The status of US assisted-suicide bills introduced in 2021

The legislative picture in 2021 is far different than last year at this time when state legislatures across the country shut down because of COVID-19, leaving bills dealing with doctor-assisted suicide to die in committees largely unheard. So far this year, 18 states have had new doctor-prescribed suicide bills introduced for their respective legislatures to consider. The measures fall into two categories: legalizations bills and expansion bills that amend a state’s existing, permissive, assisted-suicide law to allow more patients easier access to the death-inducing practice.

Legalization bills
In 14 of the 18 states with new bills—Arizona, Connecticut, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Nevada. New Mexico, New York, North Dakota, Pennsylvania, and Rhode Island—prescribed-suicide proponents introduced bills that would make it legal for doctors to prescribe lethal drug overdoses to patients diagnosed (or misdiagnosed) as being terminally ill, enabling those patients to intentionally end their lives.

As of May 20, legalization measures have been rejected in Arizona (HB 2254 & SB 1775), Connecticut (HB 6425), Indiana (HB 1074), Iowa (SF 212 & HF 475), Kentucky (HB 506), and North Dakota (HB 1415) due to inaction by committees and/or the measures failed to pass before officially set deadlines.

In addition, Minnesota’s two bills (SF 1352 & HF 1358) are identical bills introduced in both the state Senate and House. They are 2-year bills that failed to meet the deadline for passage in both chambers. They are technically dead for this year but can be brought up again in the 2022 session. Rhode Island’s measure (HB 5572) was not passed after a House Judiciary Committee hearing, but the committee recommended it be held for further study.

Legalization bills in the remaining states—Kansas (HB 2202), Massachusetts (S 1384 & H 2381), Nevada (AB 351), New York (A 4321), and Pennsylvania (SB 405)—are still alive in legislative committees.

So far, only New Mexico has passed its legalization bill. (See page 3 for more on New Mexico.)

Expansion Bills
Four states with existing assisted-suicide laws had expansion bills to consider in 2021. They are California, Hawaii, Vermont, and Washington State. All four bills would weaken or eliminate provisions in their doctor-prescribed suicide laws that supporters had claimed were “necessary safeguards” against abuse in order to convince legislators and voters to pass their proposed laws. Now, supporters claim that those “needed” safeguards are actually burdensome obstacles to a qualified patient’s

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Canada allows euthanasia for patients who are not dying

In 2016, Canada enacted a law permitting doctors to end the lives of patients if their natural deaths were foreseeable and they requested euthanasia or assisted suicide.

Then, in September 2019, a Quebec judge issued a ruling that effectively threw a wrench into the entire federal “Medical Assistance in Dying” scheme (also called MAID). The requirement that a patient’s natural death had to be foreseeable was too restrictive and consequently unconstitutional, the judge ruled.

Neither the Quebec province nor the federal government appealed the ruling. That meant the Canadian Parliament had to essentially come up with a new euthanasia law before the final deadline set by the court.

It took a while but, on March 17, 2021, the new euthanasia/assisted suicide bill (C-7) received Royal Assent and became law. The law greatly expands MAID access for more patients. Individuals must simply have a grievous and irremediable medical condition or disability to qualify for MAID. The foreseeable death mandate for all patients no longer applies.

Now, there are two pathways to an assisted death: one for patients who are near to their natural death and a more restrictive one for those who are not. People close to death no longer have to wait 10 days between their death request and their induced death. Patients not close to death would have to wait 90 days.

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Patients’ Rights

Everyday survival tips & other helpful suggestions

Part 2

This is Part 2 of a series excerpted from a new booklet by the same name recently published by the Patients Rights Council.

Beware of the POLST form

Today, more and more health care providers are having what is often referred to as “the conversation” or conducting “advance care planning” with patients. That focuses on what your health care wishes are. It is then recorded on a form with boxes checked to reflect what you do or don’t want in the future.

That form is called POLST (Physician Orders for Life-Sustaining Treatment) in many states. It goes by different acronyms such as POST, MOLST, MOST, etc. in other states.

It is generally a one-page, two-sided form printed on brightly colored paper. It has check boxes that are filled in by the physician, nurse, or other person designated by the facility. The form is then placed in the front of a patient’s medical record and becomes an immediate medical order.

Medicare pays doctors for having the conversation about advance care planning. This can take place at an annual wellness visit. But doctors aren’t the only ones who talk with a person and fill in the forms. In some places, the discussion with a person and the one who checks the boxes can include chaplains, social workers, and others, known as “facilitators.”

One facility in California developed a novel way to get more individuals to have a POLST form. Medical residents were paid a cash bonus for each form that was recorded for a discharged patient.

The items dealt with include whether one does or does not want CPR, whether a person wants “comfort care” only, whether one does or does not want antibiotics, whether one wants feeding, or whether one wants full treatment.

Many people don’t realize how broadly these terms can and are being interpreted. For example, “comfort care only” can mean that, if one develops an infection, they wouldn’t be treated for the infection but would be kept comfortable as the infection spreads. Such things as blood pressure medication and other common prescripts that a patient may be on can be withheld as long as the person is kept comfortable.

Most people don’t realize that, even if they are able to discuss their current medical condition, they may not be told that these immediate medical orders have gone into effect.

As the late Charles Krauthammer observed:

To offer government reimbursement to any doctor who gives end-of-life counseling – whether the patient asks for it or not – is to create an incentive for such a chat...[I]t is subtle pressure applied by society through a doctor. And when you include it in a health care reform whose major objective is to bend the cost curve downward, you have to be a fool or a knave to deny that it’s intended to gently point the patient in a certain direction, toward the corner of the sickroom where stands a ghostly figure, scythe in hand, offering release.

In fact, the only item on the form for which there needs to be an immediate order is that dealing with CPR. Having medical orders about the other topics addressed on the form is a convenience for care givers but a danger to patients.

If you are hospitalized, know whether you are considered an “inpatient” or an “outpatient”

If you or a friend or family member is on Medicare, it’s important to know if you are considered an “inpatient” or “outpatient” when you are in a hospital.

Even if a person stays in a hospital overnight, they might still be considered an “outpatient.” A patient on observation (“outpatient”) status gets the same care as one who is on admitted (“inpatient”) status. They are in a hospital bed, being treated by nurses and doctors and may even undergo surgery. Unless they ask, there is really no way to know what their status is.

Not knowing that status can cost a person thousands of dollars.

A person’s hospital status affects how much they pay for services. It may also affect whether Medicare will cover rehabilitation care they get in a skilled nursing facility following the hospital stay.

For example, a woman who had broken her ankle knew that Medicare would cover rehab care in a nursing home if she was admitted to a hospital for at least three days. But she didn’t know that, even though she had to have surgery on the ankle, had a rod and plate put in her foot, and stayed in the hospital for three days, she was considered to be an “outpatient.”

She was transferred from the hospital to a nursing home for rehab services. It wasn’t until she got home and received the bill for $15,000 from the nursing home that she learned that Medicare wouldn’t pay for the rehab since she had been considered an “outpatient.” She had to file for bankruptcy and go to live with her daughter.

To prevent such a situation, it’s imperative that anyone on Medicare understand what their status is if admitted to a hospital.

Know that hospice is a wonderful concept but that all hospices are not created equal

As originally instituted, the purpose of hospice was to recognize that where cure is not possible, care is provided. Hospice is to treat the entire patient by giving physical, mental and social support. And, most important, hospice is never to do anything to hasten death.

However, today, many hospices are not adhering to true hospice principles.

In the United States, insurance generally pays for six months of hospice care. Recently, there have been a number of reports of hospices overdosing patients with drugs for the purpose of hastening death. Such overdoses occurred as the six months stay approached which meant the hospice would not be getting any more insurance money.

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New Mexico legalizes assisted suicide

New Mexico has been targeted by activists for prescribed-suicide legalization dating back to 2009. This year, the pressure to pass the New Mexico End of Life Options Act (HB 47) was intensified by the financial backing, strategies, and lobbying efforts of the national groups Death with Dignity National Center (DWDNC) and Compassion & Choices (C&C), both Hemlock Society spin-off groups based in Oregon.

According to C&C’s website, HB 47 “includes landmark provisions that represent a clear path to increasing access to aid in dying.” [C&C News, 4/22/21] The bill allows advance practice nurses and nurse practitioners to replace doctors as lethally prescribing and consulting clinicians. Also, the measure streamlines the one waiting period to receive the fatal drug prescription to only 48 hours and mandates that medical providers who refuse to participate in an assisted suicide must inform patients and effectively refer them to someone who will provide the lethal drugs or to an entity that will assist in finding a willing clinician.

The bill first passed the New Mexico House this year on February 19 by a vote of 39-27. The Senate then passed the measure on March 15 by a margin of 24-17, but before amendments were added unanimously. The House subsequently approved the amendments.

One amendment removed a requirement—existing in all other state prescribed-suicide laws—that the death certificates for assisted-suicide patients be falsified by listing the cause of death as the patients’ underlying illness, instead of the actual cause of death: the lethal drug overdose.

HB 47 was signed into law by Governor Michelle Lujan Grisham on April 8. It will take effect on June 18, 2021.

So, what can you do?

If a friend or family member needs hospice care, be absolutely certain to thoroughly check out the hospice. If a primary care doctor is making the referral, ask that physician to explain what he or she knows about the hospice. Find out if the medical director is board certified in palliative care. Obtain a copy of the hospice’s written principles and policies. Make certain that food and fluids are provided, including tube feeding for patients who are unable to take food by mouth. Find someone who has had a close friend or family member in hospice care. Ask that person to describe the care that was received.

Once a loved one is in hospice care, be vigilant. Make certain that appropriate pain control is being provided. This means being given pain medication that is necessary to alleviate pain – not a toxic cocktail of morphine or other drugs to hasten death.

The status of US assisted suicide bills introduced in 2021, cont. from p. 1

right to a dignified death. All four expansion bills are 2-year bills.

Hawaii’s bill (SB 839) passed in the Senate, but the House failed to take action. The measure reduced the safeguard waiting period between patients’ oral death requests from 20 days to 15 days and eliminated it altogether if the patient was not expected to live for 15 days. It also would allow non-physicians (advance practice nurses) to facilitate assisted suicides and permit clinical social workers to conduct psychological evaluations if the patient’s judgment is in question. While technically dead for 2021, Hawaii’s measure will likely be brought up again in 2022.

Washington State’s bill passed the House but failed on the Senate floor. That bill reduced the waiting period from 15 days to only 72 hours between oral death requests. It also would allow non-physicians to practice assisted suicide. Like Hawaii’s bill, Washington’s can be heard again in 2022.

Vermont’s existing prescribed-suicide law is the only one in the country that explicitly requires assisted-suicide patients to be in the physical presence of their physicians when they make oral requests for death and when their doctors perform physical exams to qualify them as being terminally ill. Consequently, remote telemedicine visits are not currently allowed. The expansion bill (S 74) would eliminate the in-person death request requirement as well as the in-person physical exam mandate and allow the use of telemedicine instead. The bill would also do away entirely with the 48-hour waiting period between the last oral death request and the writing of the prescription for lethal drugs. Further, it would grant immunity from liability for anyone—not just a doctor—who is involved in an assisted-suicide case, as long as they are acting in good faith. The Vermont bill never got out of the first committee to which it was assigned and is dead for this year. Proponents said it will be taken up again in 2022.

California’s expansion bill (SB 380) is the only one that is currently still alive in 2021. It is progressing through the Democratic Senate with little opposition from legislators. Progress through the Assembly may not be as easy. The bill would reduce the 15-day waiting period between oral death requests to only 48 hours and requires doctors—even those who refuse to participate in the patient’s assisted suicide—to document the date of the patient’s first oral request in the individual’s medical record. The bill prohibits health care providers and facilities from engaging in false, misleading, or deceptive practices relating to information about and the refusal to practice assisted suicide and completely eliminates the sunset clause in the original law that would have repealed the law on January 1, 2026. If SB 380 were to pass, the assisted-suicide statute would be permanent, with no mandated review or evaluation by lawmakers on how the law is or is not working.

The fact that these four expansion bills in states that had been promised a certain level of safeguards by assisted-suicide supporters just to get the original laws passed is proof that a slippery slope toward ever increasing numbers of prescribed suicides truly exists.

NOTE: In the next issue of the Update, the final Part 3 of this survival tip series will include information on knowing where your doctor stands on doctor-prescribed suicide, what to do in advance for a natural disaster, and preparing for accidents. To obtain copies of the PRC’ s printed booklet, Everyday Survival Tips & Other Helpful Suggestions, please see the PRC’s contact information on page 4.
News briefs from home & abroad...

- **So far, 4 states issued reports on 2020 assisted suicide deaths:**
  - **Colorado’s End of Life Options Act** (CO-ELOA) was passed in 2016. The latest report is the fourth one issued by the state. In 2020, 188 patients were prescribed lethal drugs. That’s a 10% increase over 2019 figures. In 2020, 70 individual doctors wrote those prescriptions, and 23 individual pharmacists dispensed the lethal drugs overdoses. According to the Department of Public Health & Environment (DPHE), the agency that compiled the data, the reporting documentation submitted by doctors “may be incomplete.” Furthermore, the CO-ELOA “does not authorize or require the [DPHE] to follow up with physicians who prescribe aid-in-dying medication, patients, or their families to obtain information about the use of aid-in-dying medication.” [Colorado End-of-Life Options Act, 2020 Data Summary, 2/21.]

- **Maine’s Death with Dignity Act** (ME-DWDA) was passed in 2019. The state’s first full-year statistical report on the reported assisted-suicide deaths in 2020 contains essentially only one page of data. According to Maine’s Department of Health & Human Services (DHHS), 50 people (23 males and 27 females) “met the requirements” of the ME-DWDA. Of those, the DHHS could not find death certificates for 4 people, and “assumed that these patients are still alive.” Of the 46 with death certificates, 30 died by prescribed lethal drugs and 15 died from the underlying illnesses. One cause of death is unknown. It would be a sizeable understatement to say the Maine report is skimpy on data. [Death with Dignity Annual Report for Calendar Year 2020, 3/1/21]

- **Oregon’s Death with Dignity Act** was the first assisted-suicide law in the country. It took effect in October 1997 and is the model for all the other state laws. But, among those states, Oregon’s annual reports contain the most data. In 2020, 370 patients obtained lethal drug prescriptions. Of those, 223 took the drugs, in addition to 22 people with prescriptions from previous years, for a total of 245 deaths. Sixty-seven did not ingest the drugs and died from other causes. For 80 patients, the ingestion status is unknown. Since 1997, 1,905 have died from prescribed drug overdoses. In 2020, 142 doctors wrote 370 lethal prescriptions (1 to 31 per doctor). Only 3 patients were referred for a psychological evaluation. Once again, pain or concern about it was second to last on the list of reasons patients opted for death. Whether patients experienced significant drug complications was “unknown” for 173 people. [OR Death with Dignity Act 2020 Data Summary, 2/21]

- **Jurisdictions that passed or rejected euthanasia laws in 2021:**
  - In March, Spain’s parliament legalized both euthanasia and assisted suicide. The law will take effect in June. The Australian state of Tasmania legalized euthanasia in April with Royal Assent. It’s the third Australian state to so. In February, Germany’s highest court created a right to euthanasia that applies to all stages of a person’s life. This sweeping ruling has precipitated 2 parliamentary bills to implement the practice that will be voted on in June. In March, Portugal’s highest court ruled a euthanasia law that passed in January is unconstitutional because it was imprecise. A parliament committee in Latvia rejected a euthanasia initiative in March. In March and April, the National Assembly in France failed to pass two euthanasia bills.

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**Canada allows euthanasia for patients who are not dying, cont. from p. 1**

The new law also allows a patient near death to sign an advance assisted-death agreement with their medical provider that states they want to be euthanized on a specific date. If they lose their mental capacity before that date, the medical provider can go ahead with terminating that patient’s life at the pre-arranged time without the patient confirming their wish to die. The advance agreement is not an option for the patient who is not dying.

While not currently allowing euthanasia for patients suffering solely from a mental illness, the new law stipulates that these patients will have MAID access by March 2023 after a panel of experts studies that issue and recommends protocols and safeguards for the practice. But that’s not all. In a few weeks, a joint parliamentary committee will examine problems related to the first 2016 MAID law and review other unresolved issues, including whether euthanasia should be available for mature minors (under 18) and whether dementia patients should be allowed to sign advance euthanasia directives before they lose capacity.

Canada’s embrace of euthanasia has been overwhelming. In just three years—between 2016 and 2019—almost 14,000 people had their lives ended with medical assistance. And that’s before the new expanded law took effect!