a patient with whom the doctor has a close relationship, then, according to the court, it would be against the doctor's "freedom of conscience." He added that euthanasia, actively causing someone to die, is still unethical and against the law.

Longtime right-to-die activist Uwe-Christian Arnold, a Berlin urologist and the deputy director of the German branch of the Swiss suicide clinic Dignitas, told reporters, "We are very pleased with the decision." Arnold has openly admitted that he has helped a number of patients die. [The Local, 4/4/12; UPI, 4/4/12; German Herald, 4/5/12]

Then, just months after the Administrative Court ruling, the German media reported that Justice Minister Sabine Leutheusser-Schnarrenberger has

drafted a law that would allow friends, long-term housemates, doctors, and other caregivers to assist the suicides of patients with whom they have "a close personal relationship." Her proposed law would ban organizations with commercial interests from engaging in assisted suicide, but allow those who give "profit-free suicide advice" to the terminally ill the freedom to do so without the threat of prosecution.

But Jens Spahn, health spokesperson for German Chancellor Angela Merkel's political party, called Leutheusser-Schnarrenberger's draft law unacceptable and said it would open the door to abuse. "Where would the line be drawn?" he asked.

German Medical Association President Frank Ulrich Montgomery called the idea of the proposed law "something from a madhouse." "[T]he justice ministry wants to create a legal basis for doctors to be suicide assistants," he said. But there is a professional code of ethics for all doctors, he explained, that forbids them from killing or assisting the suicides of patients, even if patients request death. Eugen Brysch, head of the German Hospice Association, agreed. He said the justice minister was trying to encourage the social acceptance of assisted-suicide practice. [The Local, 8/1/12]

Reportedly, the government is trying to draft a law to ban assisted suicide, but there is major disagreement among the coalition government's ministers. [Bioedge.org, 8/11/12] ■

Medical group slams euthanasia

The Australian & New Zealand Society of Palliative Medicine (ANZSPM) issued a press release on August 7 unequivocally stating that both euthanasia and doctor-prescribed suicide are "unethical" and outside the practice of palliative medicine.

Further, the ANZSPM said, "This position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalized, the NZMA [New Zealand Medical Association] would continue to regard them as unethical." [ANZSPM, Media Release, 8/7/12] ■

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to vote on that state's prescribed-suicide initiative, Oregon's largest newspaper, the *Oregonian*, decided not to endorse the Washington measure. That decision was significant since the initiative was a virtual clone of Oregon's law. While it may appear that Oregon's assisted-suicide law is working, the editorial board wrote, "Washington voters should be aware, however, that this state's experience has been mixed." "Oregon's physician-assisted suicide program has not been sufficiently transparent," the board explained. "Essentially, a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know....[O]ur basic unease with physician-assisted suicide has not changed, and we cannot exhort Washington voters to take the same path." [*Oregonian*, 9/20/08]

Number one on the list of Oregon's assisted-suicide "insiders" is the advocacy group Compassion & Choices, with its established network of doctors, pharmacists, and volunteers all poised to facilitate patients' suicides. This is the same organization behind the Massachusetts initiative.

According to Dr. Kenneth R. Stevens, former chair of the Department of Radiation Oncology at Oregon Health and Science University and vice president of Physicians for Compassionate Care, C&C of Oregon participated in 78% of all reported assisted-suicide deaths between 1998 and 2009. In 2009, the group was

involved in a whopping 97% of reported prescribed suicides.

In 2008, Stevens, along with Oregon physician William L. Toffler, wrote, "The group controlling assisted suicide in Oregon is also the group controlling what the public is told." "Regardless of one's perspective on assisted suicide," they concluded, "all citizens should be concerned about the controlling influence of this death-promoting organization. In all other areas of medicine, we are striving for increased transparency...." [*Oregonian*, 9/24/08]

Yet, the Dignity 2012 campaign, the Massachusetts group pushing for passage of the initiative, keeps insisting that the Oregon law is working extremely well and that prescribed-suicide opponents who say otherwise are using "scare tactics" to unnecessarily frighten voters. [*American Medical News*, 7/16/12]

But, according to research conducted by Dr. Herbert H. Hendin, Medical Director for Suicide Prevention International, and Dr. Kathleen Foley, a neurologist at Memorial Sloan-Kettering Cancer Center in New York, implementation of the Oregon law is, indeed, scary. They found that the statute protects doctors who assist suicides but leaves patients vulnerable. While the law appears to have safeguards, they wrote, "The evidence strongly suggests that these safeguards are circumvented in ways that are harmful to patients." [*Michigan Law Review*, 5/08]

What's at stake in Massachusetts

Since assisted suicide is not practiced in a vacuum, it's important to consider the environment in which it would be offered. For example, cutting health care costs is now a definite priority for health insurance plans and government health programs. And, as medical treatments go, assisted suicide would be a cheap option. Massachusetts lawyer Robert W. Joyce put it this way: "How much do you trust insurers, hospitals, and governments? Unless you answer, 'With my life,' you should oppose the Massachusetts assisted-suicide effort." [Letter to the editor, *Boston Globe*, 3/19/12]

Another big concern is that cases of elder abuse have increased over 30% in Massachusetts since 2008. [*MetroWest Daily News*, 2/19/11] Would legalized assisted suicide provide greedy heirs with an easy way to make vulnerable patients die sooner rather than later? The initiative only contains provisions relative to acts up to the time the doctor writes the lethal prescription. It provides vulnerable patients no protection when the lethal drugs are taken. Since not all "loved ones" have the patient's best interest at heart, the patient could be forced to take the drugs, and no one would ever know. ■

For more updated information on the Massachusetts initiative see:

www.patientsrightscouncil.org

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without question, the potential problems are great.

In 2009, federal government involvement in advance care planning stirred both fear and outrage when the planning guide, "Your Life, Your Choices" came to the attention of the public. The booklet, published by the Department of Veterans Affairs (VA), was authored by five medical professionals, including lead author Dr. Robert Pearlman. Pearlman, an assisted-suicide advocate, was among those who filed a 1997 *amicus* brief in joint cases before the U.S. Supreme Court, arguing unsuccessfully that as-

sisted suicide is a fundamental right guaranteed by the U.S. Constitution. [*Washington v. Glucksberg*, 521 U.S. 702 (1997) and *Vacco v. Quill*, 521 U.S. 793 (1997)]

In the VA decision guide, veterans were asked to consider the burden that they could put on others. A checklist of scenarios that would make lives not worth living was provided for veterans to consider. [p. 21]

Following a public outcry, the booklet was withdrawn from circulation and removed from the Veterans Affairs website.

If a federal government mandate of advance care planning becomes a reality, whether through the ACA or the PSDA, will we see decision aids similar to "Your Life, Your Choices"?

Do we want to take that risk? ■

Rita L. Marker, J.D. is an attorney and the executive director of the Patient Rights Council. She is also the author of the book, *Deadly Compassion*.





News briefs from home & abroad . . .

- **Studies:** A study, published in the *Archives of Internal Medicine*, found that advanced cancer patients who are not hospitalized or in an intensive care unit, who pray or meditate, are visited by a pastor, are less anxious, and who feel an alliance with their doctors have the highest quality of life (QOL). Worry, researchers wrote, "was one of the most influential predictors of worse QOL." Another important predictor was the patients' "therapeutic alliance" with their doctors. Such an alliance means that a doctor treated the patient with respect and as a "whole person," and the patient trusted the doctor and felt comfortable asking questions about his or her care. [Zhang et al., "Factors Important to Patients' Quality of Life at the End of Life," *Archives of Internal Medicine*, 7/9/12]

According to a study presented at the American Surgical Association's annual meeting in April, "Elderly patients who sign a preoperative 'do not resuscitate' (DNR) order are more likely to die from complications following surgery than matched controls because they turn down aggressive management of their complications." Researchers called it a "failure to pursue rescue." Of the DNR patients who developed "a major complication," 57% died within a 30-day period after surgery. That was 18 percentage points higher than the death rate for patients without a DNR order. [General Surgery News, 7/12]

- **Washington:** A recent article in the *New York Times (NYT)* gave a highly supportive account of Dr. Richard Wesley's pursuit of the death of his choosing. Wesley, a Washington State doctor who has ALS (Lou Gehrig's disease), requested and was given a prescription for lethal drugs in accord with Washington's prescribed-suicide law. In the summer of 2010, his doctors were in agreement that he had only six months left to live, so he was prescribed the fatal barbiturate overdose. That was two years ago and counting—well beyond the 6-months-to-live limit mandated by the law. Currently, according the *NYT*, "[Wesley] takes classes in international politics at the University of Washington and savors time with his wife and four grown children." While his wife has accepted his assisted-suicide decision, she does not want the pills in the house. "It just feels so negative," she explained. [NYT, 8/11/12] ■

- **Switzerland:** In Switzerland, assisting a suicide is legal as long as the person doing the assisting has unselfish motives. According to recent statistics, the number of Swiss assisted-suicide cases has jumped 60% in the last five years. The increase is thought by some to be the result of a widespread fear of dying. Zurich Prosecutor Andreas Brunner, however, blames the increase on a trend to broaden the assisted-suicide "target group." "At first the argument was that it was intended for the terminally ill, then it was broadened to include the very ill facing extreme suffering," he said. "Then the idea was that it should be open to the elderly who were suffering the effects of old age or a combination of illnesses, and finally it's open to healthy people." [swissInfo.ch, 7/9/12] Apparently, there really is a slippery slope where assisted suicide is concerned.

In a bizarre twist, Dignitas, the Swiss assisted-suicide clinic near Zurich that specializes in the deaths of foreigners, is reportedly planning to sue the local police department for attempting to revive a woman who fell asleep after consuming only half the drugs intended to kill her. Swiss law mandates that a state official—usually a police officer—monitor assisted-suicide deaths. The officer thought her August 2 suicide attempt had failed, but the petite 67-year-old woman died after being rushed to the hospital. Dignitas, headed by lawyer Ludwig Minelli, wants the officer prosecuted for "interfering in a legal assisted suicide" and "abducting a patient." But the police said their rules state

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You can't take it with you

But you **can** continue to support our good work, even after you are gone.

Planned giving is a great way to support the Patients Rights Council. You can leave us a bequest in your will or trust (e.g. "I direct that 5% of all assets go to the Patients Rights Council in Steubenville, Ohio"), deeding property to us, gifting appreciated stocks (you'll get a nice tax advantage that way, too!) or creating a charitable trust. You can be assured we'll use your gift wisely, in keeping with our mission of advocating for compassionate care for all.

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Correction

The last *Update* contained a news brief about Dutch research on the wanted and unwanted effects of euthanasia and assisted-suicide drugs. We mistakenly indicated that the study was published in 2011. It was not published, just posted on the EMGO website (www.emgo.nl) under "Quality of Care - Research Projects." No date was given.

News briefs from home and abroad, continued from page 7

that, if a patient is alive two hours after ingesting the lethal cocktail, they must call for an ambulance. [*Daily Mail* (London), 8/16/12]

- **Great Britain:** Many terminally-ill patients in the UK are frightened that, without their consent, they will be placed on the widely used end-of-life care protocol called the Liverpool Care Pathway. In the late 1990s, the Pathway was developed by a Liverpool hospice program to reduce the suffering of the imminently dying. Once placed on the Pathway, patients are put under continuous sedation and all food and fluids and, in some cases, antibiotics are withheld until patients die. Some doctors have strongly criticized the protocol, saying that seriously-ill patients are routinely and often mistakenly being placed on the Pathway, sometimes without consent, insuring that they will die within days.

ALERT, a British group that opposes euthanasia and assisted suicide, has addressed the fear many patients currently feel regarding the Pathway by creating a card that they can carry with them. It simply reads: "Please do not give me the Liverpool Pathway treatment without my informed consent or that of a relative." [*Telegraph*, 6/20/12; *Daily Mail*, 7/24/12]

- **Australia:** Dr. Philip Nitschke, Australia's Dr. Death, is under investigation for two alleged importation violations. The first one deals with his application to import the pet euthanasia drug Nembutal to be used as a "sleeping aid" for terminally-ill patients. The second involves the use of his "sham beer-brewing company" to import cylinders of nitrogen gas for people to use along with a plastic bag to asphyxiate themselves. [*The Australian*, 8/31/12] ■

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.

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