



## Good news and bad news for patients

Hospice is well known for its holistic approach to providing terminally-ill patients with the overall care and effective pain and symptom relief (palliative care) they need, along with support for patients' families and loved ones. Recent research confirms palliative treatment's effective role in patient care, while health care cost-cutting seriously threatens hospice's availability for patients at the end of life.

### The good news

A study, recently published in the *New England Journal of Medicine*, found that cancer patients who were referred for palliative care soon after being diagnosed experienced greater quality of life and fewer depressive symptoms than if the referral was made later in the course of their terminal illness. Another finding—one that some found surprising—had to do with survival rates. The study divided 151 newly diagnosed lung cancer patients into two groups. The first group received standard cancer treatment; the patients in the second group received treatment as well palliative care within 12 weeks of diagnosis. Those in the second group lived approximately three months longer than those in the first group and rated their mood and quality of life significantly better than those who had received only the cancer treatment. [Ternel, et al., "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *NEJM*, 8/19/10; *The Age*, 3/3/11]

### The bad news

The results of an independent study, released by the National Hospice and Palliative Care Organization (NHPCO), indicate that two recent cuts to Medicare reimbursement threaten the financial viability of 66 percent of U.S. hospice programs, especially rural programs. Reimbursement cuts made by the Centers for Medicare and Medicaid Services

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## 2011 bills dealing with assisted suicide: Some already defeated, others still pending

So far this year, death-by-prescription advocates have had nothing to crow about. While they have introduced nine bills to legalize doctor-prescribed suicide in five states, five of those measures have already been effectively defeated. Their hopes rest with the remaining four bills that have not as yet been heard in committee. But, assisted-suicide advocates were not happy about seven other 2011 bills: two are pending, four died in committee, and—much to advocates' dismay—one passed and has been signed into law.

### Defeated measures

#### • *New Hampshire*

New Hampshire's assisted-suicide bill, HB513, was introduced on January 6, 2011, followed by a lively hearing in the House Judiciary Committee on February 28. Committee members killed it three days later by a vote of 15-1 and labeled the bill "inexpedient to legislate." Despite the committee defeat, New Hampshire legislative rules required that the bill be voted on by the full House. On March 16, the House overwhelmingly rejected the measure by a vote of 234-99.

During the Judiciary Committee hearing, the bill's co-sponsor, Steve Vaillancourt (R-Manchester), became agitated over questioning by a committee member. He shouted, "If it were up to me, I would say anybody should be able to end their life just like *that*," as he snapped his fingers. [*New Hampshire Union Leader*, 3/1/11]

#### • *Hawaii*

Hawaii is a state that has often been targeted for legislation to legalize assisted-suicide. Between 1998 and 2009, 24 bills were introduced, all of which met with defeat. This year, three more doctor-assisted suicide bills were introduced. SB803 and HB1383 were identical companion bills, both titled "Death with Dignity," and the third, HB1165, was similar to the others, but titled "Compassion in Passing." SB803, however, was the only bill that was heard in committee.

On February 7, after hearing 4½ hours of testimony, the Senate Health Committee voted unanimously to quash SB803 and held it in committee. The testimony given at the hearing—from dozens of accident survivors,

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**2011 bills dealing with assisted suicide: Some already defeated, others still pending, continued from p. 1**

health care providers, elder caregivers, and disabled state residents—was overwhelmingly opposed to the bill’s passage. [CNBC.com, 2/8/11; *Star Advertiser*, 2/8/11] While it is still possible that the Senate or House could vote to bring SB803 to a floor vote, that would be highly unlikely. It is equally unlikely that either HB1383 or HB 1165 will be heard in their assigned committees this year given the public’s strong opposition to SB803.

- **Montana**

After the Montana Supreme Court ruled in 2009 that there was no state statute explicitly banning doctor-prescribed suicide, two state senators began drafting competing assisted-suicide bills for this year’s legislative session. SB167, sponsored by Sen. Anders Blewett (D-Great Falls), would have legalized prescribed suicide, but with less restrictions than those contained in the Oregon and Washington laws. SB116, sponsored by Sen. Greg Hinkle (R-Thompson Falls), would have prohibited assisted suicide, and a second Hinkle bill, SB169, would have enhanced prison sentences for a “suicide predator” who aids or solicits another’s suicide. All three bills were heard in the Senate Judiciary Committee on February 9. All three were tabled by that committee. On the legislature’s web site, each bill is labeled “Probably Dead.” When Blewett was asked if he plans to bring back his bill later in the session, he indicated it would be unlikely. “That ship has sailed,” he said. [*Great Falls Tribune*, 2/21/11]

**Bills still pending**

- **Vermont**

Of all the bills introduced in 2011, assisted-suicide advocates are spending the most money and lobbying the hardest for the Vermont “Patient Choice & Control at the End of Life” bill. They see victory in Vermont as a springboard for victory in other New England states.

In 2010, the Oregon-based Death with Dignity National Center (DWDNC), through its political arm, Death with Dignity Political Action Fund, began preparing the way for “a full legislative campaign launch in January.” [DWDNC, 2010 Annual Report, 12/28/10] Part of that preparation involved financially supporting Peter Shumlin for governor last year. The victorious Shumlin had promised to champion prescribed-suicide legislation. DWDNC then pledged \$100,000 to the Vermont campaign to legalize Oregon-style assisted suicide. [*True North Reports*, 3/29/11]

Advocates had promised the bill would be introduced in January 2011, but, by February 1, there was still no bill. The House version, H.274, wasn’t introduced until February 17, and, the Senate bill, S.103, did not get introduced until March 29.

H.274 and S.103 have been referred to the House Committee on Human Services and the Senate Committee on Judiciary, respectively, but, as yet, neither has been scheduled

for a hearing. Human Services Chair Ann Pugh (D–S. Burlington) said there are no plans to hear the bill this year, and several Senate leaders, including Majority Leader Bill Carris (D-Rutland), do not support the bill. But Vermont’s legislative sessions are two years long, so advocates have the time and money to still drum up support. [*Burlington Free Press*, 2/18/11; *Boston Globe*, 2/22/11]

- **Massachusetts**

The Massachusetts assisted-suicide bill (H.2233) was filed by Rep. Louis Kafka (D-Stoughton) on January 21 and referred to the Joint Committee on the Judiciary on January 24. There has been no further action taken.

- **Pennsylvania**

Another Oregon-style bill, SB431, was introduced on February 7 and referred the same day to the Senate Judiciary Committee. No further action has been taken.

**Bills (apart from MT’s) that advocates did not like**

- **Idaho**

Last year, the advocacy group Compassion & Choices (C&C) began an intense campaign to convince Idaho’s residents, professional groups, and lawmakers that the state should join Oregon, Washington, and Montana and make assisted suicide a medical treatment because Idaho state law was unclear on the matter. In response, the 2011 Idaho Legislature overwhelmingly passed SB1070, a bill that explicitly made “causing or assisting” a suicide a felony under state homicide laws. The Senate vote was 31-2 for passage; the House concurred 61-8. On April 7, Governor C.L. Otter signed the bill into law. [AP, 3/28/11]

- **Connecticut**

In January, Proposed Bill 356—a bill to require a minimum prison term for the crime of assisted suicide—was referred to the Joint Judiciary Committee. Thus far, there’s been no further action taken.

- **Wyoming**

HB148 would have made assisted suicide a felony punishable by up to 20 years in prison. No action was taken in committee before the end of the 2011 legislative session.

- **Oregon**

HB2016—a bill to amend Oregon’s assisted-suicide law by requiring that suicide-requesting patients be referred for psychological counseling—was sent to the House Health Care Committee. No action was taken, so the bill is dead.

- **Washington State**

SB5378 would amend Washington’s law by mandating that “assisted suicide” be listed on the death certificate when such a death occurs. Currently, the deceased’s underlying illness must be listed as the cause of death. So far, the Senate Health Committee has taken no action on the bill. ■



## Doctor-Prescribed Suicide: Some Questions We Need to Ask

by Rita L. Marker

In states across the country, assisted suicide is being promoted as a choice that should be available—but only for adults, only in hard cases, and only under careful guidelines. Deceptively soothing words and phrases, like “death with dignity” and “aid in dying,” give the impression that what is at issue is compassionate care, greater personal autonomy and the right to be free of unwanted medical treatment.

But what is really at stake?

In 1994, Oregon voters approved the “Death with Dignity Act.” Since then, similar laws were proposed in twenty-two states. Each and every one failed until November 2008, when Washington State voters adopted a law virtually identical to that in Oregon.

Many people in Oregon and Washington, including those who voted for a “death with dignity” law, didn’t have a clue about its implications. No one could foresee that, rather than increasing choice, assisted suicide actually limits choice.

Today, pharmacies in Oregon and Washington dispense prescriptions, often accompanied by instructions such as, “Take this with a light snack and alcohol to cause death.” And, in Oregon, both private health insurance and state Medicaid pay for those prescriptions while, at the same time, they refuse to cover treatments that patients need and want, even though those treatments could extend life and alleviate pain.

When doctor-prescribed suicide becomes a medical treatment as it is in Oregon and Washington, it is only one among many options for the treatment of certain conditions. But it differs in a major way from other treatments. It is

extremely cost effective. Let’s face it, providing pain alleviation can be expensive. Death, however, is cheap.

With concerns about health care costs, general financial uncertainty, and serious talk about limiting health care for the elderly currently reaching the boiling point, we all need to ask ourselves some serious questions before we embrace the idea of permitting prescribed suicide. In this atmosphere, do

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*Not every  
patient has loved ones  
who put the  
patient’s interests  
first.*

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we trust profit-driven insurance companies or government bureaucrats to do the right thing—or will they do the cheap thing?

And, there are other considerations as well.

We hear that assisted suicide would be a matter of choice. We hear that it would be an option made available only to those diagnosed with a terminal illness. But this option of doctor-prescribed death would come at a time of great vulnerability in a person’s life. It’s a difficult, painful and confusing time. It’s a time when people are more susceptible to pressure or persuasion than ever. Are we absolutely sure that a patient’s choice would be free of pressure and coercion?

Most of us would do anything we could to protect our loved ones from pain or coercion. We’d treat them with

love and compassion, putting their interests first. But not everyone is blessed with loved ones like that. The sad truth is that sometimes even family members are motivated by greed or spite, instead of compassion and love.

If death by prescription becomes legal in additional states, how many people would lose their lives because of pressure or persuasion? How many elderly, vulnerable patients would worry secretly about becoming a burden on those they love? And, acting out of love, would they choose doctor-prescribed suicide to alleviate that burden?

Is that really an outcome we want for those we love the most?

There’s something else we should consider. That’s the reality that mistakes are made. We all make mistakes. Doctors make mistakes. Many of us know people who lived years after being told they would die within months. In Oregon, it is on record that people—who were told they had six months or less to live and were given prescriptions for lethal drugs by their doctors, but didn’t take the drugs—ended up living well beyond their doctors’ predictions. How many more would have lived longer but, out of fear, took the drugs that ended their lives?

That’s a mistake that can’t be reversed.

Do we really want to take chances with our lives and those of our loved ones? ■

*Rita L. Marker is an attorney and the executive director of the Patient Rights Council. She is the author of the book, Deadly Compassion, and has appeared on national and international TV and radio programs too numerous to list.*

## Washington issues 2nd annual report on doctor-prescribed suicide deaths

Between January 1, 2010, and December 31, 2010, 68 different doctors wrote prescriptions for intentionally lethal drugs that 40 different pharmacists dispensed to 87 patients in Washington State. Of those patients who received the death causing drugs,

- 51 ingested the drugs and died;
- 15 died without taking the drugs;
- 6 others died, but the state doesn't know if they ingested the drugs or died naturally; and,
- for the remaining 15 patients, the state has no clue if they are alive or dead.

These are the figures reported by Washington State's Department of Health (DOH) in its "2010 Death with Dignity Act Report," released on March 10, 2011. Washington's total number of reported assisted-suicide deaths for 2009 and 2010 now stands at 87.

Washington's 2010 statistical report is the second one issued by the DOH, but it is the first one that covers an entire year of assisted-suicide practice. The first official report, issued last year, covered less than ten months of 2009: from March 5 (when Washington's permissive assisted-suicide law took effect) to December 31, 2009.

The second annual report confirms trends that were seen in the first report. The overwhelming majority (94%) of patients who received death-producing drugs lived west of the Cascade Mountains. Most were "Non-Hispanic White" (95%) and most had cancer (78%). The majority were concerned about losing their autonomy (90%), not being able to engage in enjoyable activities (87%), losing their dignity (64%), and losing control of bodily functions (52%). A few were concerned about inadequate pain control (36%), being a burden on others (28%), and the financial implications of treatment (4%). A particularly troublesome trend was that only two patients (3%)

were referred for a psychiatric/psychological evaluation in 2010, down from three patients (7%) in 2009. [WA DOH, *2010 Death with Dignity Act Report*. Available at <http://www.doh.wa.gov/dwda>.]

### Oregon connection

Washington's assisted-suicide law is modeled after Oregon's 13-year-old law, and both states use virtually the same oversight and reporting system. That accounts for the similarities found in both states' annual reports. (For an overview of Oregon & Washington statistics, see the chart on page 5.)

As is the case in Oregon, Washington's oversight of doctor-prescribed death is seriously flawed. The state has no way of knowing the exact number of assisted-suicide deaths in a given year, a fact that Oregon officials have readily admitted. The state depends on doctors to honestly report their assisted-suicide cases to the DOH. But, if a doctor does not report a case—perhaps because he or she violated the law in some way—there is no procedure to alert the state that the case exists, and, even if there were, the DOH has no authority or funds to investigate.

### Recipe for abuse

The fact that Washington's DOH lost track of the status (including ingestion status) of 21 patients in 2010 should be alarming—especially considering that the DOH's deadline for data retrieval was February 9, 2011, well past the December 31 cut-off for 2010 deaths. The reason for the late deadline was to ensure that delayed patient documentation would be received and included in the 2010 report. In its first report on 2009 assisted-suicide patients, the DOH also admitted it had lost track of patients, 20 to be exact.

Furthermore, neither the Oregon nor the Washington laws requires that there be a disinterested witness present at the time in the assisted-suicide process that patients are most vulnerable—when the patient ingests the

lethal drugs. Consequently, there is absolutely no protection for patients who are being pressured to die by others or are being given the lethal drugs against their will or without their knowledge.

Washington elder law attorney Margaret Dore is concerned about the abuse risk—especially for elderly patients—inherent in the state's Death with Dignity Act. "Washington's act has significant gaps which render it a recipe for abuse," she wrote. "Washington's report, which does not even address whether administration of the lethal dose was voluntary, does nothing to alleviate this concern. The information provided is inherently unreliable." [<http://margaretdoreblog.com>, 3/11/11]

### When choice becomes no choice

According to Eileen Geller, R.N., president of the Washington group True Compassion Advocates (TCA), more and more concerned and overwhelmed patients, family members and friends are calling her office because state and federal budget cuts for elderly, caregiver, and disability services are effectively giving many patients no choice but to ask for assisted suicide. One call, she said, was from "a seriously ill, paralyzed woman who was discharged prematurely from a Seattle-area hospital and worried about being a burden to her family. She did not have financial resources for adequate care, so she requested doctor-prescribed death... because she felt she did not have any other real choices." Another call concerned "a depressed man with no health insurance" who requested assisted suicide because of "financial worries and pressure from family members."

"Assisted suicide in Washington," Geller explained, "is neither safe nor voluntary for those who feel coerced, can't afford proper health care, or are victims of unreported elder abuse." [TCA Press Release, 3/11/11] ■

## Reported Doctor-Prescribed Deaths in Oregon & Washington State

Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates.<sup>1</sup>  
 Figures are those reported by the respective states.

Oregon				Categories	Washington State		
1998 - 2008	2009	2010	TOTAL		TOTAL	2010	2009
401	59	65	525	Number of reported assisted-suicide deaths	87	51	36
Unknown <sup>1</sup>	Unknown <sup>1</sup>	Unknown <sup>1</sup>	Unknown <sup>1</sup>	Number of unreported assisted-suicide deaths	Unknown <sup>1</sup>	Unknown <sup>1</sup>	Unknown <sup>1</sup>
629	95	96	820	Number of reported lethal prescriptions written	150	87	63
??	55	59	??	Number of reporting doctors who wrote lethal prescriptions in a given year	??	68	53
Not Reported	Not Reported	15 [23%]	?	<b>Number of cases where the patient's status (living or deceased &amp; ingestion status) is reported as "unknown" by the state</b>	41 [47%]	21 [41%]	20 [55.5%]
76 [23.5%]	1 [1.8%]	6 [9.4%]	83 [18.7%]	Number of cases where prescribing doctor was present at the time of death	Not Reported	Not Reported	Not Reported
38 [9.6%]	0 [0.0%]	1 [1.5%]	39 [7.5%]	Number of patients referred for psychiatric evaluation	5 [6%]	2 [3%]	3 [7%]
				<b>Patients' reasons for requesting assisted suicide:</b>			
357 [89.9%]	57 [96.6%]	61 [93.8%]	475 [91.2%]	Loss of autonomy	104 <sup>3</sup>	60 [90%]	44 [100%]
347 [87.4%]	51 [86.4%]	61 [93.8%]	398 [87.3%]	Inability to do enjoyable activities	98 <sup>3</sup>	58 [87%]	40 [91%]
228 [83.8%]	54 [91.5%]	51 [78.5%]	333 [84.1%]	Loss of dignity	79	43 [64%]	36 [82%]
233 [58.7%]	31 [52.5%]	30 [46.2%]	294 [56.4%]	Lost control of bodily functions	53	35 [52%]	18 [41%]
152 [38.3%]	15 [25.4%]	17 [26.2%]	167 [36.6%]	Being a burden	29	19 [28%]	10 [23%]
95 [23.9%]	6 [10.2%]	10 [15.4%]	111 [21.3%]	Inadequate pain control or concern about it	35	24 [36%]	11 [25%]
11 [2.8%]	1 [1.7%]	1 [1.5%]	13 [2.5%]	Financial implications of treatment	4	3 [4%]	1 [2%]
				<b>Complications after lethal drugs were ingested:</b>			
19 [4.9%]	1 [1.7%]	1 [3.6%]	20 [4.5%]	Regurgitation	1 [3%]	0 [0%]	1 [3%]
0 [0.0%]	0 [0.0%]	0 [0.0%]	0 [0.0%]	Seizures	0 [0%]	0 [0%]	0 [0%]
1 <sup>4</sup>	0 [0.0%]	2 <sup>4</sup>	3 <sup>4</sup>	Patient awakened	2 [5%]	0 [0%]	2 [5%]
10 [2.5%]	1 [1.7%]	37 [57%]	11 [2.4%]	Cases unknown	9 [10%]	4 [8%]	5 [14%]
20	1	1	22	Reported incidents of doctor non-compliance with the assisted-suicide law	Not Reported	Not Reported	Not Reported
0	0	0	0	Penalties imposed for non-compliance with the assisted-suicide law	Not Reported	Not Reported	Not Reported

Notes:

1. The Oregon Department of Human Services (ODHS), the agency responsible for overseeing assisted-suicide practice, has acknowledged that it has no way of knowing if data provided by prescribing doctors are accurate or complete. The Pharmacy Dispensing Report simply asks for general information (i.e., patient & physician names and drugs prescribed) but contains no data on patient cases. Death certificates, by law, do not even indicate **drug overdose as the true cause of death. Washington's system of assisted-suicide data retrieval—from physician reports, pharmacy reports, and death certificates—is virtually identical to Oregon's.**
2. Since the Oregon and Washington reports do not identify the lethally-prescribing doctors, there is no way to determine the total number of doctors who wrote prescriptions beyond a year at a time. The same doctor could have written multiple lethal drug prescriptions for multiple patients over the time span since assisted suicide was legalized.
3. **The Washington report states, "Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent."**
4. The three Oregon patients (1 in 2005 & 2 in 2010), who did not die after ingesting the lethal drugs, regained consciousness and eventually died of their **underlying illnesses. While the OPHD lists the three cases under "Complications," it does not include them in the overall statistics and totals for assisted-suicide deaths.**

Sources:

Oregon Department of Human Services, **2010 Annual Report on Oregon's Death with Dignity Act**, 1/26/11. All 13 Oregon annual reports are available online at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>.

Washington State Department of Health, **2010 Death with Dignity Act Report**, 3/10/11. **Both Washington's 2009 and 2010 annual reports are available at:** <http://doh.wa.gov/dwdal>.



## News briefs from home & abroad . . .

- Diane W Meier, M.D., is a renowned expert in geriatric and end-of-life palliative care. She is the director of the Center to Advance Palliative Care at New York City's Mount Sinai Medical Center and the director of the Hertzberg Palliative Care Institute at the Mount Sinai School of Medicine. She also used to be a formidable advocate for legalized assisted suicide. She is no more.

On March 28, 2011, she addressed a medical group in Burlington, Vermont. In response to a question about the relationship between palliative care and “death with dignity,” Dr. Meier said,

I, as a young person, was strongly in favor of legalization of assisted suicide. I think I was somewhat naïve at the time, you know, kind of doctrinaire about my commitment to patient self-determination and patient autonomy. And as I got a bit older and had more experience taking care of patients and families, [I realized] that autonomy was not really relevant to the human condition. We are all parts of families and parts of communities and critically dependent on one another in ways that notions of self-determination and autonomy pretend don't exist. Bob Butler, whose photo I showed you, said to me when I was writing stuff in favor of assisted suicide that there's an old Chinese proverb: “Suicide reverberates for seven generations.” The harm to families when someone decides to leave, rather than having to leave, is substantial and has been understudied.

What's also very interesting is that the movement to legalize assisted suicide is overwhelmingly driven by the “worried well”—by people who are so terrified of the loss of control that illness and death, dying and death bring—that there's a sort of reaction formation: “Damn it, I'm gonna take control back” over something that's so terrifying. But, for millions of years, humans have lived and died in their families. And it's not that scary. It's pretty natural, like birth. And when you look at “What do sick people want?”—sick people almost always want to continue to live. And it took my experience with sick people—who, if it were me, I'd say, “I want assisted suicide”—and they still want to live. Overwhelmingly, people want to live, in spite of conditions that the “worried well” would think are intolerable.

I don't know how many of you saw the Bill Moyer's series “On Our Own Terms: Dying in America.” I don't know if you remember that patient with Lou Gehrig's disease whose wife was taking care of him and Moyers went back repeatedly, and the first time he said, “Well, if I'm in a wheelchair all the time, that's it, I'm outta here.” So, Moyers goes back six months later, he's fulltime in a wheelchair, he can't do anything for himself, and, “It's okay.” Then he says, “Well, if I have to get to a point where my wife has to

change me and bathe me and I can't take care of my own business, I'm outta here.” [Moyers] goes back six months later, that's exactly what he needs, and life is still worth living. Because people adjust, people are remarkably resilient. And life is precious, and your vision of what's worth tolerating changes.

And legalization of physician-assisted suicide in a society like ours, which is entirely driven by overwhelmed, overextended doctors chasing the dollar, is pretty scary—because the patients who might opt for this are the ones who really need thoughtful, extended conversations about what is motivating [them] to want to die at this point, and the differential diagnosis is long. And I can promise you that the overwhelming majority of doctors have neither the training nor the time to engage in that kind of careful discussion with seriously ill patients.

And I do believe that real access to palliative care that is timely, that is high quality, would essentially eliminate the need for that and the fear that drives people to vote for these ballot measures. [Video transcription provided by True Dignity Vermont. See [truedignityvt.org](http://truedignityvt.org).]

- According to a new report released by the U.S. Government Accountability Office, state-run adult protection agencies are in danger of being overwhelmed by the increasing number of elder abuse cases—cases that are complex and involve multiple types of abuse. [*NY Times*, 3/3/11] Along with physical and mental abuse, seniors are often the target for financial abuse and exploitation by family members, friends, and strangers. Elderly patients—consciously or unconsciously—say things all the time that should alert their doctors to the likelihood that these patients are being financially victimized. Unfortunately, doctors are not trained to pick up on the cues. A new educational program, however, is being introduced this year in 25 states, the District of Columbia, and Puerto Rico. Its goal is to teach physicians how to spot elderly patients at risk for this type of abuse. [*NY Times*, 3/2/11]

In Oregon and Washington where assisted-suicide is legal, elderly patients with even small estates are particularly at risk for mental and financial abuse. If heirs are impatient and want their inheritance sooner rather than later, they could pressure elderly patients with terminal conditions to request an early prescribed death. Moreover, since neither state's assisted-suicide law protects patients after they obtain the lethal drugs, it would not be difficult for greedy heirs to coerce patients to take the drugs or to surreptitiously administer them to patients.

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News briefs from home & abroad, *continued from page 6*

- Nick Klonoski, a 29-year-old Eugene, Oregon, resident, was a popular college graduate with great potential. He also endured episodes of pain and fatigue that left him seriously depressed. Earlier this year, he ended his life using an apparatus called the helium-hood kit that he ordered by mail from a small company in Southern California run by a 91-year-old mother and her 57-year-old son. “The company that sells this kit obviously is purposely targeting a vulnerable group,” Nick’s grieving brother Jake said. “They made money off my brother, they gave him the tools to take his own life without knowing him, without knowing anything about him. For \$60, they blew his life apart,” he added. “It breaks my heart.” [*Register-Guard* (Eugene, OR), 3/20/11]

Helium suicide kits are nothing new. Derek Humphry—longtime euthanasia and assisted-suicide guru and co-founder of the Hemlock Society (now called Compassion & Choices)—actively promoted the helium hood method in *Final Exit*, his how-to-kill-yourself book first published in 1992. It is also the death method used by the assisted-suicide group Final Exit Network (FEN), a national group of volunteers who travel around the country assisting the suicides of its members. Two FEN “exit guides” are currently on trial in Phoenix, Arizona, charged with manslaughter and assisting the 2007 sui-

cide of Jana Van Voorhis, a 58-year-old woman who was physically healthy, but mentally ill. FEN volunteers are also under indictment in Georgia for another helium-plastic bag death.

- The Farewell Foundation for the Right to Die (FFRTD), a newly-formed, unincorporated, assisted-suicide organization in Canada, is challenging the country’s law that bans aiding and abetting another’s suicide. The group claims Criminal Code Section 241(b) is unconstitutional and arbitrary because it deprives citizens of their right to liberty and security and denies “the right of equality to persons with physical disabilities who lack the physical ability to end their own lives.” Apparently, FFRTD is attempting to set up the Canadian version of the Final Exit Network. Its purpose, according to a press release, is “to assist its members in ending their lives humanely.” FFRTD is also challenging a ruling by British Columbia’s Registrar of Companies that denied the group’s request for nonprofit status. [FFRTD, Press Release, 2/21/11; *Courthouse News*, 4/11/11]
  - The March 1, 2011, death of British assisted-suicide advocate Nan Maitland, 85, at the Dignitas clinic in Zurich, Switzerland, has caused quite a stir in the U.K. Maitland, a member of Friends At The End (FATE) and a founding
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Hospice: The good news & bad news for patients *continued from p. 1*

and the 2010 Patient Protection & Affordable Care Act are projected to decrease hospices’ Medicare profit margins to minus 11 percent (-11%) by 2019, with rural program margins estimated to decrease to minus 16 percent (-16%).

“With the entire hospice community—rural and urban, large and small, community-based and multi-state—being hit by the same devastating slope downward,” said NHPCO President J. Donald Schumacher, “there is no way for patient access to not be negatively impacted.” [NHPCO, Press Release, 3/7/11]

Death by prescription advocates are currently campaigning across the country to make the crime of assisted suicide into a legal medical treatment—a treatment that is far less expensive than hospice care. PRC legal consultant Wesley J. Smith, a trained hospice volunteer, warns that, if we allow patient access to hospice care to be diminished by these budget cuts, “...the dark alternative of doctor-prescribed death will become increasingly attractive to a society that will have indicated a pronounced willingness to abandon and isolate the most weak and vulnerable among us.” [Wesley J. Smith, Secondhand Smoke Blog, “Hospice under Financial Pressure as Advocates Push Assisted Suicide,” 3/14/2011] ■

*Leaving a legacy...*

Did you know you pay no estate taxes on gifts you make to the Patients Rights Council through your will?

A bequest to us can be a gift of a specific dollar amount, a piece of property, a percentage of your estate, or investments that have gone up in value (**so you won't have to pay capital gains taxes, either!**). You can also name the Patients Rights Council as a contingent beneficiary if someone named in your will is no longer living at the time of your death.

A bequest to the Patients Rights Council is easy to arrange, and can be as simple as including the following words in your will or trust:

I give, devise and bequeath to the Patients Rights Council, based in Steubenville OH, the sum of [insert amount here], to be used for its educational purposes.

The Patients Rights Council is a tax-exempt 501(c)(3) charitable organization. For more information, please contact Assistant Director Jason Negri at:

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member of the Society for Old Age Rational Suicide (SOARS), had arthritis but was otherwise healthy and active. In a note she left behind, she explained that she “feared” dying of old age, “the long period of decline, sometimes called ‘prolonged dwindling.’” [Michael Irwin, MD, World Right-to-Die News List, 3/4/11] In 2008, another FATE member—identified only as Chris—feared old age and died with Dignitas’ help. He said he wanted to die because he was “determined to end my life before my body fails me.” [SOARS Newsletter, 10/10]

- A nurse in India—left permanently brain damaged after being brutally raped and strangled in 1973—will be allowed to continue living thanks to a ruling handed down by India’s Supreme Court. Aruna Shanbaug, who some say is in a vegetative state, eats

by mouth, smiles when she likes the food, and responds to commands by making sounds. Yet Pinki Virani, a journalist who wrote a book about Aruna, asked the court to order the hospital to stop feeding her and giving her fluids because, Virani said, Aruna is already “virtually a dead person” and has the right to die.

Doctors and nurses at King Edward Memorial Hospital, where Aruna worked as a nurse and where she has received care for the last 38 years, passionately argued for the continuation of her care. (The quality of her care has been so good that Aruna, now 60, has never had even one bed-sore.) The court ruled that the hospital staff was effectively her family now and that Virani lacked standing in the case. [*Hindustan Times*, 3/7/11; *Times of India*, 3/8/11; *The Hindu*, 3/8/11; BBC, 3/11/11] ■

The Patients Rights Council (formerly the International Task Force on Euthanasia & Assisted Suicide) is a human rights group formed in 1987 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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