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Patients Rights Council

Update

Intentionally ending patients' lives becomes real for California medical providers

When California's new assisted-suicide law was enacted on June 9, 2016, it posed a huge dilemma for many of the state's doctors and healthcare facilities: Do we actively engage in ending patients' lives or not?

For most doctors, their medical training had focused exclusively on saving lives, never on how to end lives. "I think everyone has that personal, ethical dilemma because we're not really taught in medical school to cause someone's death," explained Dr. Daniel Mirda, a member of the Association of Northern California Oncologists. [*Christian Science Monitor*, 6/3/16]

For Dr. Neil Wenger, director of the UCLA Health Ethics Center and a practicing internist, the prescribed-suicide law blurs what used to be a clear distinction for doctors. "We have

always, up till now, been able to say we will never hasten a death," he said. "Suddenly, that bright line is not so bright." The Hippocratic Oath, Wenger added, doesn't just say that physicians should not harm patients; it expressly forbids providing poison to kill patients. Personally, he said, it is unlikely he would ever prescribe lethal drugs because that would go against his oath to save lives. Dr. William Rajala, who has a hospice care practice in Ventura, CA, also said he will not help any patient to commit suicide. "For me personally, I think there are a lot of other options beside suicide." [*LA Times*, 6/6/16; *Ventura County Star*, 6/4/16]

But not all doctors see it that way. Dr. Lonny Shavelson—an emergency room physician for 29 years, the author of five books (one on assisted suicide),

and, most recently, a photo journalist—is a longtime assisted-suicide supporter. However, for the last two years, he's been working on a documentary on another topic, "gender fluidity." "I stopped doing medicine," he explained. "I wasn't sure if I would ever go back to it. Then this law happened." [*San Jose Mercury News*, 6/7/16]

So Shavelson seized the opportunity and opened up an assisted-suicide-only practice in a cottage office in the backyard of his Berkeley, CA, home. Thus far, it is the only assisted-suicide clinic in the state.

According to Shavelson's "Bay Area End of Life Options" website, for a fee, he will:

- advise doctors on how to address a patient's death request,

(continued on page 2)

Also in this Update

The Worst MDs Free to Be Suicide Doctors
Wesley J. Smith..... 3

Canada passes & enacts its "medical assistance in dying" law..... 5

Compassion & Choices loses big in NY court, but not in legislature...yet..... 6

Medical error is the third leading cause of death in the US..... 6

Only 5% of terminal cancer patients understand their prognosis..... 6

News briefs from home & abroad 7

NM Supreme Court rules assisted-suicide ban constitutional

The New Mexico Supreme Court has unanimously ruled that there is no "absolute and fundamental right" to doctor-prescribed suicide contained in the state's constitution and that the state's law against aiding or assisting another to end his or her life is, in fact, constitutional.

The case before the high court, *Morris v. Brandenburg*, was originally filed in district court in 2012 on behalf of two oncologists and a cancer patient by the New Mexico chapter of the ACLU and the assisted-suicide activist organization Compassion and Choices (C&C), formerly known as the Hemlock Society.

One of the plaintiff oncologists, Dr. Katherine Morris, had previously practiced in Oregon where she wrote prescriptions for lethal drugs for two patients under the state's assisted-suicide law. Aja Riggs, the patient plaintiff

with uterine cancer, had undergone aggressive treatment, and her cancer was, and is currently, in remission.

The plaintiffs had argued that what the doctors would practice would be "aid in dying," which, they claimed, is not the same thing as "assisted suicide." If the district court judge were to disagree, then the plaintiffs' backup argument was that New Mexico's assisted-suicide law violated multiple provisions of the state's constitution. The law had been passed by the legislature in 1963 and made "deliberately aiding another in the taking of his own life" a fourth degree felony.

On January 13, 2014, after conducting only a two-day hearing, District Court Judge Nan Nash ruled that competent, terminally ill patients have a "fundamental right" under

(continued on page 2)

Intentionally ending patients' lives become real for California medical providers, continued from page 1

- consult with patients who are considering assisted suicide,
- consult with patients who have asked for a lethal drug prescription, but whose doctors will not write the prescription, and
- consult with patients who want Shavelson to write the death-inducing prescription and be their "attending End-of-Life physician." [bayareaendoflifeoptions.com] (For more on Dr. Shavelson see p. 3.)

Health care facilities opting out

Hospitals and other health care programs and facilities have also had to face the dilemma of whether they will bring about the deaths of qualified patients. The new law stipulates that they, like licensed physicians, have the right to opt out of providing doctor-prescribed deaths.

As expected, all 48 Catholic or Catholic-affiliated hospitals and hospices have adopted policies stating that the facilities and their physicians will not engage in assisted suicides. That includes all facilities

that are part of the Dignity Health System and Providence Health & Services.

In addition, many secular hospitals statewide have exercised their right to opt out. To date they include:

- Arroyo Grande Community Hospital, San Luis Obispo County;
- Lompoc Valley Medical Center, Santa Barbara County;
- Cottage Health, 3 hospitals in Santa Barbara, Goleta, and Santa Ynez;
- Los Robles Hospital & Medical Center (1 of 6 Ventura County hospitals to opt out);
- Community Memorial Health System's 2 hospitals in Ventura and Ojai, as well as its network of clinics;
- Desert Regional Medical Center, Palm Springs;
- Eisenhower Medical Center, Rancho Mirage;
- JFK Memorial Hospital, Indio;

(continued on page 4)

What CA's Law Requires

- ◆ **To qualify for doctor-prescribed suicide, an individual must be:**
 - ◇ an adult,
 - ◇ diagnosed by 2 doctors as being terminally ill with less than 6 months to live,
 - ◇ mentally competent,
 - ◇ a California resident,
 - ◇ able to make an informed decision free of duress, fraud or undue influence by others, and
 - ◇ capable of self-administering and ingesting the lethal drug.
- ◆ **The individual must also:**
 - ◇ give his/her doctor 1 written death request that has been signed by the individual and 2 witnesses,
 - ◇ make 2 oral death requests at least 15 days apart, and
 - ◇ within 48-hours prior to taking the lethal drug, complete a "Final Attestation Form" of his/her intent to take the drug. (Form given to doctor *after* patient dies.)

NM Supreme Court rules assisted-suicide ban constitutional, continued from page 1

New Mexico's constitution to have a doctor provide them with the means to kill themselves. Since her ruling legalized doctor-prescribed suicide in only Bernalillo County, Judge Nash also permanently barred the state from prosecuting any doctor practicing in that county who engaged in "aid in dying." [Morris v. New Mexico, 2nd, District Court, D-202-CV, 1/13/14]

The state appealed the ruling. On August 11, 2015, the court of appeals overturned Judge Nash's ruling, finding that aid in dying is not a fundamental liberty interest under the New Mexico Constitution. [Morris v. Brandenburg, NM Court of Appeals, No. 33,630, 8/11/15]

The plaintiffs then appealed the case to the state supreme court, which heard oral arguments on October 26, 2015, and issued its ruling upholding the court of appeals opinion on June 30, 2016.

The unanimous decision, written by Justice Edward Chávez, was clear and to the point: "We decline to hold that there is an absolute and fundamental right to a physician's aid in dying and conclude that Section 30-2-4 [the assisted-suicide law] is not unconstitutional on its face or as applied to Petitioners in this case." [Morris v. Brandenburg, NM Supreme Court, No. S-1-SC-35478, 6/30/16, at 3. Hereafter cited as SC Decision.]

Further, they held,

[W]e agree with the legitimate concern that recognizing a right to physician aid in dying will lead to voluntary or involuntary euthanasia because if it is a right, it must be made available to everyone, even when a duly appointed surrogate makes the decision, and even when the patient is unable to self-administer the life ending medication. [SC Decision, at 31]

Moreover, the decision acknowledges that "end of life decisions," such as doctor-prescribed suicide, "are inherently fraught with the potential for abuse and undue influence" leaving some patients extremely vulnerable. [SC Decision, at 33]

The justices rejected the plaintiffs' contention that "aid in dying" is not "assisted suicide" and, consequently, does not come under the state's assisted-suicide ban. Based on the assisted-suicide law's "statutory language" that defines suicide as "the taking of one's own life," the justices held that "physician aid in dying falls within the proscription of Section 30-2-4 [the state's law prohibiting assisted suicide]." [SC Decision, at 15 and 18]

ACLU lawyers said they will now concentrate on getting the law changed in the legislature. Rep. Bill McCamley (D-Las Cruces) has formed a working group to come up with legislation to legalize doctor-prescribed suicide and plans to introduce the bill during the next January session. [Albuquerque Journal, 6/30/16] ■

The Worst MDs Free to Be Suicide Doctors

by Wesley J. Smith

There's an old joke that goes something like this:

"What do you call the student who graduates dead last in his class at medical school?"

"Doctor."

I bring up that old saw because of a recent story out of California, where assisted suicide has just been legalized. Lonny Shavelson—a Berkeley emergency-room doctor (who hasn't practiced medicine for two years), a long-time advocate of assisted suicide, and the author of the book *A Chosen Death*—made headlines with the announcement that he is opening a death-doctor practice. For a \$200 consultation fee, and \$1800 more if he is retained, Shavelson will evaluate and certify people who come to him—I refuse to call them his "patients"—as eligible for death, prescribe the lethal drugs, fill out the required bureaucratic forms, and presumably attend their deaths.

Think about this for a moment: Would anyone in their right mind trust *an ER doctor* to properly palliate the pain of terminal cancer or treat lethal congestive heart failure? Of course not! The ability to provide excellent care for terminally ill patients requires medical specialization and ongoing professional education in the particular disease. That is why no ER physician worth his salt would assume responsibility for the medical care of terminally ill patients outside of a temporary emergency-room or crisis context.

But death doctoring isn't about providing professional treatment for patients. Indeed, the suicide MD need not have any specialized training in terminal illnesses or be schooled in how to support such patients medically. He or she just needs to be the "attending physician," defined in the new California statute as a doctor having "primary responsibility for the health care of an individual and treatment of the individual's terminal disease."

Note that the law does not require the attending physician to be a certified specialist in the terminal disease. Since any patient can give any physician primary responsibility for providing healthcare for any condition, every licensed doctor—even the most inept or lackadaisical—can become the attending physician.

We saw this bottom-of-the-barrel phenomenon with Jack Kevorkian. As a pathologist, Kevorkian had not treated a living patient after attending medical school in the early 1950s. Yet, forty years later, he was lionized for assisting the suicides of about 130 despairing, and mostly not terminally ill, people who came to him for death by carbon

monoxide or drugs from his suicide machine. Kevorkian was ultimately convicted of murdering an ALS patient by lethal injection.

Kevorkian repeatedly said that his killings were justified because such patients fear dying from "choking on their own spit." He either didn't know or didn't care that ALS patients do not suffocate or choke to death *when they receive proper medical care from doctors who know how to ameliorate the symptoms of the disease*. Indeed, the founder of the hospice movement, the late Dame Cecily Saunders, stated that she had treated hundreds of ALS patients and not one died of choking.

This pattern of death doctors killing patients outside their areas of expertise has also been observed in the Netherlands. In *Dancing with Mr. D*, nursing-home doctor Bert Keizer writes of euthanizing a patient who he *thinks* has lung cancer, even though the diagnosis isn't certain. When asked, "Is he really suffering that badly?" Keizer responds angrily: "Is that for us to answer the question? All I know is that he wants to die more or less upright and that he doesn't want to crawl to his grave the way a dog crawls to the sidewalk after being hit by a car." The next day, as he is about to do the deed, Keizer thinks, "If anyone so much as whispers 'cortisone' or 'uncertain diagnosis,' I'll hit him."

Based on the information in his book, Keizer seems unaware that lung-cancer patients don't have to die like a dog struck by a car. Moreover, any doctor who would treat cancer pain *with cortisone*—an anti-inflammatory drug—should have his license stripped!

To make matters worse, the standard of practice required of death doctors is lower than that required of physicians treating and palliating the symptoms of diseases. For example, treating doctors can be sued for malpractice if they breach the "standard of care" required of all doctors in a particular medical situation. Not death doctors. All they have to demonstrate is that they acted in "good faith." Here's the relevant text from the California statute under which Shavelson and other death doctors will be operating (my emphasis):

443.14.

(c) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for

(continued on page 4)



Intentionally ending patients' lives become real for California medical providers, continued from page 2

- Hi-Desert Medical Center, Joshua Tree;
- Enloe Medical Center, Chico.

Many more hospitals have not as yet made a final decision whether to participate in the law. It's a complex decision, they say, with hospital boards being pressured from both sides.

But for those who have made the decision to opt out, their positions are clear. Dr. Alan Williamson, vice president of medical affairs at Eisenhower Medical Center, explained, "Eisenhower's mission recognizes that death is a natural state of life's journey, and Eisenhower will not intentionally hasten it." [*Desert Sun*, 6/9/16]

The policy adopted by Community Memorial Hospital System states: "CMHS will not permit any active interventions whose sole purpose is to intentionally cause a patient to end their own life." ["CMHA Aid-in-Dying Policy," 6/9/16]

Dr. Marcia Nelson, vice president of medical affairs at Enloe Medical Center, said simply, "We really think it's best for a patient to exercise this right outside of an acute-care hospital setting. Enloe doesn't see a role for itself in this." [*Chico News Review*, 6/30/16]

The huge Kaiser Permanente Health System as well as the Sutter Health System and the UCLA Health System are allowing induced deaths. [*LA Times*, 5/6/16]

Number of assisted-suicide cases predicted

California, with its large population, is expected to see an incredible number of prescribed-suicide cases. Dr. Lael Duncan, medical director of consulting services for the Coalition for Compassionate Care in California (CCCC), a group conducting training workshops statewide for medical professionals on implementing the new law, projects that the number of cases per year could be as high as 30,000 to 50,000 after the first year. [CCCC, End of Life Option Act Workshop, Sacramento, 5/31/16]

Matt Whitaker, the California director of Compassion & Choices—the old Hemlock Society group that ramrodded the law's passage—downplays the projected number of cases. He says that, in the first year, 34,000 people will begin the process of obtaining a lethal drug prescription, but only about 1,500 will actually use the drugs to kill themselves. [*Ventura County Star*, 6/4/16]

Website to track abuses & other problems with CA's law

Californians Against Assisted Suicide—a coalition of healthcare providers, disability rights and patient rights advocates, religious groups, and advocates for the poor that fought against the legalization of doctor-assisted suicide for many years—and the national group Patients

Rights Action Fund have set up a new website where Californians (and people in other states with legalized prescribed suicide) can share their stories of coercion, abuse, complications, and other problems that they or their loved ones experienced as a result of the assisted-suicide law. That website can be accessed at <http://patientsrightsaction.org/stories>.

Doctors challenge law in court

A lawsuit challenging the constitutionality of the new law under the state constitution has been filed by the Life Legal Defense Foundation (LLDF) on behalf of five physicians and the American Academy of Medical Ethics, which represents more than 600 California doctors and over 2 million patients. The five physician plaintiffs include two oncologists, a neurologist, and two palliative care and hospice physicians who are seeking to protect the rights of their patients.

They argue that the law violates the state's Equal Protection guarantees for those deemed terminally ill by removing criminal law, elder abuse, and mental-health protections that non-terminally ill individuals have. "The End of Life Option Act is irreparably flawed as it removes crucial protections from individuals who are most susceptible to depression, abuse, and coercion," said Alexandra Snyder, LLDF's executive director. [LLDF email, 6/8/16] ■

The Worst MDs Free to Be Suicide Doctors, from page 3

participating in this part, *including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the act*, providing information to an individual regarding this part, and providing a referral to a physician who participates in this part.

A "good faith" legal standard is a very low bar. For example, what if the death doctor mistakes a nonterminal condition for a terminal one and writes a lethal prescription? As long as that lethal mistake was made in good faith, under the provision quoted above, it would seem not to be actionable. Make the identical mistake as a treating doctor for the same patient, and prepare to meet your lawyer!

Advocates for legalizing assisted suicide assure us that such laws protect vulnerable patients. But that's a mirage. The

fact that doctors are free to prescribe lethally for people with illnesses outside their areas of medical specialization—and to do so secure in the knowledge that they are legally less accountable than if they were treating the same patient—demonstrates the folly of legalizing doctor-prescribed death. ■

Wesley J. Smith, JD, is a consultant to the Patients Rights Council and a senior fellow at the Discovery Institute's Center on Human Exceptionalism. His new book, *Culture of Death: The Age of "Do Harm" Medicine*, was just published by Encounter Books.



A divided Canada passes and implements its new “medical assistance in dying” law

Since February 2015—when the Canadian Supreme Court issued its sweeping ruling that struck down all statutes banning euthanasia and assisted suicide as being unconstitutional—the Canadian Parliament has been immersed in a highly contentious battle over how to formulate a federal law that will implement the high court’s overly broad ruling yet, if possible, still protect vulnerable patients.

On April 14, 2016, Canada’s new Liberal government introduced Bill C-14, a measure to amend the country’s criminal code to permit “medical assistance in dying” (MAID). It would be parliament’s job to pass it and make it law nationwide.

MAID is defined in the bill as including both euthanasia (the act of a “doctor or nurse practitioner” administering a lethal substance to a person who requests it) and assisted suicide (the prescribing or “providing” of that substance so that the person can self-administer it to cause death). Doctors, nurse practitioners, and other persons who “do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying” cannot be charged with “culpable homicide”—even if the doctor, nurse practitioner, or other person has a “mistaken belief about any fact that is an element of the [criminal] exception.” [C-14, §227 (1) & (2)]

In order to qualify for MAID, a person must have a “serious and incurable illness, disease, or disability” that is in an “advanced state of irreversible decline in capability” and is causing enduring, intolerable “physical or psychological suffering.” While the bill mandates no specific prognostic guess as to time before death—like six months or less to live—it does require that the person’s natural death be “reasonably foreseeable.” [C-14, §241.2 (1) & (2)]

The bill does not include mature minors or those with Alzheimer’s disease, other forms of dementia, or mental illness affecting judgment as candidates for legalized MAID.

Opposition

Parliamentarians who generally oppose

euthanasia and assisted suicide were understandably against the bill. They argued that the bill was loosely written, open to interpretation, and would be a recipe for widespread abuse of vulnerable patients.

But, perhaps, the most vehement opposition to the bill came from those who are in favor of MAID—especially from some members of the Senate. They claimed that the bill was far too restrictive and discriminated against those whose natural deaths are not “reasonably foreseeable,” yet they experience unbearable suffering, like those with progressive diseases that are not yet terminal. Moreover, those suffering with mental illness and dementia, they said, should be allowed to sign advance directives requesting MAID well before the onset of their incompetency. Senators also argued that mature minors, even if they are terminally ill and suffering, are ignored in the bill and, consequently, discriminated against.

The votes

After the House of Commons passed the bill by a vote of 186-137, the measure went to the divided Senate where it was hotly debated. The prevailing view was that the bill was far more restrictive than the Supreme Court’s decision, which did not require that individuals be terminally ill with their deaths “reasonably foreseeable.” Many legal experts supported the senators’ contention that, if passed, the law would be overturned by the high court for being unconstitutional.

The Senate added seven amendments to the bill. The main one removed the requirement that death must be “reasonably foreseeable.” The other six amendments were minor in comparison.

The bill was then returned to the House of Commons, which accepted the minor amendments but rejected the Senate’s main amendment expanding death eligibility beyond the terminally ill. The bill was now back in the Senate’s court.

Surprisingly, the Senate acquiesced and voted 44 to 28 to pass the bill without removing the “foreseeable death” requirement. On June 17, 2016, within hours of the Senate vote, the new law took effect.

As to the issues of advance death directives for dementia patients and MAID availability for minors, both houses of Parliament adopted an amendment authorizing the study of those and other issues within two-years time. A spokesperson for the Trudeau government said that the new law was a first step that can be expanded in the future. [*Globe & Mail*, 6/17/16; Canadian Press, 6/17/16; *Toronto Sun*, 6/17/16; BBC, 6/18/16]

Lawsuits filed

Within just days of the MAID law’s enactment, the British Columbia Civil Liberties Association (BCCLA) and Julia Lamb, a 25-year-old woman with the progressive neurodegenerative illness Spinal Muscular Atrophy, filed a legal challenge claiming that the new law is unconstitutional because it restricts MAID to those who are terminally ill. According to BCCLA’s head litigator Grace Pastine, “This legislation [MAID law] is clearly unconstitutional. It deliberately excludes a class of Canadians—those who are suffering with no immediate end in sight.” (The BCCLA was the group who filed the original case, *Carter v. Canada*, which resulted in the Supreme Court’s ruling in 2015 that the country’s laws banning euthanasia and assisted suicide were unconstitutional.) [BCCLA, Press Release, 6/27/16]

A second lawsuit is challenging the College of Physicians & Surgeons of Ontario’s (CPSO) requirement that doctors who conscientiously object to MAID must make “effective referrals” to other doctors who will terminate patients’ lives. The Coalition for HealthCARE & Conscience (CHCC) is asking the Ontario Divisional Court for a judicial review, which is a faster process than a normal court challenge. “In our view,” explained Larry Worthen, a Coalition member, “effective referral and participating in assisted suicide are morally and ethically the same thing.” But a CPSO spokeswoman said doctors must not abandon their patients or impede their access to assisted death. The CPSO’s MAID requirements are considered the official guidelines for prescribed-death practice in Ontario. [CHCC, 6/20/16; *Globe & Mail*, 6/22/16] ■

Compassion & Choices loses big in NY court, but not in the legislature...yet

Compassion & Choices (C&C), the national assisted-suicide activist group working to legalize doctor-prescribed suicide in targeted states, has been working overtime in New York. The courts have not been favorable to C&C's arguments for legalization, but the decision is still an open question in the legislature.

In May, a New York appellate court unanimously rejected arguments—put forth by the assisted-suicide group End of Life Choices New York (formerly Compassion & Choices of New York), three patients, and five doctors—that the laws banning assisted suicide violate the state constitution's Equal Protection and Due Process clauses. This was essentially the same argument C&C used in New Mexico that was rejected by that state's supreme court. (See page 1.)

The New York plaintiffs were appealing the October 16, 2015 case dismissal by Manhattan Supreme Court Justice Joan Kenney, who held that the U.S. Supreme Court had already ruled that New York's assisted-suicide statutes are constitutional in the 1997 case *Vacco v. Quill*. In their appeal request, the plaintiffs argued that Justice Kenney's ruling failed to address their claim that "aid in dying" is not assisted suicide and that the death practice is comparable to other legal medical practices such as terminal sedation, a practice in which a patient is rendered unconscious by sedation and all food and fluids are withheld until the patient dies from dehydration.

In its decision, the court of appeals' panel of four judges held that C&C's lawyers failed to prove their claims, including their contention that aid in dying is not the same thing as assisted suicide. The court not only upheld Justice Kenney's dismissal of the case but made her ruling even stronger by ordering it to be modified to say, "(a) NY Penal Law §§ 120.30 and 125.15 provide a valid statutory basis to prosecute licensed physicians who provide aid-in-dying, and (b) that to the extent that Penal Law §§ 120.30 and 125.15 prohibit a licensed physician from providing aid-in-dying, the application of that statute to such conduct does not violate the New York State Constitution..." [*Myers v. Schneiderman*, Appellate Division, First Department, Slip Op 03457, 5/3/16]

With the courts closing the door on C&C's legalization hopes, the group and its New York supporters are focusing their efforts in the legislature where prescribed-suicide bills have been defeated repeatedly since 1995. This year, when two different bills appeared to be languishing in committees, the sponsors merged them into one measure and began a renewed media and lobbying blitz to promote it. In May, the sponsors convinced the Assembly Health Committee to call for an unexpected hearing, taking opponents somewhat by surprise. The hearing on A 10059/S (the Medical Aid in Dying Act) was held on May 23, and the bill was passed, 14-11, by the committee. The measure has been referred to the Codes Committee. [*Legislative Gazette*, 5/24/16] ■

Medical error is the third leading cause of death in the US

According to an analysis published in the *British Medical Journal*, medical errors in the US may be responsible for over 250,000 deaths per year. Only heart disease and cancer are responsible for more deaths.

But, currently, the true number of deaths resulting from medical errors can only be estimated—usually underestimated—because there is no adequate way to track them nationally or internationally, wrote Johns Hopkins University School of Medicine professor Martin Makary and research fellow Michael Daniel, authors of the analysis. Discussions of the deadly errors often occur in limited and confidential settings, like internal review committees in hospitals where the errors occurred. The lessons learned from these reviews are rarely shared beyond the institution or department.

The authors suggest strategies for more accurate national statistics on fatal medical errors. Since death certificates simply ask for a cause of death, a more probing field could be added that asked "whether a preventable complication stemming from the patient's medical care contributed to the death." Secondly, hospitals could "carry out a rapid and efficient *independent* investigation to determine the potential contribution of error." (Emphasis added.) And finally, the analysts wrote, "Standardized data collection and reporting processes are needed to build up an accurate national picture of the problem." The current coding system is limited in its ability to capture most types of medical errors. [*British Medical Journal*, 5/3/16] ■

Only 5% of terminally-ill cancer patients understand their prognosis

A small fraction of terminally-ill cancer patients really understand their prognosis, according to a study published in the *Journal of Clinical Oncology*.

Researchers from Memorial Sloan Kettering Cancer Center, Cornell University, and Weill Cornell Medical Center asked 178 patients diagnosed with terminal cancer if they understood the seriousness of their disease and the less than six-month prognosis given to them by their doctor. They were also questioned about their stage of cancer and what their current health status was. Only five percent understood the gravity of their illnesses. "Results of this study," researchers wrote, "demonstrate how poorly patients with advance cancer understand their prognoses." Researchers also found that more recent and on-going prognostic discussions with their doctor improve patients' understanding of their conditions. [*Journal of Clinical Oncology*, 5/23/16]

One researcher, who was shocked by the results, said, "Our point is a lot of [patients] don't want to know, but they need to know basic information about the disease and illness and treatment options." [ABC News, 5/23/16] ■



News briefs from home & abroad . . .

- **Colorado:** Having failed multiple times to get bills that would have legalized doctor-prescribed suicide passed in the Colorado legislature, the assisted-suicide advocacy group Compassion & Choices (C&C) has launched an initiative campaign to put the issue on the ballot in November. Supporters will need to gather 98,492 valid voter signatures before August 8 to qualify the measure for the ballot. C&C is funding the effort and has already raised over \$5 million dollars and purchased almost \$3 million in TV air time for its campaign ads. The group is also providing all the needed technical expertise to put the measure, Initiative 145 (“The Colorado End-of-Life Options Act”), before the voters. The initiative is similar to the bills rejected by the Colorado legislature and is modeled after the Oregon doctor-assisted suicide law. There is strong opposition to the measure, especially from Not Dead Yet and other disability rights groups. [*Denver Post*, 7/5/16; *Aurora Sentinel*, 7/8/16; C&C website, 5/23/16]

In an email fundraising letter to supporters, C&C President Barbara Coombs Lee wrote, “Being successful in this venture will show the nation—our supporters and opponents alike—that our momentum is building, and we don’t plan to slow down anytime soon. Winning in Colorado could be a watershed moment for our movement and open the eyes and hearts of people all over the United States to our cause.” [C&C email letter, 6/14/16]

- **Massachusetts:** Twenty percent of the US elderly population have mental illness symptoms that are not part of the normal aging process and go unaddressed because of medical or emotional biases, according to Dr. Ricardo Mujica, a geriatric psychiatrist and medical director of New England Geriatrics. Since many doctors don’t have specialized training in geriatrics, they often miss or misdiagnose an elderly

person’s depression or mental illness. Also, when aged family members are irritable, a frequent sign of depression, the rest of the family may assume it’s just a normal part of aging, which it’s not. “[T]he combination of multiple medical problems, frequent admissions to a hospital, and moves from one place to another can alter moods and coping skills and make it difficult for older people to stave off depression and anxiety,” Mujica explained. “But if their mood is stabilized and they begin to feel better, it becomes easier for them to cope with their situation.” “We need to put the words ‘geriatric depression’ into people’s vocabulary,” he said. “It’s not a dirty little secret; it’s a disease that kills.” [*businesswest.com*, 7/12/16]

- **The Czech Republic:** The Czech cabinet has rejected a bill proposed by six deputies that would have permitted euthanasia in specifically defined cases. The final decision on the bill will be up to the Czech Parliament. The measure would allow people in hopeless health conditions to ask for death. A special commission would then decide whether each case meets the conditions for euthanasia stipulated in the bill. Agriculture Minister Marian Jurecka said he rejects the easy euthanasia solution for suffering. “I support help, loving care, solidarity and high-level palliative care,” he explained. “This is a solution.”

The government maintains that it is unsuitable for the Czech Republic to follow other countries where euthanasia is legal. Its preliminary position on the bill states, “In these countries, cases of clear misuse of euthanasia have been proved, aimed to vacate hospital beds, as well as cases of family members pushing for euthanasia for dubious reasons, and also unpublished cases of the failure to observe the conditions set by law.” [*The Prague Monitor*, 6/23/16]

(continued on page 8)

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News briefs from home and abroad, continued from page 7

- **The Netherlands:** Pressure on patients to request euthanasia and on doctors to perform it is a problem in the Netherlands. Prof. Theo Boer—a medical ethicist and a former member of one of the five Dutch regional euthanasia review committees charged with investigating reported euthanasia and assisted-suicide deaths for the government to see if each case complied with the law—says around 20% of the patients who request euthanasia are pressured to do so by family members. His estimate is based on his nine-year experience investigating such deaths. “What surprises me,” said Boer, “is that nobody is making any serious attempt to treat this as a problem.” “Sometimes it’s the family who go to the doctor,” he added. “Other times it’s the patient saying they don’t want their family to suffer.”

Boer’s observation regarding pressure exerted on doctors was confirmed by a survey published by the Dutch medical association KNMG. The survey found that 70% of doctors had experienced pressure to euthanize patients and 64% said the pressure had increased in recent years. KNMG policy officer Erik van Wijck commented, “We’ve been aware since the early 1990s that pressure is an issue.” [Dutch News, 7/3/15] So the association, which had staunchly pushed for euthanasia to be legalized in 2002, did so even though it knew that pressure on doctors to terminate certain patients’ lives would be a problem.

Dutch pediatricians are sometimes approached by parents wanting euthanasia for their seriously ill or disabled children. Under current Dutch law and practice guidelines called the Groningen Protocol, it’s permissible to euthanize babies up to the age of one as well as children 12 and over. Now Dutch Health Minister Edith Schippers has allotted 400,000 Euros for a study on euthanasia for the remaining children, ages 2 to 11. The Dutch Pediatric Association (NVK) has endorsed the idea. [BioEdge, 5/1/16]

Important Clarifications

Here at the Patients Rights Council (PRC), there have been a number of inquiries lately from supporters of the PRC asking if an organization called the Patients Rights Action Fund is part of, or affiliated with, the PRC.

The answer is "NO."

They are two entirely different organizations.

Callers have also asked if the PRC provides names of its supporters to the Patients Rights Action Fund.

The answer to that is also "NO."

The PRC does not sell, loan, trade or, in any other way, share information about supporters or others on the PRC mailing list to any other organizations or individuals.

- **Switzerland:** While the Swiss assisted-suicide industry is booming, palliative care is not. In fact, Switzerland is way behind other countries in providing comfort care, and there are very few hospices currently available. Essentially, most terminally ill and chronic pain patients with no hope of cure have two options: ask for assisted suicide or suffer. “In countries like the United Kingdom, there is a 30-year history of development of palliative care and people accept it. In Switzerland, palliative care came in very late, in the last six years,” said Dr. Steffen Eychmüller, a newly appointed professor of palliative care at the University of Bern—only the second such position in the country. [Swiss Info, 7/11/16]

Assisted suicide, on the other hand, has been practiced in Switzerland since the 1940s. Last year alone, the number of assisted-suicide deaths facilitated by EXIT, one of the largest suicide providers in the country, increased by 30%. Its membership, which has welcomed thousands of new members each of the last eight years, is around 96,000. Paid up members receive EXIT’s assisted-suicide services for free. [Swiss Info, 3/1/16; The Local, 3/2/16]

- **UK, Australia, and US:** National medical associations in the UK, Australia, and the US have been reassessing their opposition to assisted dying amid calls for neutrality by some of their members and outside induced-death supporters. Thus far, only the British Medical Association has taken a final vote. On June 21, members voted by a large margin (63% to 37%) to maintain its longstanding opposition to both euthanasia and doctor-prescribed suicide. [inews.co.uk, 6/21/16]

The American Medical Association’s Council on Ethical & Judicial Affairs will consider the neutrality issue and present its recommendations at the AMA’s Annual Meeting next year. [National Review, Human Exceptionalism Blog, 6/23/16] ■

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, POLST forms, futile care policies, health care reform, and doctor-prescribed death.

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Executive Director: Rita Marker, J.D.

Assistant Director: Jason Negri, J.D.

Consultant: Wesley J. Smith, J.D.

Editor: Kathi Hamlon

Patients Rights Council

P.O. Box 760

Steubenville, OH 43952 USA

800-958-5678 or 740-282-3810

www.patientsrightscouncil.org

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