States face renewed efforts to legalize doctor-prescribed suicide in 2012

I t’s become almost a ritual. At the beginning of each new year, assisted-suicide advocates shake off defeats from the previous year and begin ramping up their efforts to make doctor-prescribed suicide legal in targeted states. So far in 2012, those efforts are mostly focused on Massachusetts, Vermont, Hawaii, and Montana.

Massachusetts

Since 1995, prescribed-suicide advocates have repeatedly tried to get a “Death with Dignity” measure passed in Massachusetts. The last time was in January 2011 when Rep. Louis Kafka’s bill (H.2233) was introduced and referred to the Joint Committee on the Judiciary where it has languished with- out any further action taken.

Now the Hemlock Society spin-off groups Compassion & Choices (C&C) and the Death with Dignity National Center (DWDNC) have joined forces in a campaign to place a measure similar to Kafka’s bill—titled Initiative 11-12, “An Act Relative to Death with Dignity”—on the state’s 2012 ballot in November. The initiative is modeled after the Oregon and Washington State laws that allow doctors to prescribe lethal drugs to adults diagnosed as having a terminal condition with six months or less to live.

Operating under the name Dignity 2012, Initiative 11-12 supporters were able to collect well over the 68,911 certified voter signatures required by the state. On January 4, 2012, Secretary of State William Galvin officially filed the measure with the state House of Representa- tives, the next step in Massachu setts’ convoluted process for ballot measures. The initiative—called bill H.3884 while in the legislature—was introduced and referred to the Joint Committee on the Judiciary, the same committee that last year took no action on Kafka’s bill. But this time around, the legislature has until May 2 to pass the measure, vote it down, or take no action. If the measure doesn’t pass or legislators take no action on it, initiative supporters would then have until early July to collect 11,485 additional voter signatures in order to place the initia- tive on the ballot. [The Republican 1/3/12; DWDNC Update, 1/20/12]

(continued on page 2)

Misdiagnoses common for some medical conditions

Some medical conditions are tricky to diagnose correctly, and that can lead to incorrect, ineffective, or detrimental treatment plans, according to a recent Wall Street Journal article. In fact, over the past five years, almost half of the malpractice claims regarding serious harm or death at Harvard University’s medical facilities were the result of diagnostic errors.

Certain conditions—such as lymphomas, cancers of the thyroid and salivary glands, chronic pulmonary disease, and coronary artery disease—are easy to misdiagnose. Test results may be inconclusive or pathologists and radiologists may misread the x-rays or scans. Also, doctors can simply get hung up on their own diagnoses and overlook evidence that would indicate a different illness or condition.

As many as 25 percent of the patients admitted to MD Anderson Cancer Center in Houston, Texas, with diagnosed cancers end up with different diagnoses and different treatment options. “When you get cancer, the first thing you may want to do is jump to get treatment with the first person you talk to,” said Thomas Feeley, vice president of medical operations at MD Anderson. “But taking the time to get a second opinion about the diagnosis you have and a careful evaluation of what treatments there are can be lifesaving,” he explained.

Patients should not hesitate to ask for a second opinion. They are entitled to take their medical records, all test results, pathology reports, and other information to a second doctor for review. Some large medical centers already have second-opinion services that patients can contact either on their own or with their doctor’s referral. [“What if the Doctor Is Wrong?” Wall Street Journal, 1/17/12]
But the campaign Dignity 2012 will encounter formidable opposition between now and the November election. The Massachusetts Medical Society's House of Delegates has voted by a large majority to reaffirm its policy opposing doctor-assisted suicide. “Physicians of our Society have clearly declared that physician-assisted suicide is inconsistent with the physician’s role as healer and health care provider,” said Lynda Young, M.D., the Society’s president. “At the same time,” she added, “we recognize the importance of patient dignity and the critical role that physicians have in end-of-life care.” [MMS, Press Release, 12/3/11]

In addition, the Massachusetts Alliance Against Doctor-Prescribed Suicide—a broad-based coalition of health care professionals, ethicists, disability rights advocates, and others—is working to ensure that the state remains “one where doctors save lives rather than end them.” [www.nodoctorprescribedsuicide.com] A new disability rights group, Second Thoughts, was also formed expressly to oppose the initiative. [www.second-thoughts.org]

**Vermont**

In 2011, with great fanfare and high expectations, Vermont prescribed-suicide advocates introduced two corresponding “Patient Choice & Control at the End of Life” bills: House bill H.274 and Senate bill S.103. Polls and other research conducted by the Death with Dignity National Center (DWDNC) and Compassion in Choices (C&C) all pointed to a landmark victory making Vermont the first state to pass a legislative bill—not a voter initiative—to legalize doctor-assisted suicide.

But that didn’t happen, in spite of the all-out support and lobbying efforts of Vermont’s governor, Peter Shumlin. Instead, both bills stalled in committees and were never heard. They were, however, held over for the 2012 legislative session.

So far, there still doesn’t appear to be a lot of interest in legalizing assisted suicide during the new legislative session. Instead legislators are focusing on more pressing issues, such as the budget, health care, and the damage left by Hurricane Irene. Even without those priority issues, needed support in the Senate for doctor-prescribed suicide has simply not materialized. [VT Public Radio, 1/23/12]

But advocates are persistently ramping up their lobbying efforts. “I’ve heard many bills be called dead for the session that come back to life,” said Governor Shumlin. [WCAX.com, 1/25/12]

**Hawaii**

After 10 years of repeatedly trying to pass bills to legalize doctor-assisted suicide in Hawaii, C&C’s president, Barbara Coombs Lee, and its legal director, Kathryn Tucker, are now claiming that the practice is already legal in Hawaii because of an obscure 1909 law enacted before Hawaii became a state. This statute, they say, allows doctors to prescribe lethal drugs to patients who are “hopeless and beyond recovery.”

But that is not how Hawaii Attorney General David Louie interprets the statute. “We do not believe that (Hawaii Revised Statutes) 453-1 provides authority for a physician to assist with dying,” the attorney general’s official opinion stated. “A physician who provided such assistance could be charged under Hawaii’s manslaughter statute.” [Honolulu Star-Advertiser, 1/17/12]

The part of the 1909 statute that C&C claims makes prescribed suicide legal states:

(W)hen a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person’s attendant, nothing herein shall forbid any person from giving or furnishing any remedial agent or measure who so requested by or on behalf of the affected person.” [HI Revised Statutes 453-1]

The attorney general’s opinion states that there is nothing in the statute’s legislative history that “supports a conclusion that the term [remedial agent or measure] includes lethal dosages of medications.” [Star-Advertiser, 1/17/12]

Hawaii attorney Jim Hochberg agrees. He researched why the 1909 legislature passed the statute and found a report by the Committee on Public Health that clearly stated the law’s intent. “The object of the bill being to give those afflicted with Leprosy, Asthma, and Tuberculosis the opportunity of availing themselves of any hope of relief which might be offered without subjecting those willing to render them aid to the indignities of prosecution or persecution.” The intent was clearly the relief of symptoms, not ending lives. At that time, leprosy, tuberculosis, and asthma were deadly diseases without cures. The 1909 law allowed non-physicians to treat sufferers with non-traditional herbal remedies. [Hawaii Free Press, 12/10/11]

Prior to the attorney general issuing his opinion, C&C announced that it was looking for a patient who would be willing to test the law by requesting a doctor to assist in ending his or her life. C&C already has a willing doctor, retired Kaiser physician Nathan Nathanson, who has offered to prescribe the lethal drugs. [Star-Advertiser, 10/23/11, 1/17/12]

Meanwhile, C&C still has three bills to legalize prescribed suicide pending in the Hawaii legislature. SB 803, HB 1383, and HB 1165, were introduced in 2011 but held over for the 2012 legislative session.

**Montana**

While a 2009 ruling by the Montana Supreme Court found that there are no state statutes or public policies that prohibit assisted suicide, C&C has still not been able to convince Montana doctors that they won’t be prosecuted if they prescribed lethal drugs to patients. To that end, C&C has announced that it wants to hire a “Montana Coordinator” who, among other things, will lobby the legislature for a bill to expressly legalize doctor-prescribed suicide. [idealist.org, 12/9/11]
Georgia Supreme Court overrules ill-conceived assisted-suicide law

Since Georgia had no law explicitly banning assisted suicide, state legislators passed a law in 1994 aimed at keeping Jack KeVorkian-type suicide assistants out of Georgia. This ill-conceived law stated that any person “who publicly advertises, offers, or holds himself or herself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose is guilty of a felony.” [GA Code §16-5-5 (b)]

In March 2010, four members of the Final Exit Network (FEN)—a national assisted-suicide group that dispatches “exit guides” to help its members commit suicide—were charged with violating Georgia’s law. FEN medical director Dr. Lawrence Egbert, regional coordinator Nicholas Sheridan, and exit guides Thomas Goodwin and Claire Blehr all played a role in the helium/plastic bag death of Georgia resident John Celmer, 58, who was cancer-free when he died. FEN is known for advertising its services on strategically placed billboards across the country.

Lawyers for the four defendants challenged Georgia’s law, charging that it violated the defendants’ free speech rights. The case ended up being heard by the Georgia Supreme Court.

The high court issued a unanimous ruling on February 6, 2012. “[We] conclude [Georgia Code] §16-5-5 (b) restricts speech in violation of the free speech clauses of both the United States and Georgia Constitutions,” the court held. “Had the State truly been interested in the preservation of human life, however, it could have imposed a ban on all assisted suicides with no restriction on protected speech whatsoever. Alternatively, the State could have sought to prohibit all offers to assist in suicide when accompanied by an overt act to accomplish that goal. The State here did neither.”

Further, the court said, “The State has failed to provide any explanation or evidence as to why a public advertisement or offer to assist in an otherwise legal activity is sufficiently problematic to justify an intrusion on protected speech rights.” [Final Exit Network, Inc. et al v. State of Georgia, S11A1960, 2/6/12]

PRC’s executive director, Rita Marker, called the court’s ruling “legally correct, but with tragic results.” Georgia, she warned, is now “fertile ground” for assisted-suicide advocacy groups. “And from the standpoint of vulnerable patients, this is not a good thing,” she said. [AP, 2/6/12] PRC’s legal consultant, Wesley J. Smith, agreed. “Georgia’s legislature had better remedy this fast or Georgia could become known as the Assisted Suicide State—all comers welcome….” [National Review, 2/6/12]

Reportedly, lawmakers are considering introducing legislation this session to address the problem. Meanwhile, all charges against the four FEN suicide facilitators have been dropped. [AP, 2/6/12]

Cancer specialists found to be lacking in palliative care skills

Cancer patients with undertreated pain should request a pain specialist consultation

A new survey of over 600 cancer specialists, published in the Journal of Clinical Oncology, found that oncologists aren’t really as good as they think they are at managing cancer pain. In fact, when given two hypothetical vignettes about a cancer patient who was experiencing pain, most of the oncologists came up with treatment plans that a real pain specialist considered “unacceptable.”

The study was modeled after a 1990 survey that asked cancer specialists to assess their knowledge, attitudes, and practices related to pain management, also known as palliative care. In both the 1990 and 2011 surveys, oncologists rated their ability to relieve cancer pain as “fairly good,” while rating the pain management skills of their peers as being inadequate.

Comparing the data from both surveys, the authors of the 2011 study concluded that there has been disturbingly little progress made in oncologists’ pain treatment skills in the twenty-year span between surveys. “Additional efforts are needed to achieve meaningful progress,” they wrote. [Breuer et al., “Medical Oncologists’ Attitudes and Practice in Cancer Pain Management: A National Survey,” Journal of Clinical Oncology, 11/14/11]

In an accompanying editorial, Drs. Jamie H. Von Roenn and Charles von Günter maintain that inadequate training is the main reason for oncologists’ lack of pain management skills. They cite a 1998 survey by the American Society of Clinical Oncologists that found “serious shortcomings in the training and clinical practice of a large proportion of oncologists.” “Most oncologists,” they explained, “learn their pain management skills from trial and error.” But, there are excellent new educational programs in pain management and palliative cancer care, according to Von Roenn and von Günter. “If we are to provide patients with the care they deserve,” they wrote, “we must not just integrate training in pain management into every fellowship program, we must expect oncologists to practice what they learn.” [Editorial, Journal of Clinical Oncology, 11/14/11]

In the meantime, Dr. Brenda Breuer, lead author of the 2011 study, wants patients in pain to know that there is help available. “Patients need to know that there is such a thing as pain medicine and palliative care specialists. These are recognized specialties that you get board certification in,” she said. “Patients can ask for consults. That is the best advice I can give them.” [Health Day, 11/17/11]
When a patient’s wishes are ignored

By Margaret Walsh

Over the years, I’ve heard many end-of-life stories of betrayal, but NEVER thought I would witness one first-hand. Then my dear friend Bob (not his real name) had a massive stroke.

He was hospitalized and put on a ventilator. Within a matter of eight hours, the organ transplant team was in his room caressing the back of Bob’s mother and offering their services. Thankfully, her mother vehemently declined their “services,” but this was just the beginning of the horror.

Besides being my close friend, Bob and I used to work together on important social issues. He was an active defender of life (at all stages) and was particularly compassionate about the defenseless. In fact, he had just been to Rome with his boss to defend brain-injured patients against invasive and often irreversibly damaging medical procedures and tests. Ironically, just a few months later my friend would find himself in this type of situation.

After Bob was hospitalized, his family found a card that he had received from a doctor declaring Bob’s medical care wishes in the event he found himself in this type of situation. The card stated that he did not want an Apnea Test to determine brain death. It also stated that he was not an organ donor, and the transplant team was in position to harvest his organs.

I was heartbroken to see him so vulnerable. Moreover, I had been warned that certain members of Bob’s family were not open to any outside influence regarding his medical care. In fact, I was told by one close relative, “I don’t want to have to take care of him for the next 40 years.” I thought, “Did I hear that correctly? That can’t be possible coming from the very family my friend loved so dearly.”

I reminded the family about the card in Bob’s wallet that indicated the type of care he wanted, and they reassured me that they had already made a copy of it for his doctor. I was greatly relieved, but, while the card was instructive, it was not a legally recognized advance health care directive.

It was excruciating to see his family talking around him, sharing memories as if he were already dead.

Bob was in a coma at this point. Seeing him reminded me of articles I had read and TV news stories I had seen about how comatose patients can hear even though they can’t respond. I decided to whisper in his ear that I was there to fight for him and that I would never give up.

Recent studies have shown that doctors’ prognoses for patients with traumatic brain injuries are often wrong. A few years ago, NBC’s Dateline aired a special about a young man who suffered just such an injury. The CT scans showed no signs of brain activity whatsoever. He was an organ donor, and the transplant team was in position to harvest his organs.

Luckily, this young man’s aunt was a nurse. She questioned the doctor’s diagnosis, so she ran her fingernail up the bottom of her nephew’s foot. He pulled his foot back. The doctor reassured the family that this was just a simple reflex and that the young man was in fact brain dead. Then the aunt performed another test and got the same type of reaction. This time, however, the doctor got nervous and halted the organ harvesting. Several weeks later, this young man appeared on national news programs telling his story about how he could hear everyone planning on donating his organs. He also expressed how frustrated and angry he was because he was alive, yet could not speak to defend himself.

As a result of seeing this show, I decided to run my fingernail up the bottom of Bob’s foot. Sure enough, he too pulled his foot back. Overjoyed, I immediately told his family and actually showed them his reaction. Their response mirrored the doctor’s first reply in the Dateline special: Bob’s reaction was just a reflex, and his brain was so severely damaged that there was simply no hope. Worst yet, they said that right in front of Bob! I couldn’t believe the apathy. As his family saw it, it was game over—even though his blood pressure was strong, and his heart and circulation were excellent.

Bob’s boss, who shared Bob’s concerns about the misdiagnosis of brain death and subsequent organ harvesting, contacted a leading neurological specialist on severe brain injury. This renowned doctor said there was still hope for Bob and offered suggestions on treatments to try. The treatment (continued on page 5)
Committees in Canada & UK issue reports advocating prescribed-death practices

Last November, a panel of six “experts” commissioned by the Royal Society of Canada (RSC) issued its report, “End-of-Life Decision Making.”

Only one of the experts was actually a member of the Royal Society, which describes itself as a Canadian organization of distinguished scholars, artists, and scientists. Most of those on the panel were acknowledged euthanasia advocates, as were those whom the panel consulted. The report is so biased in favor of legalized euthanasia and assisted suicide that Canadian ethicist Margaret Somerville called it an “unabashed pro-euthanasia manifesto.” [Montreal Gazette, 12/7/11]

The report strongly recommends that both voluntary euthanasia and assisted suicide should be legalized and made available to all competent adults, even if they are not terminally ill. For Canadians, the panel wrote, autonomy is a “paramount value” that is the foundation for the “moral right” of “competent and informed individuals who have decided after careful consideration of the relevant facts, that their continuing life is not worth living…” [RSC, “End-of-Life Decision Making,” “Report in Brief,” 12/11, p. 18; hereafter cited as RSC]

The panel discounted slippery slope arguments against prescribed-death legalization. “The evidence does not support claims that decriminalizing voluntary euthanasia and assisted suicide poses a threat to vulnerable people, or that decriminalization will lead us down a slippery slope…to non-voluntary or involuntary euthanasia.” [RSC, “Executive Summary,” p. 2]

On January 5, 2012, the UK’s Commission on Assisted Dying (CAD) published its 417-page report on the legal status of assisted suicide. After more than a year of hearings and inquiries, the far-from-impartial CAD concluded “that the current legal status of assisted suicide is inadequate and incoherent” and that “it is possible to devise a legal framework” for those deemed to have a year or less to live to safely “be assisted to die.” [CAD Report, 1/5/2012, pp. 19-20]

CAD’s stand on assisted suicide came as no surprise. The commission was sponsored by Dying in Dignity (formerly the Voluntary Euthanasia Society), funded by author Terry Pratchett and businessman Bernard Lewis (both euthanasia supporters), and chaired by Lord Charles Falconer (a longtime advocate of assisted suicide). Falconer even handpicked the commission’s 11 members—nine of which were well-known backers of assisted suicide. [London Times, 1/8/12; Daily Telegraph, 1/5/12]

CAD’s bias was so palpable that 46 individuals and 40 organizations, all invited to testify by the commission, refused to do so. Included were the British Medical Association, the Royal Colleges of Physicians and Nurses, Motor Neurone Disease Association, British Institute of Human Rights, Disability Alliance, and the Patients Association, to name a few. [P.J. Saunders Blog, 1/4/12]

Like the report issued in Canada, the CAD report claimed, “It is difficult to see how assisted suicide could in any way lead to a slippery slope toward non-voluntary euthanasia…” [CAD, p. 318] Yet, Lord Falconer has admitted there is no induced-death system that is “completely water tight.” [Daily Mail, 1/5/12]

When a patient’s wishes are ignored, continued from page 4

…suggestions were rejected immediately. Thus began my friend’s slow deterioration and death.

It was excruciating to see his family talking around him, sharing memories as if he were already dead. Nothing was being tried. Everyone had surrendered. Rather than remain in Bob’s hospital room listening to his relatives laugh and discuss his pending death, I decided to leave. But before I left the ICU, one of the doctors approached me and said, “I know you really care about your friend. Because you are not family I’m not supposed to give you information, but after seeing your frustration, I wanted to let you know that there were several measures we could have taken for your friend—especially yesterday—but we are under strict instruction by his family to do nothing.”

To this day, even though months have passed since Bob died, recounting the happenings surrounding his injury and death still upsets me greatly. I cannot believe that he is dead and that he died the way he did.

But I’m compelled to use the example of his death to inspire others to make sure their medical wishes are ironclad through the use of a durable power of attorney for health care—more specifically, the Patients Rights Council’s Protective Medical Decisions Document (PMDD). It is crucial that everyone 18 or older execute such a legal advance directive now, prior to the onset of any debilitating illness or injury. The document enables an individual to choose a trusted family member or friend to make health care decisions in the event the document’s signer is unable to make those choices. This surrogate decision maker or agent will be empowered to see to it that the signer’s health care wishes are honored.

If only my friend, Bob, had signed a PMDD prior to his stroke....

Margaret Walsh is the penname used by an active supporter of the Patients Rights Council and its work. She is particularly committed to educating the public regarding the PRC’s Protective Medical Decisions Document (PMDD). The story about her friend’s death actually happened.

Editor’s note: For more information on the PMDD, please visit the PRC’s web site at: www.patientsrightscouncil.org (click on “Advance Directives”). To obtain a state-specific or multi-state PMDD packet, please contact the PRC at 740-282-3810 or 800-958-5678.
Articles and reports claiming that there is no ethical “slippery slope” associated with legalized euthanasia and assisted suicide have been in the news lately.

Usually the authors base that claim on the rate of euthanasia deaths in the Netherlands, the country with the most extensive experience with prescribed-death practices. One article concluded that, since the rate of reported voluntary euthanasia was 1.7% of all deaths in 1990, 2.4% in 1995, 2.6% in 2000, and back to 1.7% in 2005, “there is no evidence of a slippery slope.”

[Ottawa Citizen, 11/17/11]

Apparently the author wasn’t aware of the Dutch government’s 2009 Annual Report issued by the country’s five regional euthanasia review committees that revealed the number of reported euthanasia deaths in 2009 had jumped to 2% of all deaths, an unprecedented 13% increase over the number of cases reported in 2008. [2009 Annual Report, p. 2, online PDF version; NRC Handelsblad, 6/15/10] In 2010, the committees’ annual statistics showed the number of reported euthanasia deaths increased a whopping 19% over the figure for 2009— from 2,636 in 2009 to 3,136 in 2010, nearly double the number reported in 2006. [British Medical Journal, 9/17/11]

But the increased number of reported euthanasia and assisted-suicide deaths shouldn’t be the only standard for judging whether an ethical slippery slope exists. Equally important is whether accepting the premise—that death is preferable to life for a small group of patients under very limited circumstances—will inevitably lead to policies and practices which place more and more groups of patients at risk in the future.

Since 1973, the Dutch have openly allowed euthanasia and doctor-prescribed suicide under what they call “strict conditions.” In 2002, when those death practices were formally legalized, the conditions were codified into law. They include the following requirements: the patient must be competent, able to make a voluntary request for death after careful consideration, and be suffering unbearably with no possibility of improvement. In addition, only a physician can euthanize a patient or prescribe lethal drugs for a patient in accordance with “due medical care and attention,” and there must be no other reasonable alternative to the patient’s intractable suffering other than death. [“Termination of Life on Request and Assisted Suicide Act,” 2002]

For over 25 years, the Patient Rights Council (PRC) has extensively chronicled the evolution of Dutch euthanasia practice. (See www.patientrightscouncil.org/site.holland.) What the Dutch said would be a tightly secured and restricted law has ended up being so elastic that it’s been stretched beyond limit. To paraphrase PRC legal consultant Wesley J. Smith, Dutch doctors have gone from euthanizing the terminally ill to the chronically ill, to people with serious disabilities, to those who are emotionally and mentally ill, as well as infants born with serious disabilities. And calls for more euthanasia access for more people have become even louder in the last two years.

In 2010, 21 early-stage dementia patients were euthanized by lethal injection, calling into question their ability to make an informed choice and voluntarily request death. Also in 2010, the life of a 64-year-old woman with severe, late-stage Alzheimer’s was terminated even though she was unquestionably incapable of asking for death. The Dutch Medical Association (KNMG) argued that patients “in early (or late) stages of dementia...have equal recourse” under the euthanasia law. [British Medical Journal, 11/21/11]

The group Right to Die-NL (NVVE) has been conducting public meetings to encourage elderly people to consider the right to die even if they are in good health but fear the possibility of future dementia. [Daily Mail, 11/9/11] The strategy appears to be working. The pro-death group Of Free Choice (OFC) was able to garner more than 177,000 signatures in support of its proposal to allow the “self-chosen death” of anyone over the age of 70, especially if they are tired of living or feel there is nothing left to live for. The Dutch Parliament’s Lower House has agreed to debate the proposed law early this year. [Radio Netherlands, 1/6/12] According to OFC, there needs to be two laws: the existing euthanasia law that deals with unbearable suffering from a medical perspective—death-eligible suffering that the KNMG has already redefined to include minor ills like poor eyesight and fatigue—and a new “dying assistance” law that deals only with those 70 and older from a “humanity perspective.” [OFC, “Self-chosen death of the elderly,” 8/11, pp. 6-7] If OFC’s proposed law is ever enacted, it won’t be long before it’s expanded to include anyone who is depressed or despairing about life—regardless of age.

Meanwhile the NVVE is aggressively pushing for further expansion of the eligibility requirements in the existing euthanasia law. It claims that 80% of patients with mental illnesses and dementia are unjustly excluded from eligibility by that law. In addition, on March 1, NVVE will be initiating six mobile euthanasia teams that will make house calls to terminate patients’ lives if those patients’ regular doctors have refused to do so. These have-death-will-travel teams will be dispatched from clinics that only end lives, which advocates say will be modeled after Dignitas, the infamous Swiss suicide clinic. [Dutch News.nl, 11/16/11 & 11/30/11; Daily Mail, 12/7/11; Radio Netherlands, 2/6/12]

Given the well-documented history of euthanasia and assisted-suicide practice in the Netherlands, it’s unbelievable that anyone would claim “there is no evidence of a slippery slope.” Simply saying it’s so doesn’t make it so.

Kathi Hamlon is the editor of the Update and a policy analyst for the Patients Rights Council.
**Europe:** A resolution passed by the Parliamentary Assembly of the Council of Europe (PACE) is being called a major victory for those concerned about euthanasia promotion in Europe. On January 26, PACE approved resolution No. 1859 (2012) that states in part, “Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited.” According to PACE, this is the first time in decades that a European political institution has so unequivocally rejected euthanasia practice. The resolution was passed a year after the European Court ruled there is no right to euthanasia or assisted suicide under the European Convention. Gregor Puppinck, Director of the European Center for Law and Justice, said, “This resolution is a clear indication that the growing majority of Europeans is opposed to euthanasia.” He added that it will have a real influence on both the legislative and judicial processes in Europe, especially on the European Court of Human Rights case-law. [Parliamentary Assembly, Resolution 1859 (2012); Zenit, 1/26/12]

**Canada:** There are currently three high-profile cases winding their way through the Canadian judicial system. All three have the potential to profoundly endanger patients’ rights in that country. Two of the cases—Carter v. Attorney General of Canada in British Columbia (BC) and Leblanc v. Attorney General of Canada in Quebec—seek to have Canada’s law banning assisted suicide overturned. Both cases were brought on behalf of women with ALS (Lou Gehrig’s disease) who want help to end their lives. It is likely that these cases will eventually be heard by the Supreme Court of Canada. The third case, Rasouli v. Sunnybrook Health Sciences Centre, concerns Hassan Rasouli, 59. His doctors say he is in a permanent vegetative state, and, in their medical judgment, they are compelled to remove his ventilator so that he dies quickly instead of enduring a slow death. Rasouli’s family, however, refuses to give their consent to the removal, saying that his condition is improving and removing his life-support at this point is against his religious beliefs. Two lower courts have sided with the family, ruling that the doctors need to obtain consent. His doctors have appealed, and the Supreme Court of Canada has agreed to hear the case. [Canadian Medical Association Journal, 9/6/11; Vancouver Sun, 12/22/11]

**Permanent Vegetative State:** A study done on patients diagnosed as being in a vegetative state (PVS) found that 20% were actually consciously aware, meaning they were misdiagnosed. These findings mirrored data found in earlier studies using expensive functional magnetic resonance imaging (fMRI). But, in this latest study, researchers used the far less costly, widely available, and portable electroencephalography (EEG) technology that measures electrical activity in the brain. Researchers studied 16 PVS patients and 12 healthy control subjects. Three of the 16 patients “could repeatedly and reliably generate appropriate EEG responses to two distinct commands, despite (continued on page 8)

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**Things to think about**

The Patients Rights Council (PRC) deals a lot with end-of-life issues, and we encourage everyone to seriously consider the decisions that really matter, such as determining the type of medical care you want or selecting the person you would like to make health care decisions for you if you are ever incapacitated. Educating people regarding health care issues, particularly when they threaten the rights and lives of patients, is a major part of the PRC’s mission.

Our work is truly a partnership. The PRC operates completely on donations. Without YOUR support, our work protecting the vulnerable does not get done. That is why we also suggest that you consider making a planned gift to further our efforts. Many tax-advantaged financial tools can be used to support the PRC and our fight to protect patients against life-threatening policies and laws. For instance, you can

- make a tax-free gift from your IRA.
- gift appreciated securities to the PRC, which could cost you less than the tax deduction you would receive.
- make the PRC a beneficiary of your will, revocable trust, or retirement plan—costing you nothing during your lifetime.
- gift assets that you no longer need or want—perhaps a vacation home, land, or a life insurance policy.

For more information about these and other planned-giving vehicles, please contact your tax advisor and attorney. If you then decide to proceed and would like to discuss the possibility of a planned gift with us, please contact:

**Jason Negri, Assistant Director**

Patients Rights Council  
P.O. Box 760  
Steubenville, OH 43952  
Phone: 800-958-5678  
jnegri@patientsrightscouncil.org
being behaviourally entirely unre-
sponsive.” [Cruse et al., “Bedside de-
tection of awareness in the vegeta-
tive: a cohort study,” The Lancet, 11/10/11] “It doesn’t mean all vegeta-
tive patients are aware,” explained
senior researcher Dr. Adrian M. Owen.
“It’s only some. But when you think of
the number of patients that there are
around the world in this situation, it is
quite a lot,” he said. In the US alone,
it’s estimated that there are around
20,000 people in a vegetative state
and anywhere between 100,000 to
300,000 in the related condition called
minimally conscious state.
[Washington Post, 11/9/11; British
Medical Journal, 11/11/11]

- **Pain Control**: US researchers have
begun a clinical trial to test the effec-
tiveness of a gene therapy using the
body’s natural painkillers for patients
not helped by conventional drugs.

The hope is that a single injection of
the gene will relieve severe pain for
six months in patients for whom mor-
phine and other drugs either do not
work or cause unacceptable side-
effects. The therapy—proved to be
safe in an earlier 2011 study of cancer
patients with intractable pain—works
by using a modified virus to place the
gene into sensitive nerves under the
skin causing the cells to release the
natural painkiller enkephalin. Because
doctors inject the gene, they can tar-
get specific parts of the body rather
than using drugs that affect the entire
body. According to Dr. David Fink, lead
researcher at the University of Michi-
gan, “We have started with people
who are in pain from terminal cancer,
but the approach is applicable for in-
tractable pain from inflammatory con-
ditions, such as arthritis of the hip and
any number of other situations.” [The
Observer, 11/12/11]