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Update

Vermont lawmakers enact an assisted-suicide law devoid of patient protections

After years of trying, national and local assisted-suicide advocates finally got an assisted-suicide law passed in Vermont, a state demographically similar to Oregon. It wasn't easy, though. Since 1995, these activists persistently targeted the Vermont Legislature by introducing measures to legalize the death-producing practice. Up until this year's bill, all their efforts went down in defeat.

The original version of the 2013 bill (S.77), called "Patient Choice at the End of Life," was not much different than the previously defeated bills. But this time around, the battle was less about the content of the bill and more about the pressure on legislators to make assisted suicide legal at all costs.

Not only did the national assisted-suicide activist groups Compassion & Choices and the Death with Dignity National Center funnel significant sums of money and other support for professional lobbying efforts and TV ads to the local advocacy group Patient Choices Vermont, but Vermont Gov. Peter Shumlin—who vowed to make assisted-suicide legal during his election *and* reelection campaigns—exerted pressure on his fellow Democrats, who made up the majority in both houses of the legislature.

During the waning months of the latest legislative session, lawmakers who strongly favored doctor-assisted suicide were so determined to pass S.77 that they were more than willing

to compromise on the bill's provisions. That became immediately evident in the Senate when the original, 22-page, Oregon-style assisted-suicide measure was drastically gutted. The resulting one-page bill merely granted immunity from prosecution to doctors and family members if the patient took lethal drugs that were properly prescribed by the doctor. Gone were any of the illusory safeguards and reporting requirements of the Oregon law. But, in order for the bill to pass out of the Senate—the chamber with the most resistance to government-run prescribed suicide—supporters had to compromise. The strategy worked. The amended bill passed by a vote of 22-8.

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Assisted suicide's "collateral damage" evident in Oregon

Advocates often claim that doctor-prescribed suicide laws, like the one in Oregon, are safe for society as a whole because only a few patients each year use the law to obtain lethal drugs, and even fewer actually take the drugs to end their lives.

Their statistical claim would appear to be true if one only looks at Oregon's official reports on the annual number of assisted-suicide deaths—77 in 2012—reported by the doctors who facilitated those deaths. But, Oregon's overall, soaring suicide rate should make people pause and ask the question: Does a permissive assisted-suicide law for the relatively few carry with it the risk of collateral damage for the many?

Two recent government reports lend credibility to the concern that the assisted-suicide law actually affects far more than just the terminally ill.

The first report, released by the Oregon Public Health Division (OPHD) in September 2010, revealed that Oregon's suicide rate for all ages was 35% higher than the national average, with women age 45-64 showing a staggering 55% increase in suicide deaths between 2000 and 2006. [OPHD, *Suicides in Oregon: Trends & Risk Factors*, 9/9/10]

The second and most recent report, issued by the Centers for Disease Control and Prevention (CDC) on May 3, 2013, indicated that, between 1999 and 2010, Oregon's suicide rate for men and women aged 35-64 sharply increased by 49%, while the rest of the country saw a rise of 28%. And, according to the CDC, "suicide rates likely are an underestimate of the actual prevalence because suicides might be undercounted in the NVSS (National Vital Statistics System)." [CDC, "Suicide Among

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Maine's legislators reject prescribed-suicide bill

When Vermont lawmakers enacted their doctor-prescribed suicide law on May 20, 2013, assisted-suicide activists boasted that other targeted East Coast states would soon follow suit. One of those states, Maine, proved them wrong. By June 6, just over two weeks after Vermont's bill became law, both Maine's House and Senate had soundly defeated LD 1065, a bill that would have legalized death by prescription.

Like the Vermont bill, LD 1065 was an assisted-suicide bill that masqueraded as a measure for "end of life care." In fact, the use of ambiguous language to camouflage its intent was evident immediately in its title, "An Act Regarding Patient-directed Care at the End of Life." Also, like the Vermont bill, LD 1065 contained no real provisions to protect vulnerable patients. (See pages 1 & 4 for more on Vermont's law.)

Maine's bill would have allowed doctors to "order or deliver" drugs to end patients' lives as long as those patients—who could have had dementia or impaired judgment or been under pressure or coercion to choose death—signed an

"end-of-life care document." This unwitting, signed document stated that the patient had made an "informed decision"—after discussing his or her medical condition and treatment options with the doctor—"to accept care that is ordered or delivered by the physician that may hasten or bring about the patient's death." In addition, the physician would be required to sign a companion "physician document" that said, in part, "the physician is committed to provide care as directed by the [patient's] end-of-life document." If both documents were signed, the doctor would have immunity from civil and criminal prosecution, and from professional sanctions. [LD 1065, Sec. 1. 24 MRSA §2908 (3) & (4)]

Nowhere in the bill was state oversight mandated. Neither was the patient's self-administration of the lethal drugs. In fact, the ambiguous wording—that the death-producing "care" would be "ordered and delivered by the physician"—might have been interpreted as allowing doctors to give lethal injections. Luckily for patients, Maine's legislators were able to see through the bill's ambiguity. ■

Status of assisted-suicide bills that are still pending

Massachusetts: H.1998 was introduced on 1/22/13, just 2 months after voters defeated a ballot initiative that would have legalized prescribed suicide. This Oregon-style bill has huge loopholes that put patients at serious risk. It was referred to the Joint Committee on Public Health. No further action has been taken.

New Jersey: A.3328, another Oregon-like bill, was introduced last September and passed out of the Assembly Health & Senior Services Committee on 2/7/13. There has been no subsequent action taken. However, the prescribed-suicide group Compassion & Choices and the bill's primary sponsor are ramping up their efforts to advance the bill.

Hawaii: HB606, also patterned after the Oregon law, was introduced, passed its first reading, and was referred to committees on 1/22/13. No hearings or further actions have taken place.

Kansas: HB2108 & HB2068 are virtually identical Oregon-style bills. Both were introduced & referred to the House Health & Human Services Committee in January 2013. There's been no further action. Currently, the legislature is adjourned until January 2014.

Assisted suicide's "collateral damage" evident in Oregon, continued from page 1

Adults Aged 35-64 Years—United States, 1999-2010," *Morbidity & Mortality Weekly Report*, 5/3/13]

The soaring Oregon suicide statistics in both the OPHD and CDC studies do not include the reported assisted-suicide deaths over the same period. That's because Compassion & Choices (C&C), the activist group that facilitates the vast majority of Oregon's prescribed-suicide deaths, convinced the state—reportedly with hints of a lawsuit if the state didn't agree—to adopt the policy that deaths under the state's Death with Dignity law are not really suicides, even though patients clearly kill themselves by intentionally ingesting a lethal drug overdose. Also, while the Oregon law doesn't specifically prohibit assisted suicide being listed as the cause of death on the patient's death certificate, doctors usually, if not always, list the patient's underlying terminal illness instead of suicide. [*Oregonian*, 11/11/06; Right-to-Die email list, "What will it say on the death certificate," 10/17/06]

It's important to note that the OPHD's overall suicide report includes mostly data from 1991 to 2007 and the CDC's report spans years 1999 to 2010. Both include data during the time period that Oregon's assisted-suicide law has been in

effect. The law was enacted in October 1997, but the first annual report that was issued by the state was not published until 1999. The OPHD said at the time its general suicide report was released, "After decreasing in the 1990s, suicide rates have been increasing significantly since 2000." [OPHD, Press Release, 9/9/10]

So is there an unintended, yet inherent, message in Oregon's assisted-suicide law for those who may be physically healthy, but emotionally vulnerable? The statistics certainly point that way.

When a state approves a public policy that permits ending the lives of the terminally-ill who are suffering physically or mentally—or who just anticipate future suffering, as happens most often in Oregon—emotionally vulnerable individuals can interpret that as society's tacit approval for them to end their equally compelling suffering by committing suicide.

According to the OPHD report, over 70% of the suicide victims had "a diagnosed mental disorder, alcohol and/or substance use problems, or depressed mood" at the time of death. It wouldn't take much for the vulnerable to see dying as their best option—especially when the state calls suicide "death with dignity." ■

Washington surpasses Oregon in 2012 assisted-suicide deaths

Last year, the *Update* reported that Washington State appeared to be on the assisted-suicide “fast-track” with its rapidly increasing number of annual cases since the practice was legalized in 2008. The latest *2012 Washington Death with Dignity Act Report*, issued on June 20, 2013, confirms that observation once again.

This new report revealed an historic first for Washington: After only four years of legalized assisted-suicide practice, the state’s number of reported doctor-prescribed deaths (83) outnumbered those reported in Oregon (77) during the same time period. (Assisted suicide has been legal in Oregon since 1997—11 years longer than in Washington. (See *Update* 2013-1 for more on Oregon’s *2012 Death with Dignity Act Report*.)

Washington’s assisted-suicide body count has significantly increased each year. Between 2009 and 2010 it jumped 71%, followed by a 73% rise in 2011, and then a 84% leap in 2012. Likewise, the number of lethal drug prescriptions written each year has also dramatically increased. In 2010, there were 72% more written than in 2009, followed by a 84% increase in 2011, and a 85% jump in 2012.

According to the latest report, 121 individuals received prescriptions for lethal drugs. Of those, 83 died after ingesting the drugs, 18 died without taking the drugs, and 3 others died, but the state does not know whether they took the drugs or not. For the remaining 17 patients, the state has no clue whether they are alive or dead, since the Washington Department of Health has not received the required documentation on each patient’s status. Incredibly, the report also states that the status of two assisted-suicide patients in 2009, two in 2010, and two in 2011 “is still unknown.”

Ninety percent (90%) of the 2012 prescribed-suicide “participants” lived in Western Washington, west of the Cascade Mountains. Ninety-seven percent (97%) were white (non-Hispanic), 43% were married, and 82% had some college education. Most (73%) had cancer. At least one patient in 2012 had an alarmingly short relationship with his or her lethally-prescribing doctor: “0.3 weeks” or just 2 days. [Washington State Department of Health, *2012 Death with Dignity Act Report*, 6/20/13] ■

Reported Assisted-Suicide Deaths in Washington 2009-2012

Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates. ¹

Figures and percentages are those reported by the state.

Categories	TOTAL	2012	2011	2010	2009
Number of reported assisted-suicides	240	83	70	51	36
Number of unreported assisted-suicide deaths	Unknown ¹				
Number of reported lethal prescriptions written	374	121	103	87	63
Number of reporting doctors who wrote lethal prescriptions in a given year	? ²	87	80	68	53
Number of cases where the patient’s status (living or deceased & ingestion status) is reported as “unknown”	75	20	14	21	20
Number of cases where prescribing doctor was present at the time lethal drugs were ingested	12	5 [6%]	2 [3%]	2 [4%]	3 [8%]
Number of patients referred for psychiatric evaluation	13	3 [3%]	5 [5%]	2 [3%]	3 [7%]
Patients’ reasons for requesting death:³					
Loss of autonomy	277	94 [94%]	79 [87%]	60 [90%]	44 [100%]
Inability to do enjoyable activities	269	90 [90%]	81 [89%]	58 [87%]	40 [91%]
Loss of dignity	235	84 [84%]	72 [79%]	43 [64%]	36 [82%]
Lost control of bodily functions	161	56 [56%]	52 [57%]	35 [52%]	18 [41%]
Being a burden	141	63 [63%]	49 [54%]	19 [28%]	10 [23%]
Pain or concern about it	103	33 [33%]	35 [38%]	24 [36%]	11 [25%]
Financial implications of treatment	13	5 [5%]	4 [4%]	3 [4%]	1 [2%]
Complications from lethal drugs:					
Regurgitation	2	0 [0%]	1 [1%]	0 [0%]	1 [3%]
Seizures	0	0 [0%]	0 [0%]	0 [0%]	0 [0%]
Patient awakened	2	0 [0%]	0 [0%]	0 [0%]	2 [5%]
Other ⁴	1	1 [1%]	—	—	—
Cases unknown	17	3 [4%]	5 [7%]	4 [8%]	5 [14%]
Reported cases of doctor non-compliance with the assisted-suicide law	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Penalties imposed for non-compliance with the law	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported

Notes:

1. The Washington State Department of Health (WSDH), the agency responsible for overseeing assisted-suicide practice, has no way of knowing if data provided by prescribing doctors are accurate or complete. The Pharmacy Dispensing Report simply asks for general information (ie., 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.
2. Since the WSDH 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. This category was not included in the 2009, 2010, and 2011 annual reports.

Source:

Washington State Department of Health, *2012 Death with Dignity Act Report*, 6/20/13. Washington’s 2009, 2010, 2011, and 2012 annual reports are available online at: <http://doh.wa.gov/dwda/>.

Vermont lawmakers enact an assisted-suicide law devoid of patient protections, continued from page 1

What happened next was akin to a tennis match between the Senate and the House, with S.77 as the ball. When the gutted Senate bill arrived in the House for approval, the Human Services Committee immediately reinstated the Oregon language. After some more tweaking, the bill passed the full House on April 30 by a vote of 80 to 51. But, the bill that was hit back to the Senate's court was drastically different from the one it passed previously, so, once again, a compromise was reached enabling the bill to pass 17-13. Now back in the House's court, another compromise wedded both the Senate and House versions, which allowed the bill to pass out of the legislature before time ran out in the session. S.77 instantly became law on May 20, 2013, when Gov. Shumlin gleefully signed it in front of a roomful of cheering supporters.

What the Vermont law says and does not say

S.77, now called Act 39, is a disaster for vulnerable patients. Essentially, the law is comprised of two phases. The first one (Sec. 5283)—in effect only until July 1, 2016—is a diluted version of Oregon's already flawed law. It contains some of Oregon's requirements: the patient must be terminally ill, competent (capable) at the time of the death request, not have impaired judgment, be able to make an informed decision, be able to self-administer lethal drugs (but the VT law does not expressly require self-administration), and the imposition of waiting periods before the drugs can be prescribed. However, other requirements are missing, such as the state is not required to issue an annual statistical report on assisted-suicide deaths and there is no provision encouraging notification of the patient's next-of-kin or that someone be present when the patient takes the lethal drugs. With no disinterested witness present, there can be no data on the time it took to die, if there were any complications, or whether the patient voluntarily took or was forced to take the drugs. Most conspicuously absent is the mandate that doctors who violate the law must be reported to the state medical board. [Act 39, 18 V.S.A. § 5283, "Requirements for Prescription & Documentation; Immunity"]

The second phase of the law—in effect starting on July 1, 2016—is even more dangerous and strips away any suggestion of patient protection. What it does is repeal all of Sec. 5283, the Oregon-like model, and replaces it with what has been called a "Medical Model" that Vermont lawmakers *hope* will be created sometime in the future by the medical profession as part of its good practice standards. In the Medical Model there is no state mandated written and oral death requests by the patient, no waiting periods to ensure that the patients truly wants to die, no state oversight of the practice at all, no reporting requirements, no required second opinion by a consulting physician to verify that the patient is terminally ill and competent to make an informed decision, and no mandated psychiatric or psychological evaluation if the doctor thinks the patient might have "impaired judgment."

The only thing Act 39's Medical Model states is that a physician will be "immune from any civil or criminal liability or pro-

fessional disciplinary action for actions performed in good faith compliance with" the following:

- (1) "the [lethally-prescribing] physician determines that the patient is capable and does not have impaired judgment;
- (2) "the physician informs the patient of all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;
- (3) "the physician prescribes a dose of medication that may be lethal to the patient;
- (4) "the physician advises the patient of all foreseeable risks related to the prescription; and
- (5) "the patient makes an independent decision to self-administer a lethal dose of medication." [Act 39, 18 V.S.A. § 5288, "Protection of Patient Choice at End of Life" and § 5290, "Immunity for Physicians."]

In other words, the Medical Model is all about giving physicians civil, criminal, and professional immunity for facilitating patients' deaths, not about patients' safety and protection—even though supporters, assisted-suicide activists, and lawmakers say otherwise. As Vermont pharmacist Bob Orleck put it, for Vermont lawmakers, "Casualties were acceptable!" "For these folks, physician-assisted suicide was more important to them than the wrongful and tragic loss of innocent human life." [True Dignity VT Blog, 7/12/13] That was also the conclusion reached by Edward J. Mahoney, president of the Vermont Alliance for Ethical Healthcare. "Vermont legislators should be mortified that they have enacted a law to allow and promote 'aid-in-dying' with virtually no protections for vulnerable patients," he wrote. "One might contend that they have committed legislative malpractice..." [Burlington Free Press, 7/5/13]

Vermont hospitals opting out of Act 39

Act 39 has a limited exception rule that allows health care facilities to prohibit physicians from writing lethal drug prescriptions for inpatient residents who intend to take the drugs on the facility's premises—as long as the doctors have been notified about that policy in writing. [Act 39, 18 V.S.A § 5286] Following advice given by the Vermont Association of Hospitals & Health Systems, most Vermont hospitals have opted out of assisted-suicide practice, at least for now. Some facilities, like Northwestern Medical Center (NMC) in St. Albans, VT, have adopted more permanent opt-out policies. According to Jill Berry Bowen, NMC's CEO, "[W]e did not find our community hospital to be the proper setting for administration of a lethal dose of medication." [St. Albans Messenger, 6/26/13]

Patient protection services available

True Dignity Vermont, a broad-based coalition of health care professionals, disability advocates, and others who oppose the new law, has launched an abuse hotline for people to call if they suspect that patients are being pressured, coerced, or forced to request or take lethal drugs. The group is also compiling a registry of doctors and health professionals who won't abandon patients to assisted suicide, and care facilities where patients are safe. [vtdigger.org, 5/20/13; truedignityvt.org, 5/19/13] ■

Quebec tries new strategy to legalize euthanasia

Following last year's recommendation by the Quebec National Assembly Committee on Dying with Dignity, Quebec Junior Health Minister Véronique Hivon has introduced a bill in the province's National Assembly that would legalize active euthanasia by not calling it euthanasia.

That's how euthanasia supporters plan to circumvent the Canadian Criminal Code, which makes both euthanasia and assisted suicide crimes, punishable by up to 14 years in prison. Knowing that the federal government has no plans to change that law in the near future, Quebec has decided to do an end-run around law and make euthanasia an official medical treatment, placing it under provincial, not federal, jurisdiction. Obviously taking its cue from Compassion & Choices' strategy in states like Vermont, the drafters of the new bill have employed euphemisms and other terminology to make the bill look like something that it is not.

Bill 52, titled "An Act respecting end-of-life care," states that the bill affirms "the right of everyone to end-of-life care that is appropriate to their needs." To accomplish this, the bill creates a new definition for "end-of-life care" that includes the purported treatments "medical aid-in-dying" (MAD) and "terminal palliative sedation" (TPS). The bill does not define MAD, but requires that doctors, not patients, administer it—which is clearly euthanasia. TPS is also not defined, but terminal sedation usually refers to the practice of rendering patients unconscious and then stopping all food and fluids so the patient will die. Noted Canadian bioethicist Margaret Somerville calls MAD and TPS "fast and slow euthanasia." [*Globe & Mail*, 6/19/13]

Incredibly, Bill 52 states that every health care facility *must* offer end-of-life care that includes MAD and TPS, and stipulates that no one can be denied this care "for previously having refused to receive a treatment or procedure or having withdrawn consent to a treatment or procedure." In other words, patients could be euthanized even if there were beneficial or curative treatments available for their conditions. [Bill 52, Preface; Title II, Chap. I-III] ■

Dutch doctors propose killing disabled babies so parents don't suffer

The Royal Dutch Medical Association (KNMG) has issued a report justifying euthanasia for seriously disabled babies so their parents do not have to suffer.

While infant euthanasia has been officially permitted in the Netherlands since 2004 as a result of the adoption of a policy called the Groningen Protocol, this new report adds another justification for these killings, thereby expanding the scope of the original protocol.

The new policy, titled "Medical decisions about the lives of newborns with severe abnormalities," states that it is acceptable and sometimes necessary to give lethal injections to disabled, dying newborns when "[t]he period of gasping and dying persists and the inevitable death is prolonged, in spite of good preparation, and it causes severe suffering for the parents." It goes on to say that the possibility of doctors being prosecuted for ending the lives of these children of distressed parents must be removed so that doctors can "focus on the quality of life and death of these newborns." [KNMG, "Medical decisions about the lives of newborns with severe abnormalities," 6/12/13]

KNMG estimates that, out of the 175,000 babies born each year in the Netherlands, possibly 650 would be eligible for euthanasia.

According to Dr. Eduard Verhagen, chief architect of the Groningen Protocol and co-author of the new report, "These children are gray and cold, they get blue lips and suddenly every few minutes they take extremely deep breaths. That's very nasty to see, and it can go on for hours and sometimes days." That's why parents should be spared from the "abomination" of seeing their child die that way. But Verhagen also admitted that, while watching these babies might be distressing, the infants may not be experiencing terrible suffering. [*Volkscrant*, 6/12/13]

Michael Cook, editor of Mercator.net and *BioEdge*, observed, "Today it is severely disabled babies; tomorrow it could be brain-damaged teenagers; the day after it could be the demented elderly. You would have no heart if you didn't suffer because of these cases; you would have a heart of stone if you killed them to stop your own pain." [Mercator.net, 6/14/13] ■

Britain's Lord Falconer tables "Assisted Dying" bill

In May, Britain's former Lord Chancellor, Lord Falconer of Thoroton, submitted a bill to the House of Lords to legalize "assisted dying," the euphemism for assisted suicide most often used by British supporters.

The bill (HL Bill 24), formally titled "Assisted Dying Act 2013," was drafted after Lord Falconer convened a commission to study the "assisted dying" issue. Of the 12 members he chose for the commission, nine were on record as being in favor of assisted suicide. The latest bill is his second attempt to legalize the practice. The first attempt was defeated in 2009.

Bill 24 is patterned after Oregon's law. While using different wording, the

bill essentially contains the usual Oregon "safeguards": patient must be an adult, terminally ill, competent, request death voluntarily, and so on. It also contains a written declaration of the patient's wish to die—dubbed a "death contract" by the press—that is signed by the patient, one witness, and two doctors. [HL Bill 24, 5/15/13; *The Independent*, 5/16/13]

Bill 24 has many vocal critics. Baroness Finlay, a parliament member and professor of palliative medicine at Cardiff University is one. She wrote the trouble with the bill's "safeguards is that they assume a perfect world" that doesn't exist. "[W]e must consider the harm that changing the law could bring to vulnerable patients." [*The Times*, 5/16/13] ■

New CPR technique greatly improves chances for recovery

A new Australian cardiopulmonary resuscitation (CPR) machine may eventually cause people to second guess do-not-resuscitate orders (DNRs) for themselves as well as for patients for whom they make health care decisions.

The new CPR device, called AutoPulse, is currently being tested at Melbourne's The Alfred Hospital, and the results after the first two years of the trial are exciting, said senior intensive care professor Dr. Stephen Bernard. So far, three cardiac arrest patients brought to the hospital's emergency room were successfully revived after being clinically dead for between 40 and 60 minutes. All three patients were able to return to their homes without any of the disabling effects, like brain and internal organ damage, that can result from a lack of oxygen getting to critical areas of the body.

One of those patients was Colin Fiedler, 39, who was declared clinically dead soon after he arrived at the hospital in June 2012. While he was still alive in the ambulance, the paramedics gave him the choice of going to one of two hospitals. "For some reason, I said The Alfred, which is pretty lucky because they are the only one that has [the CPR device]," he later recalled. "I'm so grateful, more than I could every say."

AutoPulse works by making continual chest compressions while the heart-lung machine component keeps blood and oxygen flowing to the brain and other organs. It also frees up doctors to determine the cause of the cardiac arrest and rapidly treat it.

Currently, in addition to the hospital, only three ambulances are equipped with the machine, but Dr. Bernard said the company distributing the AutoPulse has offered to provide more. [*Herald Sun*, 5/12/13; *Fox News*, 5/13/13] ■

Study finds improved CPR outcomes for elderly patients in US hospitals

A study, published in the *New England Journal of Medicine (NEJM)* earlier this year, found that nearly 60% of elderly survivors who were resuscitated after cardiac arrest in the hospital were alive after one year, and their three-year survival rate was similar to that of patients who had experienced heart failure, not cardiac arrest.

Researchers studied data on 6,972 adults, age 65 or older, who were discharged from hospitals after going into cardiac arrest while hospitalized between 2000 and 2008. After one year, 58.5% were still alive, and 34.4% had not be readmitted to the hospital. The one-year survival rates were higher for younger patients than older ones (63.7% for those 65 to 74 years-old, 58.6% for those 75 to 84, and 49.7% for patients 85 or older). Women's survival rates (60.9%) were slightly higher than men's (58.6%). White patients' chances of surviving one year were significantly higher than African American patients (60.4% versus 52.5%). One-year hospital readmissions were higher for African Americans, women, and those with a substantial neurological disability. [Chan et al., "Long-Term Outcomes in Elderly Survivors in In-Hospital Cardiac Arrest," *NEJM*, 3/14/13]

The study's lead author, Dr. Paul Chan said the results indicate that there is reason for hope. "If you make it out alive, you have a significant chance of being alive one year later," he told the *New York Times*. "We shouldn't hold a nihilistic attitude toward resuscitating the elderly, given these results."

Dr. Benjamin Abella, clinical research director at the Center for Resuscitation Science at the University of Pennsylvania School of Medicine, said hospital resuscitation improvements "have changed outcomes significantly, including among elderly patients." Those improvements include quicker cardiac arrest response times, advances in performing CPR, and most significantly, the increased use of therapeutic hypothermia to reduce brain swelling and inflammation to decrease the chance of brain damage. "If an older patient is cognitively intact," Dr. Abella explained, "he or she might want to consider allowing resuscitative care." But ultimately," he added, "this is a very personal, individualized decision." [*New York Times*, 3/14/13] ■

Elderly patients with DNR orders are more likely to die of surgical complications

The results of a study presented last year at the annual meeting of the American Surgical Association indicate that elderly patients who sign preoperative do-no-resuscitate (DNR) orders are more likely to die from surgical complications than non-DNR patients because the DNR order prevents aggressive management and treatment of any serious complications.

Based on data collected by the American College of Surgeons between 2005 and 2010, 25,518 patients over 65 had undergone emergency surgery. Of these patients, 1,061 (4.2%) had signed DNR orders. According to the study, 37.2% of the elderly DNR patients died in the 30 days following surgery and 42% experienced major complications. The 30-day death rate was significantly higher for DNR patients (36.9%) than for the

non-DNR patients (22.3%)—in spite of the fact that the incidence of major complications were similar between the two groups (42.1% for DNR patients and 40.2% for non-DNR patients).

Lead author Dr. John Scarborough explained, "It's not that [DNR] patients die after massive attempts to prevent their deaths; it's that these patients or their families refuse to accept aggressive management of their complications."

Dr. Ronnie Rosenthal, surgery professor at the Yale University School of Medicine said, "The ethical dilemma is that the surgeon may feel that rescue from the complication is possible but... patient autonomy demands respect for the patient's right to stop further treatment." [*General Surgery News*, 7/12] ■



News briefs from home & abroad . . .

- **New Hampshire:** When HB 403 was introduced in the New Hampshire House of Representatives last January, its stated intent was to establish “a commission to study death with dignity for persons suffering from a terminal condition.” (Often such commissions are created by supporters of the issue being studied to advance their cause.) By June, the bill had enthusiastically passed both legislative houses and was sent to the governor for approval. But approval was not forthcoming. Instead, Gov. Maggie Hassan vetoed the measure on July 12, saying,

With any discussion of the complex and emotional issues related to end-of-life decisions, our focus must always be first and foremost on helping all of those in our society to fully live their lives with the dignity that they deserve.

In New Hampshire, we have approached these issues very seriously and thoughtfully, always seeking to include the input of those who understand these issues best: doctors, patients, advocates for the elderly and those who experience chronic conditions or disabilities, and the people of New Hampshire....

Therefore, I see no need for the study committee outlined by HB 430 and have vetoed the legislation. [Governor’s Press Release, 7/12/13]

- **Australia:** Australia’s “Dr. Death,” Dr. Philip Nitschke, is running for a Senate seat in the next federal election. Frustrated after 15 years of unsuccessfully campaigning for legalized euthanasia and assisted suicide, Nitschke formed his own political party, aptly named the Voluntary Euthanasia Party. Not surprisingly, he is the party’s first candidate for a federal office. [ABC News, 7/23/13]

Earlier this year, Nitschke announced plans to have an unnamed travel agent create travel packages to Switzerland for Australians who want to end their lives at Dignitas, the Zurich-based, assisted-suicide clinic that caters to foreigners.

“People who are ill, if they are thinking of making this journey, it’s a lot of work and almost impossible for them,” he told reporters. Just the travel plan will cost these ill folks \$1,000 (Australian dollars). [*Herald Sun*, 5/29/13]

- **Switzerland:** Problems with diagnoses have been evident in the Swiss assisted-suicide trade lately. One case was especially tragic. It involved Pietro D’Amico, a 62-year-old magistrate from Italy, who, after receiving a terminal diagnosis, traveled to Switzerland to end his life before his condition progressed. But when an autopsy was performed, it was discovered that the father-of-one had been given the wrong diagnosis by his Italian doctor and a Swiss doctor. In fact, he was not suffering from any life-threatening condition at the time of his death. [*The Local*, 7/11/13]

A second case involved a Swiss doctor, Dr. Philippe Freiburghaus, who was convicted of prescribing a lethal dose of a barbiturate to an elderly man without getting a proper diagnosis. The doctor received a token punishment: a fine of just \$536. [*The Local*, 7/9/13]

- **Great Britain:** The UK’s National Health Service (NHS) has been rocked by recently revealed scandals involving inadequate care and patient abuse. In 2009, horror stories began to surface about elderly and terminally-ill patients being inappropriately placed on the Liverpool Care Pathway (LCP), an initially well-intentioned, palliative care plan for the end-of-life that was adopted by the NHS. Most of the revealed cases involved patients who had been placed on the LCP without their knowledge or consent or that of their families. Often, the patients were drugged, deprived of food and fluids, and died. The lucky patients had loved ones who figured out what was happening and demanded that the patient be taken off the LCP. It was estimated that 130,000 elderly and terminally-ill patients were dying each year while on the LCP. One doctor wrote an anonymous

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article in the *British Medical Journal* [11/1/12] on disabled newborns being dehydrated to death on the LCP as well. A subsequent government investigation found that poorly trained doctors and a lack of compassion on the part of nurses were mostly to blame for the grossly inadequate care. According to Baroness Julia Neuberger, who headed the investigation, "Ultimately, it is the way the LCP has been misused and misunderstood that has led to such great problems." She also said that the pathway could not be saved and will be abolished. [*The Guardian*, 7/15/13]

But the LCP isn't the only NHS scandal. Earlier this year it was revealed that hundreds of patients at Mid Staffordshire Hospital were dying unnecessarily due to unspeakably bad care and conditions. Stories surfaced de-

scribing patients being left in their own excrement and dehydrated patients having to drink water from flower vases because nurses neglected to bring them fresh water. Respected lawyer Robert Francis, who chaired a public inquiry into the charges against the hospital wrote, "This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety.... Patients were let down by the Mid Staffordshire NHS Foundation Trust. There was a lack of care, compassion, humanity and leadership. The most basic standards of care were not observed, and fundamental rights to dignity were not respected." [Robert Francis, Press Release, 2/6/13] ■

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

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

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