



2013
Vol. 27, No. 4

Patients Rights Council

Update

Outrage mounts over Belgium's euthanasia law and its toll on the country

Since 2002, when Belgium legalized euthanasia, a mentality of absolute individual autonomy has profoundly altered the medical community's treatment of patients and has isolated vulnerable individuals so much that they no longer feel connected to others.

Drs. Tom Mortier and Steven Biese- man, both lecturers at the Leuven Uni- versity College in Belgium, have se- verely criticized the country's euthana- sia law for having fundamentally changed Belgian society for the worse. "Euthanasia is hardening from a medi- cal option into an ideology," they wrote. "Questioning it has become taboo because the absolute right of the individual might be violated." Anyone who opposes doctor-induced death is

"marginalized as rigid and heartless." Doctors and volunteers undergo "indoctrination in self-determination" and "wear their euthanasia enabler certificates as badges of honor," they explained. [Mortier & Biese- man, "How legal euthanasia changed Belgium for- ever," Mercator.net, 5/17/13]

Dr. Mortier's position on euthanasia is certainly understandable. On April 20, 2012, he was informed by the Free University of Brussels Hospital that his 64-year-old mother, former teacher Lieve De Troyer, had been euthanized the day before. She did not have a ter- minal illness or any incurable disease. But she was clinically depressed. An oncologist at the hospital had given her a lethal injection on the recommenda-

tion of just one psychiatrist. Other psy- chiatrists she had seen had refused her euthanasia request because they felt her depression was treatable, and her prognosis was good. Her unexpected and unnecessary death left her chil- dren and grandchildren devastated. [Newswire Canada, 9/12/13]

Drs. Mortier and Biese- man are not the only Belgians voicing their opposi- tion to the euthanasia law for what it has done to their country. A new web- site, entitled "Euthanasia Stop," was created this year and is described as "a citizen's initiative, driven mainly by uni- versity professors, lawyers and health professionals, from all over the country and various philosophical backgrounds."

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Doctors affirm the profession's rejection of prescribed death

Physicians, nationally and internationally, are reaffirming their individual and collective opposition to both euthanasia and assisted suicide.

NEJM Poll

A recent survey of *New England Journal of Medicine (NEJM)* readers on the issue of doctor-prescribed suicide elicited responses from 74 countries (2356 votes) and 49 U.S. states (1712 votes). The survey's responses, mostly from doctors, indicated that "65% of the readers thought that physician-assisted suicide should not be permitted; the rate among U.S. voters was similar, with 67% voting against physician-assisted suicide."

The country with the largest number of votes (37) for the death practice was Mexico. In the U.S., 18 out of the 49 states had a majority of votes in favor of prescribed suicide, but Oregon, Washington, and Vermont—states

that have formally legalized the practice— were not among them. A large number of the comments by survey responders on both sides of the issue emphasized the importance of good palliative care to help terminally ill patients manage their symptoms. [Colbert et al., "Physician-Assisted Suicide—Polling Results," *NEJM*, 9/12/13]

World Medical Association

Earlier this year, the World Medical Association (WMA) formally reaffirmed its longstanding opposition to both euthanasia and assisted suicide:

"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural

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Canadian courts issue 2 landmark decisions that protect patients' rights

Two landmark rulings—one issued by the Supreme Court of Canada, the other by the British Columbia Court of Appeals—are huge victories for the country's most vulnerable patients.

Cuthbertson v. Rasouli

On October 18, 2013, the Supreme Court of Canada dismissed an appeal filed by two doctors who wanted to remove life-sustaining treatment without consent from a man who had suffered substantial brain damage due to an infection after surgery to remove a benign tumor.

The doctors, Brian Cuthbertson and Gordon Rubinfeld, decided in October 2010 that Hussan Rasouli, 61, was in a persistent vegetative state (PVS) and there was no realistic hope that he would recover. Given their pessimistic prognosis, the doctors wanted to pull the plug on Rasouli's life support, which included a ventilator and food and fluids through a tube, and simply provide him with care to relieve his distress until he died.

The only problem was that Parichehr Salasel—Rasouli's wife and his legal substitute decision maker as well as a physician in her own right—refused to give consent to her husband being taken off life support. She insisted that her husband was a devout Muslim and removing his life-sustaining treatment would go against his religious beliefs. She also said that he was not PVS and that he was showing signs of improving. She was ultimately proven right when a subsequent assessment by two neurologists resulted in Rasouli's condition being upgraded to being in a "minimally conscious state." [*National Post*, 10/18/13; *Canadian Press*, 10/18/13; *Metro News*, 10/18/13]

The case was eventually heard by two lower courts in Ontario where the doctors argued that consent was not required because removing life support was not considered medical treatment. That included consent from Rasouli's wife and the Consent and Capacity Board, which had been established by Ontario's Health Care Consent Act (HCCA) in 1996 to expressly deal with conflicts over consent for incapable patients. Further, the doctors

argued, not to remove life-sustaining equipment violated their ethical standards since being on life-support would eventually harm the patient. When both lower courts rejected the doctors' claims, they appealed to the Canadian Supreme Court.

In a 5 to 2 decision, Chief Justice Beverley McLachlin, writing for the majority, upheld both lower court rulings. "While the end-of-life context poses difficult ethical dilemmas for physicians," she wrote, "this does not alter the conclusion that withdrawal of life support constitutes treatment requiring consent under the HCCA." [*Cuthbertson v. Rasouli*, 2013 SCC 53, at 76]

Carter v. Canada

The second landmark decision was issued on October 16, 2013, by the British Columbia (B.C.) Court of Appeals. The court overturned the controversial 2012 ruling by B.C. Supreme Court Justice Lynn Smith in *Carter v. Canada*, which struck down Canada's law banning assisted suicide on the grounds that it was discriminatory and unconstitutional.

Justice Smith had suspended her ruling from taking effect for one year in order to give the Canadian Parliament time to pass a new law that would allow doctor-prescribed death practices and incorporate the conditions and safeguards that she had outlined in her lengthy 400-page opinion. However, both the B.C. attorney general and the attorney general of Canada appealed the ruling before parliament took any action on possibly changing the law. (See *Updates*, 2012, nos. 3 & 4 for more on Smith's ruling.)

The B.C. Court of Appeals, in a 2-1 decision, found that Justice Smith erred when she concluded that she was not bound by a precedent setting ruling handed down by the Supreme Court of Canada 20 years ago. In that case, *Rodriguez v. British Columbia*, Canada's highest court ruled that the laws prohibiting euthanasia and assisted suicide were, in fact, constitutional.

The arguments in both the *Rodriguez* and *Carter* cases were strikingly similar. In the earlier case, ALS (Lou Gehrig's Disease)

patient Sue Rodriguez claimed that the laws banning assisted suicide and euthanasia violated her rights under Canada's *Charter of Rights and Freedoms* because she was disabled and could not end her own life without assistance. In the *Carter* case, plaintiff Gloria Taylor, who also had ALS, made essentially the same argument. But instead of recognizing the *Rodriguez* decision as a binding precedent, Justice Smith concluded that, since much had changed in the debate over induced death practices in the last 20 years, aspects of the plaintiff's arguments in *Carter* were open to her discretion.

The Court of Appeals, however, did not agree. "[I]t is our view that although the law with respect to the *Charter* has certainly evolved since 1993," the appellate justices wrote, "no change sufficient to undermine *Rodriguez* as a binding authority has occurred, and that the trial judge [Smith] erred in deciding to the contrary." Later in their decision the justices again addressed the precedent issue: "With all due respect to the trial judge, we believe that she was bound by *stare decisis* [precedent] to conclude that the plaintiff's case had already been determined by the Supreme Court of Canada." [*Carter v. Canada*, 2013 BCCA 435, at 246 & 316. Hereafter cited as BCCA.]

The appellate justices also held that any change in the federal statute regarding euthanasia and assisted suicide could only be made by the Canadian Parliament, not the courts. [BCCA, at 241] But, any such change is not likely since doctor-prescribed death supporters have repeatedly introduced bills to legalize those practices over the years, and Parliament has rejected every attempt at legalization. The last bill was overwhelmingly defeated by lawmakers in 2010. The vote was 228 to 59.

Immediately after the appellate court issued its ruling, the B.C. Civil Liberties Association, who along with four plaintiffs had filed the original *Carter* lawsuit in 2011, announced that it would appeal the ruling to the Supreme Court of Canada. [*Vancouver Sun*, 10/10/13] ■



Bureaucracy Lives!

How many experts does it take to advise a dying patient?

Wesley J. Smith

Back when the mess that is Obamacare was working its way through the legislative sausage factory, warnings about “death panels” almost derailed the entire enterprise. There were two, somewhat related, areas of concern: (1) that Obamacare’s many cost/benefit bureaucratic boards would lead to explicit health care rationing; and (2) that doctors paid to “counsel” elderly and dying patients about end-of-life treatment would actually pressure them to refuse expensive treatments. Owing to the lack of popular trust, the end-of-life counseling provision was dropped to grease the way for Obamacare’s final passage.

Now, the proposal is back in both the House and Senate, with bipartisan support. The Care Planning Act of 2013 is the most far-reaching of the bills. Supported by the AARP and sponsored by Senators Mark Warner (D-Va.) and Johnny Isakson (R-Ga.), the bill ostensibly aims to compensate medical providers who accept Medicare and Medicaid for participating in end-of-life treatment discussions with patients. But that’s just the tip of the proverbial iceberg.

No one is against doctors discussing end-of-life treatment options with patients. That’s part of good medical practice. But once the federal government sets the pay, it will make the rules. It won’t be enough for doctors to talk to their patients about tube feeding, cardiopulmonary resuscitation, and the like. If they want to be reimbursed, doctors will have to structure the conversations in the way the government instructs.

Ever wonder why the health care bureaucracy is becoming so byzantine and sclerotic? This bill—meant to encourage conversations—is *46 pages long*. It would create a Care Planning Advisory Board, an “expert” panel of 15 members, three appointed by the president and the remainder by the four partisan leaders of the House and Senate (three apiece). Imagine the patronage opportunities!

Typical of how such boards are composed, the experts are to be selected from among every conceivable constituency:

Patient advocacy groups? Check.

Older patients? Check.

Individuals with cognitive or functional impairments? Check.

Family caregivers? Check.

Hospice providers? Check.

Researchers, ethicists, faith communities, and health care facilities? Check, check, check, and check.

Among its other duties, the care planning board will advise the Health and Human Services secretary about how to “assure that individuals with advanced illness receive person- and family-centered care.” The board will also investigate and recommend ways the government can ensure that qualified patients “develop a treatment plan that is formed around their goals, values, and preferences, that is informed by research on disease trajectory.” Not only that, but the board’s proposal is expected to ensure that care plans are “realistic, actionable, and concrete.”

And what expert government advisory board has ever been created that wasn’t required to “develop quality measures” to enable providers to send data back to the bureaucrats for the requisite bean counting. Also, the board will help the government “develop and promote best practices in communications about advanced illness between providers, individuals, and family caregivers in different settings, including acute care hospitals.” Good grief.

Since patients can only receive paid counseling—“once in each 12-month period”—the bill establishes bureaucratic hoops through which providers must jump. First, the patient must be “eligible.” That would mean, for example, having advanced cancer or late-stage diabetes, or needing “assistance with two or more activities of daily living”—or meeting “other criteria determined appropriate by the Secretary.” Translation: Still more regulations will be needed. Patients are to receive the services of a multidisciplinary “core team,” made up of a “physician or an advanced practice registered nurse, a social worker, a nurse, and a minister or the individual’s personal religious or spiritual adviser.” The core team can be expanded “when necessary” to include “a pharmacist, a licensed clinical social worker, and a psychologist,” along with anyone else who meets the “requirements that may be established by the Secretary.”

One wonders: Isn’t helping patients decide on appropriate treatment already part of a doctor’s job? Moreover, hospices—covered by Medicare and Medicaid—now use the multidisciplinary approach without having been told to by Washington.

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process of death to follow its course in the terminal phase of sickness.

“Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However, the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.”

At its 194th Council Session, held in April 2013 in Bali, Indonesia, the WMA passed its “Resolution on Euthanasia,” which simply states:

“The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principle of medical practice, and the World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions.” [WMA, 4/13]

National medical associations

Most major national and international medical associations in countries where prescribed-death practices are being considered for legalization already have strong opposition policies in place.

In the U.S., for example, the American Medical Association (AMA) has consistently maintained its policy: “Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer.” [Policy H-270.965]

Likewise, the Canadian Medical Association (CMA) has traditionally been strongly opposed to both death-inducing practices, and reaffirmed that policy in 2007. While some think CMA members’ opposition may be waning, a poll conducted by the CMA, published earlier this year, found that only 20% of the doctors surveyed would be willing to practice euthanasia if it were legalized. Forty-two percent (42%) said they would refuse to engage in the practice, 23% were not absolutely sure how they would respond, and 15% did not answer the question. Just 16% of the doctors said they would assist a suicide, 44% would refuse outright, 26% were unsure,

and 15% did not respond to the question. [CMA Bulletin, 3/5/13] Also, during the CMA’s annual meeting in August, delegates voted down a motion to urge all levels of government to conduct public hearings on medically assisted “aid in dying.” [Vancouver Sun, 8/21/13]

The major national medical associations in Australia, New Zealand, and Great Britain—all countries where bills to legalize prescribed death practices are being or have been hotly debated—have long-held, unequivocal policies opposing those practices as being unethical.

In Australia, where states have repeatedly had bills to legalize euthanasia and assisted suicide introduced in local parliaments, the Australian Medical Association in South Australia (AMA SA) sent a letter, last May, to the parliament’s House of Assembly clearly stating its “strongest possible” opposition to the euthanasia bill “Ending Life with Dignity 2013.” It stated: “Even for individuals who may support euthanasia, the AMA SA regards [this bill] to be in the realm of dangerous folly which [has] the potential to damage the basic tenets of clinical practice in ethical and compassionate end-of-life care.” [Letter from Dr. Patricia Montanaro, AMA SA President, 5/14/13] ■

Bureaucracy Lives! How many experts does it take to advise a dying patient? continued from page 3

The bill also requires that the government provide “culturally and educationally appropriate training for individual and family caregivers to support their ability to carry out the plan.” Again, imagine the rule-making possibilities!

The bill purports to facilitate the creation of advance directives and care-planning consistent with patient values. Great. But what if the culturally appropriate, multidisciplinary care-giving team disagrees with the patient? Who prevails?

Not necessarily the patient. The bill specifically permits doctors to refuse to provide wanted end-of-life care based on their own “conscience,” if such refusals are allowed by state law.

End-of-life care is a crucial aspect of medical practice. And to be sure, problems exist in ensuring that all patients

receive optimal care. But do we really want doctors marching to the drumbeat of memos from the secretary of Health and Human Services?

A far less centralized approach—such as encouraging continuing medical education programs and public awareness efforts by the nonprofit sector—would surely improve end-of-life care, and far less intrusively than allowing government to transform dying into a public-sector regulatory growth opportunity. ■

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Outrage mounts over Belgium's euthanasia law and its toll on the country, continued from page 1

As of October 22, 2013, 43 professionals have risked their reputations by posting their names on the website. (See <http://www.euthanasiestop.be/why-euthanasia-stop.es>.)

A nurse, identified only as "A nurse working in Brussels," authored an article on the effect of euthanasia practice on nurses that is available on the website. "[N]urses do not always have something to say, or do not always dare to speak and express their thoughts," the nurse wrote. "They are afraid to contradict the doctor... they are afraid to go against the opinion of everyone, to lose their job or to even be penalized by bad work schedules or moral harassment from their colleagues." At one point, the nurse directly addressed doctors:

Do you know, dear doctors, how much your patients are suffering, when you only spend ten minutes a day at their bedside?...

You tell us [nurses] that there is nothing more to do, that no more medical treatment can be found for this patient and that, after a long terminal illness, you decide "to offer an easy death to him," with no pain, often not asking for his own opinion, sometimes even without consulting the rest of the family, and generally without even consulting [the] nurses who are concerned by this patient's illness and who have meanwhile often [gotten] closer to him. ["Should nurses in Belgium dare to speak out?," www.euthanasiestop.be]

One of the doctors whose name is posted on the website is Dr. Georges Casteur, the former medical director of a neurological rehabilitation center in Ostend, Belgium. He recently told a gathering in Quebec City, Canada, that the "strict" safeguards in Belgium's euthanasia law are not working. He said that studies have shown that one-third of the patients who were euthanized by doctors were not capable of giving informed consent to being killed and almost 50% of all the euthanasia deaths are not even reported to authorities. He further explained that pressure exerted by family members, heirs, health care providers and administrators lacking available hospital beds, can make it impossible for patients to make "free and unbiased decisions" to be euthanized. [Canada NewsWire, 10/10/13]

Recent cases go beyond "limits" of the law

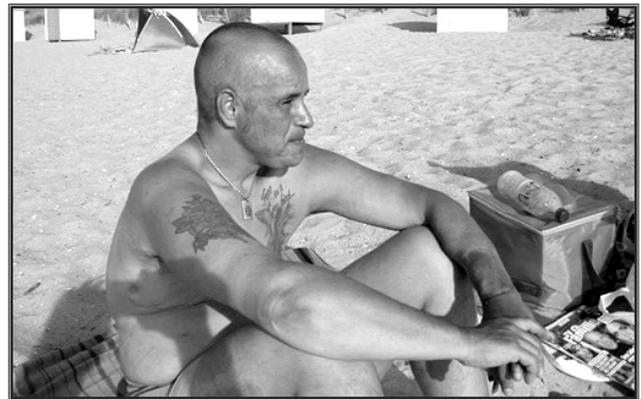
Belgium's euthanasia law states that citizens can have their lives ended if two doctors determine that they are suffering constant and unbearable physical or psychological pain resulting from an accident or incurable illness.

The identifying details and circumstances of most individual euthanasia and assisted-suicide cases, however, never become public knowledge, with the resulting dead patient simply ending up as a sterile statistic in an official annual report. But the particulars of recent tragic cases actually made headlines and caused outrage around the world—but not in Belgium.

Nathan Verhelst, 44, was euthanized on September 30, 2013 at a hospital in Brussels. A doctor there had declared him

qualified to be killed under Belgium's euthanasia law after sex-change operations failed to produce the male body Nathan expected. When he saw his body in the mirror, he was "disgusted." "I do not want to be... a monster," he told the Belgian newspaper *Het Laatste Nieuws* the night before he was given the lethal injection. According to the euthanasia doctor, Nathan was experiencing "unbearable psychological suffering." His death was filmed and broadcasted by a local TV station.

Nathan was born a girl, named Nancy, and grew up with parents that treated their only female child with utter contempt. "I was the girl that nobody wanted," he told the newspaper. "While my brothers were celebrated, I got a storage room above the garage as a bedroom. 'If only you had been a boy,' my mother complained. I was tolerated, nothing more." After his death, Nathan's mother confirmed his assessment of his early family life as a girl. "When I first saw Nancy, my dream was shattered. She was so ugly." "For me, this chapter is closed," the mother said. "Her death does not bother me. I feel no sorrow, no doubt or remorse. We never had a bond which could therefore not be broken." [*Het Laatste Nieuws*, 9/29/13, *Daily Telegraph*, 10/1/13, 10/2/13; Agence France-Presse, 10/1/13; *Daily Mail*, 10/2/13; *BioEdge*, 10/5/13]



Nathan Verhelst

Daily Telegraph columnist Dr. Tim Stanley summed up what was so tragic about Nathan's medicalized killing. "Nathan Verhelst was clearly a lonely man in desperate need of human sympathy and kindness" he wrote. "Yet that kindness came not in the form of love but a lethal injection. Is this the West's idea of humane behavior?" [*Daily Telegraph*, 10/7/13]

Not surprisingly, it was Dr. Wim Distelmans, Belgium's leading euthanasia advocate, who declared Nathan qualified for death under law and who gave him the injection—the same doctor who euthanized the deaf, but generally healthy, 45-year-old twins, Marc and Eddy Verbessem, last December. (See *Update*, 2013-1) They were depressed over the likelihood that they would go blind as a result of a genetic condition. For two years, they searched for a doctor willing to euthanize them

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Dutch report skyrocketing number of euthanasia and assisted-suicide deaths

The annual number of euthanasia and assisted-suicide deaths in the Netherlands has steadily increased since both practices became officially legal in 2002, with a huge jump in the number of cases reported in 2012.

According to the latest statistical report issued by the five regional euthanasia review committees charged with overseeing the country's doctor-prescribed death practices, a record-setting 4,188 euthanasia and assisted-suicide deaths were reported in 2012. That's a 13% jump over the previous year and more than double the number reported in 2003.

Between January 1 and December 31, 2012, there were 3,965 cases of active euthanasia and 185 cases of doctor-assisted suicide reported. In 38 cases, the death was the result of a combination of both. The vast majority of patients had some form of cancer (3,251), followed by patients with nervous system disorders (257) and cardiovascular diseases (156). There were also 42 patients with dementia and 14 with psychiatric disorders whose lives were terminated. Whether or not these patients were competent at the time of the death request or when their lives were terminated was not indicated.

Out of the total 4,188 induced deaths, the committees reported that there were ten cases where the doctor had not acted with "due diligence" as required by law.

Two of the cases involved patients with severe dementia and the problem of such patients giving informed consent to being killed. The ten cases were referred to health ministry inspectors, but no further information was reported. [Regionale Toetsings Commissies Report, 2012; DutchNews.nl, 9/24/13]

Based on the 2012 figures, nearly one in every 30 deaths (3%) nationwide is intentionally induced by doctors. Some say the jump in the number of deaths was due to the implementation of mobile euthanasia teams last year. These death squads travel to patients' homes, most often to give lethal injections to patients after their own doctors have refused to do so. [Daily Telegraph, 9/24/13; Daily Mail, 9/24/13]

The actual number of euthanasia and assisted-suicide deaths is far higher than the number released by the euthanasia committees since doctors do not always report all the deaths they have intentionally induced. Also, the official numbers do not include the many terminal-sedation deaths that occur—where patients are purposely rendered unconscious and all food and fluids are withheld until the patient dies from dehydration. Nor are the "life terminations without explicit request" (non-voluntary euthanasia deaths) or the accepted medical killing of disabled babies included in the reported statistics.

According to PRC legal consultant Wesley J. Smith, if you included the actual number of induced deaths, the euthanasia rate would be closer to 13% of all Dutch deaths, not the 3% that's been reported. Translated into U.S. terms, that would be 300,000 medicalized killings per year. [Smith, Human Exceptionalism Blog, *National Review Online*, 9/24/13]

Often the Dutch argue that there is no euthanasia "slippery slope" evident in the Netherlands, lest their country be criticized for stretching the law's boundaries and expanding the categories of patients doctors are willing to kill. But that claim is hard to justify when you consider the skyrocketing body count and the questionable cases that come to light. Most recently, the euthanasia death of an unnamed, 70-year-old woman was made public. The woman, who lived alone, was born with poor eyesight but went blind as she approached old age. Reportedly, it was the first time an otherwise healthy blind person was legally euthanized. But, she wanted to die and, as required by law, two doctors determined she was "suffering unbearably." According to Dutch health specialist Lia Bruin, the woman's case was "exceptional." "She was, for example, obsessed by cleanliness and could not stand being unable to see spots on her clothes," Bruin said. [DutchNews.nl, 10/7/13] ■

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with no success. Then they found Dr. Distelmans, who has received numerous awards and was declared a "hero of autonomy" for his "pioneering" euthanasia work in April 2012. [T. Mortier, Mercator.net, 10/4/13]

Another extremely tragic death that occurred late last year involved a woman who suffered with anorexia nervosa for 25 years. Referred to only as Ann G., the woman went to see a psychiatrist who was an expert on anorexia for help with her condition. Instead of the help she so desperately needed, the psychiatrist, Dr. Walter Vandereycken, sexually abused her—as he reportedly had done to other patients for years. Ann G. accused him of abusing her on national TV, but, instead of being quickly prosecuted, he was allowed to return to private practice. Ann G. was left distraught because she not only had to live with her anorexia but the memory of the sexual abuse

as well. A new psychiatrist gladly granted her wish to be euthanized. [BioEdge, 2/8/13; Mercator.net, 10/4/13]

The number of euthanasia victims will continue to escalate, especially since Belgium's Parliament plans to pass a law, at the urging of some doctors, to extend the right to be killed to children and those with Alzheimer's and other "diseases of the brain." [London Times, 10/6/13; Independent, 10/6/13]

According to Dr. Tom Mortier, "The Belgian medical profession has become judge, jury and executioner..." "The only argument for euthanasia which makes any sense at all in a humane society in the developed world is respect for autonomy," he added. "But after having been tested in Belgium's living laboratory, this starry-eyed notion stands condemned as a hollow fraud." [Mercator.net, 10/4/13] ■



News briefs from home & abroad . . .

- **Pennsylvania:** The town of Pottsville has been the center of controversy ever since Barbara Mancini was charged with assisting the suicide of her 93-year-old father, Joe Yourshaw, last February. While she was visiting her father, who was suffering from a series of end-stage illnesses and receiving hospice care at his home, Yourshaw asked Mancini, a nurse, to give him his prescribed bottle of morphine, which she did. When the hospice nurse arrived at the home, she discovered that he had overdosed on the drug and was not responsive. The hospice nurse called 911. When the paramedics arrived, Mancini told them that her father, who had previously signed a do-not-resuscitate order, did not want further treatment and wanted to die at home. A local police captain, who had responded to the 911 call, overruled her. Yourshaw was taken to the hospital, revived, given an antidote for the morphine overdose, then eventually given more morphine for his pain, and died four days later in the hospital. An autopsy was done, and “morphine toxicity” that complicated high blood pressure and heart disease was listed as the cause of death. According to the police captain’s report, the hospice nurse “told me that her client had taken an overdose of his morphine with the intent to commit suicide” and that Mancini gave him the morphine “at his request so that he could end his suffering.” [*Philadelphia Inquirer*, 8/1/13]

At a preliminary hearing on August 1, the hospice nurse testified that Mancini had asked Yourshaw’s doctor for more morphine a week before he died, but the doctor wrote a prescription for a lower dose than she had requested. Also, according to court papers, Mancini had told the authorities that her dad had asked for all his morphine so he could end his life, and she gave it to him. The judge ruled that there was sufficient evidence to charge Mancini with assisting her father to commit suicide. A gag order was also put into effect. [WNEP, 8/1/13] On October 10, another hearing was conducted. This one was on her lawyers’ motion to dismiss

the charges against her. That motion is still under consideration. [*Pittsburgh Tribune-Review*, 10/10/13]

The national assisted-suicide activist group Compassion & Choices has been waging a public campaign for a dismissal of the case and “to let prosecutors know they should respect these very personal and private decisions.” [*Patriot-News*, 8/13/13]

- **Minnesota:** A three-judge panel of the Minnesota Court of Appeals has ruled that the part of the state’s assisted-suicide law prohibiting advising or encouraging someone to commit suicide violates the U.S. Constitution’s free speech protections. Actually assisting a suicide, however, is still a crime carrying a 15-year prison sentence. [*Minneapolis Star Tribune*, 9/30/13; MPR News, 9/30/13]

The case before the court involved the 2007 death of Apple Valley resident Doreen Dunn, 57, who was not terminally ill, but suffered with chronic pain, insomnia, and depression. Originally, her death was ruled the result of natural causes. She actually died as a result of placing a plastic bag filled with helium over her head—the suicide method of choice of the national do-it-yourself assisted-suicide group Final Exit Network (FEN). An investigation of Dunn’s death resulted in a 17-count grand jury indictment against FEN and four of its “exit guides,” who advise clients about their suicide options and are present to facilitate their deaths.

FEN’s lawyer, Robert Rivas, argued that the state can prohibit “assisting” a suicide, but it is unconstitutional for the law to make “advising” or “encouraging” a suicide illegal, since those are simply acts of speech. A lower court judge had ruled that only the term “advises” unconstitutionally infringes on the right to free speech. Both Rivas and the Dakota County district attorney appealed the ruling. A further appeal to the state supreme court is expected.

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- **Australia:** Euthanasia advocates in Australia are not happy after sustaining a major defeat in Tasmania. On October 17, after more than 10 hours of emotionally-charged debate, the lower house of the Tasmanian Parliament defeated the latest euthanasia and assisted-suicide bill by a vote of 13 to 11. "The Voluntary Assisted Dying Bill" was sponsored by Tasmanian Premier Lara Giddings and Green Party leader Nick McKim. Giddings had campaigned hard for the bill, calling upon lower house members to "vote for the principle... vote for what you believe in." She called it a "tragedy" if the members who were in favor of the bill in principle but had problems with its details did not pass it so it could reach the next level of scrutiny in the upper house. But the bill was seriously flawed and wide open to abuse, a fact that the sponsors could not over-

come. [AAP, 10/17/13; Paul Russell's Blog, noeuthanasia.org, 10/18/10; BioEdge, 10/19/13]

- **New Zealand:** Labor MP Maryan Street withdrew her "End of Life Choice Bill" because of the concern that the expected euthanasia debate would become a political football in an election year and would distract from the party's other policies, deterring more conservative voters from supporting them. New Zealand Prime Minister John Key said that, while he supported the principle of voluntary euthanasia, his government would not adopt it as policy because there was no clear party consensus and many national parliament members do not support it. He also felt that Street's bill went too far. She plans to reintroduce it after the election. [*New Zealand Herald*, 10/16/13] ■

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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