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Update

Opponents attempt to stop implementation of two new assisted-suicide laws

In 2019, 20 state legislatures considered bills to legalize doctor-assisted suicide. Eleven states outright rejected those measures, and only seven states (Delaware, Massachusetts, Minnesota, New Hampshire, New York, North Carolina, and Rhode Island) still have bills that are considered technically alive. Sadly, two states passed their assisted-suicide measures, and the governors of both states signed the bills into law.

New Jersey

New Jersey was the first of the two states to pass its prescribed-death law—but only by the minimum number of votes required. Reportedly, sponsors of the measure engaged in some underhanded tactics in order to get the measure passed in the legislature. In the last committee hearing needed to pass the bill, Senate President Steve Sweeney, a sponsor of the bill, replaced two “no”

vote committee members with himself and another sponsor of the bill—both obviously “yes” votes. The measure would not have passed otherwise. [NJ.com News, 8/15/19]

New Jersey’s governor, Phil Murphy, signed the bill into law on April 12, 2019, and the law took effect on August 1, which meant that qualified patients could request assisted death, but, given the law’s initial 15-day waiting period, no patient could legally receive a lethal drug prescription until August 15.

However, on August 14, Superior Court Judge Paul Innes issued a restraining order to temporarily block the law from being implemented. His ruling came as a result of a lawsuit filed on August 8 by Dr. Yesef Glassman, a geriatrics specialist, who argued that the new law required the state’s Department of Health (DOH) and six other

state agencies to issue rules and regulations governing the new law. Neither the DOH nor any of the other specified state agencies had done so. According to court records, this lack of compliance with the law’s mandates rendered the

“entire process of death wholly and dangerously unregulated, leaving ambiguities and contradictions in statutory language, and omissions in definitions of practitioners’ duties to be resolved by medical practitioners’ individual interpretations in a vacuum of judicial cognizability.” [Glassman v. Grewal, Verified Complaint for Injunctive & Declaratory Relief, 8/8/19, p. 5]

In addition, Dr. Glassman argued that the law violated his right to practice medicine without breaching his fiduciary duty to his patients. The law

(continued on page 2)

Also in this Update

Medical diagnostic errors can be deadly..... 2

CA & WA reports issued on aided-suicides 2

Assisted-suicide leader says eliminate waiting periods Wesley J. Smith 3

News briefs from home & abroad..... 4

HHS reports expose serious deficiencies in hospice programs

Finding a good hospice program for terminally ill loved ones can be difficult these days since the information needed to determine whether specific hospices provide deficient care is usually not available to consumers. But two reports issued by the Health & Human Services (HHS) Office of the Inspector General (OIG) in July indicate just how important finding a good hospice can be for vulnerable patients.

According to the first report, “Hospice Deficiencies Pose Risks to Medical Beneficiaries,” over 85% of the 4,563 hospice programs surveyed nationwide had at least one deficiency, including poor care planning, inadequate patient assessment, and mismanagement of services. An alarming 20% had serious deficiencies in the quality of patient care. A serious

deficiency means “the hospice’s capacity to furnish adequate care was substantially limited or the health and safety of beneficiaries [patients] were in jeopardy.” According to the report, the number of hospices with serious deficiencies almost quadrupled (74 to 292) between 2012 and 2015.

Between 2012 and 2016, more than 700 hospices had severe complaints filed against them, meaning that the hospices were in “substantial noncompliance” with Medicare requirements or had more grievous complaints of “serious injury, impairment or even death to a [patient].” The number of hospices with severe complaints increased each year between 2012 and 2016—more than tripling in number (78 to 285).

(continued on page 3)

Medical diagnostic errors can be deadly

Congress has authorized that \$2 million be allocated this year to the US Agency for Healthcare Research & Quality (AHRQ) to study and define the scope of medical misdiagnoses.

Diagnostic errors can be a significant danger to patient safety. It is estimated that 1 in 20 US adults each year experiences missed, delayed, or incorrect diagnoses. Of the 12 million Americans affected by diagnostic errors, 4 million suffer serious harm. Postmortem research has found that those errors contribute to 10% of patient deaths, while medical record reviews indicate that they account for 6% to 17% of “adverse events” in hospitals. [AHRQ Blog, 6/13/19; Institute of Medicine, “Improving Diagnosis in Health Care,” 9/15]

It would seem that deaths associated with misdiagnoses might be even higher in states where doctor-assisted suicide is legal. Patients need a terminal diagnosis (6 months or less to live) to qualify for a prescribed lethal drug overdose to end their lives prematurely. But what if that diagnosis is off or wrong, and they took the fatal overdose and died before the diagnostic error was identified?

Assisted-suicide advocates would say that can’t happen because two doctors need to agree on the diagnosis. While that might be true, there has been no research done on just how carefully or critically that second doctor looks at the first doctor’s diagnosis before rubber stamping his or her approval. And there is evidence that both doctors have been very wrong in predicting that a patient only has six months or less to live.

(continued on page 4)

Reports issued on aided-suicide deaths

Washington State and California recently released their annual statistical reports on known physician-assisted suicide (PAS) deaths that occurred in 2018.

Washington State’s PAS law was enacted in 2009. Since that time, there have been 1,622 reported assisted-suicide deaths. According to the 2018 report, 267 patients were prescribed lethal drug overdoses by 158 different doctors, and 61 different pharmacies dispensed the drugs. Of those patients, 203 ingested the drugs and died, 29 did not take the overdose and died, and the ingestion status for 19 deceased patients is unknown—bringing the total number of known 2018 PAS deaths to 251. But the “alive or dead” status for 16 other patients who were dispensed lethal drugs is still unknown by the state. [WA DOH, “2018 Death with Dignity Act Report,” 7/19]

California’s 2018 PAS report shows that 452 patients received lethal drug prescriptions, written by 180 different doctors. Of those patients, 314 ingested the drugs and died. In addition, 23 patients, who received their drugs in 2017, took them in 2018 and died. That brings the total of drug induced deaths to 337. Fifty-nine patients (59) died of natural causes, while there remain 79 patients for whom their status is unknown by the state. California’s PAS law was enacted in June 2016. In just two years, 807 patients have reportedly died by prescribed drug overdose. [CA Dept. of Public Health, “California End of Life Option Act 2018 Data Report,” 7/19]

In both states, most PAS patients were white, had cancer, were college educated, and had some form of health insurance. ■

Opponents attempt to stop implementation of two new assisted-suicide laws , continued from p.1

also violated his right to practice his Orthodox Jewish beliefs by requiring that he participate in the assisted-death process by transferring the medical records of patients who want to die to doctors who will provide patients with fatal drug overdoses.

New Jersey Attorney General Gurbir Grewal quickly appealed to the state Appellate Division asking the court to immediately dissolve Judge Innes’ restraining order. On August 16, the appeals court denied that request, but said it would expedite a review of the issues submitted by the attorney general (AG) and Dr. Glassman’s lawyers. The AG also filed a request with the state Supreme Court asking that court to overturn the restraining order, but the high court declined to do so and deferred the case to the Appellate Division.

It didn’t take long for two Appellate judges to complete their expedited re-

view of the case. On August 27, they granted the AG’s motion and overturned the restraining order, ruling that the lower court “abused its discretion in awarding preliminary injunctive relief,” in part by failing “to consider adequately the interests of qualified terminally-ill patients.”

The court remanded the case back to the lower court for a scheduled October 23, 2019, hearing on the issues raised in Dr. Glassman’s complaint. [Glassman v. Grewal, Superior Court of NJ, Appellate Division, Order on Emergent Motion, 8/27/19]

Maine

Maine’s “Death with Dignity Act” (LD 1313) narrowly passed in the House on June 3, 2019, by a vote of 73 to 72. The Senate followed suit the next day by approving the measure by a margin of 19 to 16. On June 12, Governor Janet Mills signed the bill into law.

The new law is scheduled to take effect on September 18, but opponents of the measure are attempting to give voters the final say on whether assisted suicide becomes legal in Maine. The state has what is called the “People’s Veto Referendum,” which allows measures passed by the legislature to be placed on a statewide ballot for voters to approve or disapprove. In order to qualify for the ballot, opponents of the prescribed-suicide bill need to gather over 63,000 valid voter signatures before September 18. The question to be placed before voters is, “Do you want to reject the new law that allows terminally ill adults to use a legal process to end their own lives?”

If the needed valid voter signatures are obtained, submitted to the state, and officially verified before the deadline, the legalization question would appear on the March 2020 ballot, which will also be the Presidential Primary. ■

HHS reports on hospice, continued from p. 1

Hospices with at least one serious deficiency or one substantiated severe complaint were categorized as “poor performers.” For-profit hospices accounted for most of the poor performers (67%), while nonprofit hospices accounted for 21%. [OIG, “Hospice Deficiencies Pose Risks to Medicare Beneficiaries, July 2019]

The second report issued by the OIG described the types of serious deficiencies that were found in 2016—cases where patients’ poor care resulted in serious harm or unnecessary suffering. In one case, a patient with untreated pressure ulcers on both heels developed gangrene and had to have part of one leg amputated. In another case, the hospice allowed maggots to infest the area around where the patient’s feeding tube had been inserted. In still other cases, hospices failed to take action when patients were being abused by caregivers or family members. [OIG, “Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm,” July 2019]

The reports emphasized that these types of cases do not represent the majority of hospices. Nevertheless, they do point to real problems with hospice oversight and reporting.

The US Centers for Medicare & Medicaid Services (CMS) is responsible for making sure that hospices receiving funding for Medicare patients comply with Federal requirements and provide quality care for those patients. It relies on state agencies and accrediting organizations to perform onsite surveys and complaint investigations, but the requirements for reporting problems to CMS are very limited. Also, patients’ families often do not know how to effectively file complaints regarding hospice care. Reporting deficiencies to CMS, state agencies, or law enforcement is essential to patients’ wellbeing and safety.

The OIG has compiled recommendations for CMS to increase and improve its oversight of hospices. One recommendation is that CMS include hospice deficiencies, complaints, and reports on its website, Hospice Compare, so that patients and their families can have more in-depth information about the quality of care provided by different hospice programs. ■

Assisted-Suicide Leader Says Eliminate Waiting Periods

by Wesley J. Smith

Funded bounteously by George Soros money and backed by an enthusiastic and generally uncritical media, assisted-suicide advocates push their death agenda with a pack of lies.

First, they promise that protective guidelines will protect against abuse to ensure that only those with *no other way* to alleviate suffering but to take poison pills receive them—and then, only after a careful process.

Second, to convince cowardly medical associations to cease opposing legalization and assume a position of “studied neutrality”—whatever the hell that means—they promise that doctors will never be forced to participate in assisted suicide.

Here’s the problem. Those promises are not meant to be, you know, permanent. They are expedients to (choose your cliché) get the ball over the goal line, place the foot in the door, wiggle the camel’s nose under the tent, etcetera.

Once the law is firmly in place, we suddenly are told that the oh, so carefully crafted protective guidelines *are actually obstacles* to achieving “death with dignity.” And we are told that doctors’ right to refuse participation in suicide—known as medical conscience—discriminates against sick patients. It’s all such a scam.

Here’s the latest example in the ever-assisted suicide friendly *New York Times*, where “The New Old Age” columnist Paula Span complains:

But while the campaign for aid in dying continues to make gains, supporters are increasingly concerned about what happens after these laws are passed. Many force the dying to navigate an overly complicated process of requests and waiting periods, critics say. [NYT, 7/8/19]

And opt-out provisions—which allow doctors to decline to participate and health care systems to forbid their participation—are restricting access even in some places where aid-in-dying is legal.

See what I mean?

If you think these complainers are on the fringe of the suicide movement, think again. No less than Kim Callanan, the head of Compassion and Choices, the country’s most influential assisted-suicide advocacy organization (formerly more honestly known as the Hemlock Society), now suggests that waiting periods—one of the most important protective guidelines touted for years by C&C—should be tossed:

“There’s too many roadblocks in the existing legislation,” said Ms. Callanan, whose organization has long promoted that legislation. “They’ve actually made it too difficult for patients to get through the process.”... [NYT, 7/8/19]

Perhaps, Ms. Callanan proposed, aid-in-dying laws shouldn’t require waiting periods. “It takes people a long time to find a first doctor, to make an appointment, to find a second doctor, to find a pharmacist,” she said. “The process itself is a waiting period,” one often exceeding 15 days.

Indeed, the Oregon Legislature just passed a bill waiving the 15-day waiting period if the patient is expected to die imminently.

Whatever you might believe about the wisdom of enacting assisted-suicide laws, please understand that activists’ blithe assurances about strict protections are not meant to be a ceiling that permanently constrains the lethal practice. Rather, once a tipping point of popular acceptability is reached, the existing laws will become launching pads to enable a far broader facilitated suicide, and eventually euthanasia, authorization.

Those with eyes to see, let them see.

Wesley J. Smith, JD, is a consultant to the Patients Rights Council and a senior fellow at the Discovery Institute. His article is reprinted with his permission from the National Review, 7/8/19.





News briefs from home & abroad . . .

- **California:** In 2015, as the battle over a bill (End of Life Option Act) to legalize assisted suicide raged in the California legislature, critics of the measure argued that, with rising health care costs, many poor, terminally-ill Californians would find that the only health care treatment “option” they can afford is doctor-prescribed death. This was a particular concern for Latinos, who comprise nearly 40% of the state’s population. The United Way that year reported that around 50% of Latino households in California were at the poverty or near-poverty line.

But Compassion & Choices (C&C), the assisted-suicide activist group behind the bill, ramped up its push to get the bill passed by targeting Latino groups with “education” outreach programs in predominantly Hispanic areas, setting up Spanish-speaking telephone hotlines, and recruiting noted Hispanic spokespersons to assure Latinos that the bill would give them an added, much needed treatment option. According to then C&C California campaign director Toni Broaddus, “Our Latino communications media strategy heavily influenced the passage of California’s End of Life Option Act.” [C&C Press Release, 10/13/16]

A study conducted by the UCLA Center for Health Policy Research, published just last month, found that California Latinos still lack health care insurance and access to care—in spite of the Affordable Care Act (Obamacare). “This lack of coverage,” researchers found, “has important implications for the well-being of these California Latinos, because not only are uninsured Latinos in poorer health than those who are insured, but they also have less access to health care services”—meaning uninsured Latinos are more likely to forego needed care and treatment due to cost. [UCLA, “Still Left Behind: Health Insurance Coverage & Access to Care Among Latinos In California,” August 2019] In other words, doctor-assisted suicide, which is cheaper by far than care for a terminal illness, is for many Latinos their only “treatment” option.

- **Connecticut:** Connecticut State Senator Will Haskell and neurologist Robert A. Levine want to fix the state’s “broken” health care system by passing a law that would require adults who want to sign up for Medicare, Medicaid, or private health insurance to complete and sign a “universal” advance health care directive—a legal document listing the types of treatment patients would want or not want if they were not able to make their own treatment decisions in the future. “The directives would be on file at these agencies,” they wrote in the *Hartford Courant*, “and would also be a part of everyone’s electronic health record.” There is a need for a law to require directives, they said, because the use of cardiopulmonary resuscitation (CPR), respirators, feeding tubes, and other life support measures, keep patients with a poor quality of life alive, “causing emotional distress for their families while draining financial resources.” “Having universal advance directives would lower health care costs,” they wrote, “and guarantee that patients are always able to receive the care they desire.” Senator Haskell said he plans to introduce a bill mandating advance directives during Connecticut’s next legislative session. [*Hartford Courant*, 8/9/19]

Haskell’s bill, however, would likely violate federal law. The Patient Self-Determination Act, passed by Congress in 1990, requires hospitals and other health care facilities that receive federal funding to inform patients about advance directives when the patients are admitted to those facilities. If a patient wants to execute a directive, the health care facility can assist the patient to complete it. But, requiring the patient to do so is strictly forbidden.

- **Victoria, Australia:** In 2017, Victoria’s parliament passed the Voluntary Assisted Dying Act to legalize assisted suicide and euthanasia. The law took effect on June 19. It requires that patients wishing to end their lives obtain a death permit. Reportedly, 11 patients have been given formal permits. Over 300 doctors have completed assisted-dying specialist training to facilitate deaths. [racgp.org.au, 9/4/19] ■

Medical diagnostic errors can be deadly, *continued from page 2*

Data from Oregon’s annual assisted-suicide reports—issued by the Oregon Public Health Division every year since the prescribed-suicide law took effect in 1997—indicate that a significant number of patients took the lethal drugs more than one or two years after the prescription was written. Oregon’s report for 2018 (the latest one published) states, “11 people with prescriptions written in previous years ingested [lethal] medication during 2018.” [OPHD, “Oregon Death with Dignity Act - 2018 Data Summary, Fig. 2, p. 5, 2/15/19; emphasis added]

In 2016, the number was 19 people—19 patients whose doctors mistakenly told them they were terminal with less than 6 months to live, qualifying them for a legal, premature death when they really had years left to live. [OPHD, “Oregon Death with Dignity Act - Data Summary 2016, Fig. 2, p. 5, 2/10/17] ■

The Patients Rights Council is a human rights group formed to promote and defend the right of all patients to be treated with respect, dignity and compassion and to work with individuals and organizations to resist attitudes, programs and policies which threaten the lives of those who are medically vulnerable. To those ends, the PRC compiles well-documented and up-to-date information on a whole range of end-of-life issues, including health care advance directives, futile care policies, health care reform, and doctor-prescribed death.

The *Update* is available to the general public; suggested minimum donation is \$25.00 [U.S.] a year. Add \$3.00 for foreign postage.

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