



Our name has changed, but not our mission

As you may have noticed in the above *Update* masthead, our name has officially changed from the International Task Force on Euthanasia and Assisted Suicide to the Patients Rights Council.

For those charged with fitting our old, awkwardly-long name into limited newspaper print space or on TV news screens to identify our spokespersons, the change to a shorter name is most welcomed. But that, of course, isn't the main reason for the change.

An organization's name should reflect the work or mission of that group. When we first opened our doors in 1987 as the International Anti-Euthanasia Task Force, the old 1930s euthanasia movement was in the process of being resurrected internationally by the World Federation of Right to Die Societies and nationally by two organizations, the Hemlock Society and the Society for the Right to Die. The stated goal of these groups was the legalization of euthanasia—the active termination of a patient's life by a third person, usually a doctor. At the time, our name reflected exactly who we were and what our position was (and still is): anti-euthanasia.

When American euthanasia groups figured out—after defeated initiative drives in California (1988 & 1992) and Washington State (1991)—that voters were not likely to legalize euthanasia in the foreseeable future, they decided to lessen their ambition and take “baby steps” toward their goal. The first baby step was to dump the word “euthanasia” and, instead, campaign for the legalization of “physician-assisted suicide”—meaning a willing doctor writes a prescription for a lethal drug overdose that a patient takes to commit suicide. The next step was to try their new strategy in Oregon, where they succeeded in passing their assisted-suicide initiative, the Oregon Death with Dignity Act, in 1994.

While internationally the battle was still about euthanasia, at home our efforts largely

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New round of 2011 doctor-prescribed suicide bills introduced in targeted states

Along with snow, rain, and freezing temperatures, the new year brought with it another round of new bills dealing with assisted suicide. Thus far, bills have been introduced or are in the pipeline to be introduced in Montana, Vermont, Hawaii, New Hampshire, and Connecticut.

Montana

When the Montana Supreme Court handed down its 2009 decision in *Baxter v. Montana*—finding that no Montana statute expressly makes doctor-assisted suicide illegal—the court was essentially telling the state's legislators that it would be up to them if they wanted to prohibit the practice or legalize it. To that end, two senators have drafted competing bills that were introduced in January.

Senator Anders Blewett (D-Great Falls) wants to make doctor-prescribed suicide legal. He is the main sponsor of SB 167, the “Montana Death with Dignity Act.” As its name suggests, the bill is a virtual clone of the Oregon and Washington State assisted-suicide laws. Representative Dick Barrett (D-Missoula) will be introducing the House version of the bill at a later date.

Senator Greg Hinkle (R-Thompson Falls) wants death by prescription to be illegal in Montana and has sponsored two bills addressing the risks that assisted suicide poses for vulnerable citizens. SB 116 would protect the elderly from the abuse of being pressured or coerced into choosing assisted suicide so that others could benefit financially and other ways from their deaths. The bill explicitly prohibits aid-in-dying, assisted suicide, euthanasia, and mercy killing. The second bill, SB 169, sets minimum prison sentences and fines for a “suicide predator,” defined as one “who purposely or knowingly causes the death of a second person by suicide or who purposely or knowingly aids or solicits another to commit suicide.” [SB 169, Section 3(2)]

Vermont

Last November, the prescribed-suicide advocacy organization Death with Dignity National Center (DWDNC) announced with great fanfare that Vermont would be the next state to legalize assisted suicide. According to DWDNC Executive Director Peg Sandeen, the group's research and polling indicated that the passage of a bill sometime in 2011 would be doable, now

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Assisted suicide advocacy: rhetoric or reality?

The arguments used by assisted-suicide advocates when they are campaigning to legalize death by prescription in targeted states is usually scripted and predictable. They claim that adult patients have the right to decide when, where, and how they will die. But not every patient has that right. The only patients who would qualify for “aid-in-dying” (advocates’ term for assisted suicide) are terminally-ill patients with six months or less to live, who are of sound mind (capable) and able to take the lethal drugs on their own. Not to worry, they say, those restrictive safeguards against abuse would be in concrete if the state passed their measure to legalize doctor-prescribed suicide.

Yet, comments from the assisted-suicide advocacy group Compassion & Choices (C&C), regarding a recent case in Connecticut, indicate that the “concrete” safeguards that advocates talk about may be just that—talk.

The case involved the death of 82-year-old George Brodigan, an Alzheimer’s patient whose condition deteriorated rapidly a couple of months before he died last September of an overdose of alcohol and an anti-depressant that had been prescribed to his son, Bruce Brodigan.

Bruce claimed that his father had said previously that he wanted to take his own life before he became totally incapacitated, so Bruce helped him. In Connecticut, however, assisted suicide is a felony, so the son was charged with second-degree manslaughter, tampering with evidence, making false statements, and interfering with the police. He allegedly followed procedures explained in the suicide manual *Final Exit*, something, police said, his father would not have been capable of given his dementia. According to the local police chief, “You’ve got a person who is a party here who has an interest in the outcome who is assisting the suicide.” [*Hartford Courant*, 1/11/11; *West Hartford Patch*, 1/13/11]

When word of the Brodigan case hit the news, C&C issued a press release titled, “Prosecution of Son Shows Need for Rational End-of-Life Policy in Connecticut.” “This gentleman should have been able to... find a peaceful, legal way out of the dilemma of advancing dementia,” said C&C president Barbara Coombs Lee. “...George Brodigan and his family should have had better end-of-life options,” she added. The press release then listed the 800 number for C&C’s End-of-Life Consultation program that, according to the release, responds “to requests for information on a client’s options for a peaceful, dignified death.” [C&C Press Release, 1/11/11]

Nowhere in C&C’s press release does it state that George had Alzheimer’s and, therefore, was not capable of making a decision on death options. If advocates’ claims are to be believed, that alone should have disqualified him from a C&C-style “peaceful, dignified death.” Furthermore, the fact that he had Alzheimer’s does not mean he was terminally-ill with a life-expectancy of six months or less—another disqualifying factor.

As the press release shows, C&C is adept at using vague language to advance its agenda. Coombs Lee never specifies what those “better end-of-life options” are or what a “rational end-of-life policy” would be—just that Connecticut badly needs one. Moreover, what could possibly be a “way out of the dilemma of advancing dementia” other than death? After all, there is currently no cure for dementia, but she doesn’t say what the “way out” is. She was, however, careful to use the word “legal” to describe that “way out,” giving the impression assisted suicide couldn’t be it since the practice is currently illegal.

But, what if it were legal? Then, Coombs Lee has already set the stage for assisted suicide to be an integral part of the “rational end-of-life policy” that she says the state needs. Given C&C’s history of repeated attempts to legalize the practice in Connecticut, don’t count on it giving up any time soon.

And, as for the claims by assisted-suicide advocates that the restrictive safeguards of assisted-suicide laws will absolutely prevent the abuse of patients like George Brodigan, well, that’s just rhetoric. ■

Final Exit Network in the news... again

Final Exit Network (FEN), a national group of volunteers who travel around the country to assist the suicides of its members, is heavily into self-promotion. Starting in January, 48 U.S. airports will be running public service announcements on monitors throughout their terminals pushing assisted suicide, promoting FEN membership, and asking for support.

In addition, an interview with FEN’s president, Jerry Dincin, will play on over 4,000 American and European flights during January and February. In the interview, Dincin talks about FEN’s “compassionate support” for members who want to die because of an “irreversible illness” that

they feel is unbearable. [FEN Press Release, 1/3/11]

Meanwhile, FEN and four of its volunteers still face felony charges in Georgia for assisting the suicide of a man and holding his hands down so he couldn’t remove the helium-filled, plastic bag over his head. In a counter maneuver, FEN’s lawyers have charged in court that Georgia’s assisted-suicide law is unconstitutional because it violates FEN’s right of free speech under the First Amendment. Since the law is unconstitutional, the lawyers argued, FEN should not be prosecuted and the case should be dismissed. As yet, no ruling has been handed down. [*Atlanta Journal-Constitution*, 12/9/10] ■

Oregon releases skimpiest annual report yet on assisted-suicide deaths

Once again, the Oregon Public Health Division (OPHD) has released an annual assisted-suicide report that contains less information than the year before. The OPHD is required by Oregon’s Death with Dignity law to gather data on doctor compliance with the law and issue a yearly statistical report on assisted-suicide practice and the deaths that occurred in a given year. But over the years, the reports have given the public less and less data to adequately assess doctor-prescribed suicide practice.

According to the most recent 2010 report, released on January 26, 2011, 59 doctors wrote 96 prescriptions for lethal drugs in 2010. Of the 96 patients who received those prescriptions, 59 died by taking the drugs. Six more patients—who had their drugs prescribed to them before 2010, but took them in 2010—also died, bringing the total reported assisted-suicide deaths for 2010 to 65. The total reported body count over the 13-year period since the assisted-suicide law took effect in 1997 has now reached 525.

The OPHD admits the 2010 report is incomplete. The data comes from doctors’ reports and death certificates submitted to the OPHD on or before January 7, 2011. Since there is often a delay in receiving these documents, there were probably more assisted-suicide deaths in 2010 than the 65 reported, but the OPHD hasn’t as yet received the requisite documents. The report states the OPHD simply does not know the status of 15 patients who received prescriptions in 2010.

Moreover, as a result of a mid-year “procedure revision,” the 2010 report only has data on the “time of and circumstances surrounding death” for 32 of the 65 patients who reportedly died. That means the report is missing data on 33 patients at the most crucial time in the assisted-suicide process.

The report does reveal, however, that two patients did not die after taking the prescribed drugs. Both eventually regained consciousness and died of their underlying illnesses—one after five days, the other three months later.

As in previous reports, the referral rate in 2010 for psychiatric evaluations was extremely low. Only one patient out of the 65 reported to have died was referred for a consultation to determine whether the patient’s death request was the result of “impaired judgment,” depression, or outside influence.

One doctor seriously violated the law by not waiting the required 48 hours after getting the patient’s written death request before writing the lethal drug prescription. He was referred to the Oregon Medical Board, but no non-compliant doctor has ever been penalized since the law took effect. ■

Reported Assisted-Suicide Deaths in Oregon 1998-2010				
<i>Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates.¹</i>				
<i>Figures and percentages are those reported by the state.</i>				
Categories	1998 - 2008	2009	2010	TOTAL
Number of reported assisted-suicide deaths	401	59	65	525
Number of unreported assisted-suicide deaths	Unknown ¹	Unknown ¹	Unknown ¹	Unknown ¹
Number of reported lethal prescriptions written	629	95	96	820
Number of reporting doctors who wrote lethal prescriptions in a given year	? ²	55	59	? ²
Number of cases where prescribing doctor was present at the time of death	76 [23.5%]	1 [1.8%]	6 [9.4%]	83 [18.7%]
Number of patients referred for psychiatric evaluation	38 [9.6%]	0 [0.0%]	1 [1.5%]	39 [7.5%]
Patients’ reasons for requesting assisted suicide:				
Loss of autonomy	357 [89.9%]	57 [96.6%]	61 [93.8%]	475 [91.2%]
Inability to do enjoyable activities	347 [87.4%]	51 [86.4%]	61 [93.8%]	459 [88.1%]
Loss of dignity	228 [83.8%]	54 [91.5%]	51 [78.5%]	333 [84.1%]
Lost control of bodily functions	233 [58.7%]	31 [52.5%]	30 [46.2%]	294 [56.4%]
Being a burden	152 [38.3%]	15 [25.4%]	17 [26.2%]	184 [35.3%]
Inadequate pain control or concern about it	95 [23.9%]	6 [10.2%]	10 [15.4%]	111 [21.3%]
Financial implications of treatment	11 [2.8%]	1 [1.7%]	1 [1.5%]	13 [2.5%]
Complications after lethal drugs were ingested:				
Regurgitation	19 [4.9%]	1 [1.7%]	1 [3.6%]	21 [4.4%]
Seizures	0 [0.0%]	0 [0.0%]	0 [0.0%]	0 [0.0%]
Patient awakened	1 ³	0	2 ³	3 ³
Unknown	10 [2.5%]	1 [1.7%]	37 [57%]	48 [9.1%]
Reported incidents of physician non-compliance with the assisted-suicide law	20	1	1	22
Penalties imposed for non-compliance with the assisted-suicide law	0	0	0	0
Notes:				
1. The Oregon Public Health Division (OPHD), the agency responsible for overseeing the practice of doctor-prescribed suicide, has acknowledged that it has no way of knowing if deaths went unreported or if the 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 no data on patient cases. Death certificates, by law, do not even indicate drug overdose as the true cause of death.				
2. Since the OPHD 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 suicide prescriptions for multiple patients over the 13-year time span that assisted suicide has been legal.				
3. The three 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.				
Source: Oregon Public Health Division, <i>2010 Report on Oregon’s Death with Dignity Act</i> , 1/26/11. All 13 annual reports are available online at: http://oregon.gov/DHS/ph/pas/ar-index.shtml				



For Kevorkian, Killing Was a Path to Fame and Fortune

by Wesley J. Smith

I try not to get into personalities here. But Jack Kevorkian is an icon of all that I see going wrong with our culture. The man was not—and is not—about compassionate help for people who are suffering. His assisted-suicide campaign was always about *him*.

Why do I bring this up? Because a recent press release, heralding a talk Kevorkian gave at UCLA on January 15, described the convicted murderer this way:

Los Angeles, CA – Dr. Jack Kevorkian, *one of America's most prominent physicians*, and widely considered a leading expert on Euthanasia, will be the guest of honor at a lecture at University of California, Los Angeles's Royce Hall.... (Emphasis added.)

A “most prominent physician”? I guess that’s why Michigan suspended his license to practice medicine in 1991 and California followed suit in 1993. But California didn’t stop there. The state permanently revoked his license in 1994. At the time of the suspension, the California Attorney General’s office issued a statement saying that Kevorkian is “*fundamentally unfit to practice medicine*”!

The press release on Kevorkian’s UCLA speech also called him “a world renowned pathologist.” He was no such thing during his medical career. He blazed no trails. He developed no new techniques. Until he began making headlines, he had made few ripples. In fact, when he could no longer find work as a pathologist, he applied for a job as a paramedic. He didn’t get it.

What is amazing—and truly appalling—is that the facts about Kevorkian don’t matter a whit anymore. But it’s important to keep those facts about Kevorkian in the public sphere in case anybody wishes to restore sanity about those we laud in public life:

- **Kevorkian’s goal was not the relief of suffering.**

His ultimate goal was to receive a license to engage in human vivisection. Kevorkian explained this yearning in his 1991 book *Prescription Medicide: The Goodness of Planned Death*, where, on page 214, he admitted that assisting “suffering or doomed persons kill themselves” was “merely the first step, an early distasteful professional obligation.” Instead of wanting to help the dying, Kevorkian candidly acknowledged, he was actually pursuing his own obsession. “What I find most satisfying is the prospect of making possible the performance of *invaluable experiments or other beneficial medical acts* under conditions that this first unpleasant step can help establish—in a word, obitriatry.”

- **Before beginning his assisted suicide campaign, he traveled to prisons in America where executions were carried out, asking to experiment on prisoners as part of the execution process.**

He even met with some prisoners seeking consent. He only turned to the ill and disabled when he had been thwarted from using the criminal justice system to satisfy his macabre obsessions.

- **The majority of Kevorkian’s assisted suicides were not people with terminal illnesses.**

Autopsies showed that at least five weren’t even sick!

- **Some of his victims were coerced or clearly depressed.**

For example, Judith Curren, age 42, may have been a victim of spousal abuse. A woman who reportedly abused prescription drugs, Curren had reported her husband to the police for violently abusing her—that was shortly before he flew her to Kevorkian to die in 1996. She had been diagnosed with chronic fatigue syndrome, but her autopsy detected no illnesses.

- **He is bigoted against people with disabilities.**

He once called quadriplegics and paraplegics who were not suicidal “*pathological*,” and exposed his sympathy for eugenics in a court document, asserting, “*The voluntary self-elimination of individual mortally diseased and crippled lives taken collectively can only enhance the preservation of public health and welfare.*” (In fact, his preying on depressed people with disabilities was the primary reason that the disability rights community jumped into the fray staunchly opposing assisted suicide. The respected group Not Dead Yet held its first demonstration in front of Kevorkian’s residence.)

- **He ripped out the kidneys of one of his assisted suicide victims—an ex-cop named Joseph Tushkowsky—who was depressed over his quadriplegia.**

Kevorkian’s “surgery” job was so crude that the Oakland County Medical Examiner called it a “*bizarre mutilation*,” something you’d see in a “*slaughterhouse*.” The medical examiner also noted that Kevorkian simply lifted up Tushkowsky’s sweater, did his dirty work, and tied off the blood vessels with twine. Kevorkian later held a press conference offering Tushkowsky’s kidneys on a “first come, first served” basis to anyone who wanted them. There were no takers, and the media simply yawned.

Back in 1998, in the wake of the Tushkowsky news, I wrote about the real Kevorkian in the *Weekly Standard*:

Jack Kevorkian is a quack, a ghoul, and a fiend. He is a quack because, though once trained as a pathologist, he has no training or expertise in diagnosing or treating depression, and he has not treated a living patient, at least not one who survived his “treatment,” since his

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For Kevorkian, Killing Was a Path to Fame and Fortune, *continued from page 4*

residency and military service in the 1950s. (His license to practice medicine was lifted in 1991.) Yet he purports to advise despairing sick and disabled people about their medical prognoses. He is a ghoul because he is obsessed utterly with death. Indeed, his “Dr. Death” moniker dates back to his medical school days, when he would haunt hospital wards at night, staring into dying people’s eyes. He is a fiend because his fondest dream is to slice open living people. He may also be the world’s most clever serial killer, as one media observer once put it, since his victims come to him. [“The Serial Killer as Folk Hero: Kevorkian Proceeds with His Plan,” *Weekly Standard*, 7/6/98]

I also put Kevorkian into a wider societal context:

The ultimate horror of Jack Kevorkian lies not in the hollowed-out body of his latest victim, but in the hollowness he has exposed in the society that

tolerates—and even celebrates—his increasingly gruesome killing spree. [*Weekly Standard*, 7/6/98]

And it has only gotten worse. Al Pacino played Kevorkian in a puff propaganda biopic for HBO in which none of the above facts about Kevorkian made it into the original script, much less the film. Yet, the movie, *You Don’t Know Jack*, received an Emmy for best miniseries, and Pacino won one for best actor.

Few things better illustrate the degradation and degeneration of our culture than the elevation of Kevorkian in the media and popular culture to respectability and adulation. ■

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New round of doctor-prescribed suicide bills introduced in targeted states, *continued from page 1*

that Vermont has a new Democratic governor who is a staunch assisted-suicide supporter and the state legislature is overwhelmingly Democratic. [DWDNC Press Release, 11/3/10]

The DWDNC, in partnership with the local assisted-suicide group Patient Choices Vermont (PCVT), announced that a bill would be introduced by the end of January. However, as of January 31, no measure had been introduced. A draft version of an Oregon-style bill—titled the “Vermont Patient-Directed Dying Bill”—can be viewed on PC-VT’s web site (<http://patientchoices.org/?p=258>).

If and when a bill is introduced, it won’t be as easy as DWDNC says it will to pass the measure. Senate President John Campbell, a Democrat, has already said that he will not support the bill, and Senate Judiciary Committee Chairman Dick Sears, also a Democrat, has said publically that he has “grave concerns” about legalized assisted suicide. On the House side, there is also no guarantee of passage. A 2007 assisted-suicide bill was defeated by a margin of 82-63 in the House, and the vote did not follow party lines. [*Burlington Free Press*, 1/4/11; *Bennington Banner*, 1/6/11; *Times Argus*, 1/12/11]

Hawaii

Hawaii is one of the states that has been repeatedly targeted by right-to-die advocates. Since 1998, Hawaii has had 24 bills to legalize doctor-assisted suicide introduced in its legislature. All of those measures failed.

In January, death-by-prescription proponents introduced three bills. SB 803 and HB 1383—identical companion bills, both entitled “Death with Dignity”—were introduced on January 21 and 25, respectively. Both have passed their first

reading, and SB 803 has been referred to the Senate’s Judiciary & Labor Committee and the Health Committee. The third bill, HB 1165, is similar to the companion bills, but it is titled “Compassion in Passing.” This measure appears to be on the fast-track. It was introduced, passed its first reading, and was referred to two House committees all in one day, January 26. But, after so many attempts to legalize assisted suicide over the years, Hawaii has a strong opposition coalition in place to counter all three bills.

New Hampshire

Like Vermont and Hawaii, New Hampshire has been a repeated target for prescribed-suicide bills. The current bill, HB 513, is virtually identical to a measure that advocates introduced in 2009. That bill, HB 304, was overwhelming defeated in a House floor vote on January 13, 2010. The vote was 242-113 against passage.

Resurrected for the 2011 legislative session, HB 513 was introduced on January 6 and referred to the House Health, Human Services, and Elderly Affairs Committee. The deadline to vote it out of committee is March 10. The bill would allow people who are not state residents to qualify for assisted suicide as long as they are “regularly treated in a New Hampshire health care facility.” [HB 513, §137-L:2 XII.]

Connecticut

Unlike bills introduced in other targeted states to legalize assisted suicide, Connecticut’s Proposed Bill 356 would establish a “mandatory minimum term of imprisonment for the crime of assisted suicide” for anyone convicted of “intentionally causing or aiding another... to commit suicide.” Two years of any sentence imposed “shall not be suspended or reduced by the court. [LCO No.2084] ■

Belgian doctors harvest organs after euthanasia

Euthanasia has been legal in Belgium since 2002. Now, a group of doctors from the University Hospitals of Antwerp, Leuven and Liège have gone beyond terminating patients' lives to also harvesting those patients' organs for transplantation.

Three of the doctors even put together a PowerPoint presentation—explaining the procedure in a font that is more reminiscent of a pre-schooler's bedtime story than a medical text—and showed it at a conference held by the Belgian Royal Medical Academy in Brussels last December.

According to the presentation, high quality organs can be procured from euthanized patients with neuromuscular disorders—about 20% of all euthanized patients in Belgium. In 2008, there were more than 700 euthanasia cases reported.

The obvious benefit to harvesting these organs, the doctors say, is to increase the number of available high-quality organs, thereby solving the organ shortage problems in Belgium and other countries willing to accept organs from euthanized patients.

Just as with claims that euthanasia can only occur under strict rules or guidelines, the Belgian doctors say that

a strict protocol must be followed when organs are taken from euthanized patients. Included in the protocol are the requirements that there be a “strict separation” between the euthanasia request, the euthanasia procedure, and the organ procurement, as well as a written “informed consent” from the donor and his/her relatives. The euthanasia must be performed by a neurologist or psychiatrist and two hospital doctors, and the organ retrieval can occur only after three doctors have made a “clinical diagnosis of death.” Finally, the involvement of doctors and nurses in these procedures must be on a voluntary basis. [Ysebaert et al., “Organ Donation after Euthanasia: Belgian Experience,” 12/9/10. PowerPoint presentation available at: www.scribd.com/doc/47509584/Organ-Donation-After-Euthanasia]

This expansion of Belgian euthanasia practice to include organ harvesting prompted Michael Cook, editor of MercatorNet and the bioethics newsletter *BioEdge*, to write, “This seems like the ultimate in utilitarian compassion: make paralyzed people feel useful by killing them for their organs.” He added facetiously, “It’s something to look forward to if euthanasia ever gets legalized.” [MercatorNet, 1/24/11] ■

Labeling euthanasia a big problem in Belgium

In a country where it's legal, how can euthanasia practice be controlled if doctors there don't know when they have euthanized someone and, therefore, don't report it? The answer: It can't be controlled.

That is the finding of a Belgian study published in the *European Journal of Public Health*. Researchers found that the main reason why at least half of Belgium's euthanasia deaths are going unreported is that many cases are “not labeled as euthanasia by the physician involved in the decision.” That is also the reason why cases go unreported in the Netherlands.

Seven years after Belgium euthanasia law took effect, there are still doctors who confuse euthanasia with other end-of-life treatment options, like the withdrawal of life-sustaining treatment or aggressive pain management. In the study, two out of 10 doctors failed to correctly label an obvious case as euthanasia, and three out of 10 were unaware of the reporting requirement. In addition to the confusion over definitions, some doctors are simply unwilling to report euthanasia cases to official committees. [Smets et al., *European Journal of Public Health*, 12/3/10] ■

Scotland, France, Israel reject euthanasia bills

● Scottish Parliament Member Margo Macdonald was dealt an overwhelming defeat when her End of Life Assistance (Scotland) Bill was rejected by a vote of 85-16 on December 1, 2010.

The bill would have allowed both euthanasia and doctor-assisted suicide. Anyone who was 16 or older and was terminally ill or “permanently physically incapacitated” would have qualified for a doctor-prescribed death. If the bill had passed, it would have made Scotland the only jurisdiction in the U.K. where euthanasia and assisted suicide was legal. Macdonald, who has Parkinson's disease, has vowed to try again to legalize both practices if she is reelected.

Parliament's strong opposition to the bill centered primarily on concerns about the protection of vulnerable patients. Scottish Health Secretary Nicola Sturgeon told those present, “I personally find myself particularly concerned and fundamentally concerned about the difficulty I think would always and inevitably be present in determining that someone choosing to end their life had not been subjected to undue influence.” [BBC News, 12/1/10; *Scotsman*, 12/2/10; *Herald Scotland*; 12/2/10]

● The French Senate also defeated a bill—by a vote of 170-142—that would have legalized euthanasia for those with terminal illnesses or incurable conditions that cause physical or mental pain. Shortly before the January vote, Prime Minister François Fillon voiced his strong opposition, calling the bill “very dangerous” for patients and caregivers. The National Academy of Medicine opposed the measure as well. [MercatorNet, 2/1/11; *NCR*, 1/27/11]

● Similarly, the Israeli Knesset rejected a measure, titled “Death by Prescription,” that would have allowed doctors to prescribe lethal drugs to terminally-ill, adult patients. In January, just 16 Knesset members voted for the bill, while 48 voted it down. [Ynet News, 1/19/11] ■



News briefs from home & abroad . . .

- Prescribed-death advocates in Oregon often claim that their assisted-suicide law has been instrumental in improving the quality of health care throughout the state and making Oregon a national leader in patient-centered medical treatment. But, that's far from the truth if you consider that Oregon's Long-Term Care Ombudsman Program—required by Federal law to protect the rights of patients in long-term care facilities—is ranked dead last among all 52 U.S. states and territories.

In an average state, there is one ombudsman monitoring 2,220 beds. Oregon only has one for 6,692 beds. The situation is so bad that there are no ombudsmen regularly monitoring two-thirds of Oregon's adult-care homes and none at all in six counties. And, while other states pay their ombudsmen, Oregon's are unpaid. They are a group of 150 volunteers who work a minimum of 16 hours a month. According to one volunteer, VeAnna Morgan, "When people are too ill or too weak or too old to really stand up for their rights, it's helpful to have someone there who is watching and making sure they are getting good care." [*Oregonian*, 12/31/10]

The dire ombudsman situation begs the question: If no one is there to ensure that those stuck in long-term care facilities receive the care and treatment they need, what's to stop these vulnerable patients from requesting an assisted suicide just to end the loneliness and inadequate or abusive treatment?

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involved creating and disseminating documented information on assisted suicide: providing testimony, when asked, in state legislatures and in Washington D.C.; analyzing policy statements; writing articles; providing data and training in states targeted for assisted suicide measures; and appearing on TV and radio programs. We eventually decided to add "assisted suicide" to our name and became the International Task Force on Euthanasia and Assisted Suicide.

So, why change our name again? Because, while we staunchly oppose both euthanasia and assisted suicide as practices that abandon patients when they are most vulnerable, our broader focus is on protecting the rights of patients in all end-of-life situations, including cases involving the unwanted withholding of food and fluids from incompetent patients or the denial of wanted life-saving treatment deemed futile by providers. We created our state-specific Protective Medical Decisions Document to make sure that patients have an advance directive that will ensure their wishes and prohibit induced-death practices. We are about protecting patients' rights. We are the Patients Rights Council. ■

- The European Court of Human Rights (ECHR) has unanimously ruled that **Switzerland's** requirement that a lethal suicide drug can be only dispensed if there is a doctor's prescription does not violate any personal privacy rights guaranteed by Article 8 of the European Convention on Human Rights. The case, *Haas v. Switzerland*, was brought by Ernst Haas, a Swiss resident who has had a serious bipolar disorder for 20 years. He had unsuccessfully attempted suicide twice before and wanted a lethal dose of sodium pentobarbital to ensure a pain-free death. When no doctor would write the necessary prescription, he turned to government authorities to allow him to get the drug without a prescription. Again, he was unsuccessful. Haas then brought his case to the ECHR, charging that the Swiss government had violated his privacy rights. But the court ruled that privacy rights had to be balanced with the protection of the right to life, and the prescription requirement protected people from making hasty decisions and prevented abuse. Referring specifically to Switzerland's permissive assisted-suicide policy, the court said, "The risk inherent in a system which facilitated assisted suicide could not be underestimated." [Bloomberg, 1/20/11; humanrightseurope.org, 1/20/11; SwissInfo, 1/20/11]
- In February 2010, Britain's Director of Public Prosecutions (DPP) issued guidelines for determining whether assisted-suicide cases will be prosecuted in England

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Please remember the Patients Rights Council when planning your estate...

The Patients Rights Council's mission is to protect the rights of all patients, including those with disabilities and those who are vulnerable due to age, circumstance, and the pressures of doctor-prescribed death. Leaving a bequest shows your active and on-going support for this extremely important work.

A planned gift can take the form of a specific dollar amount, a piece of property, or a percentage of your estate. It can be done via your will or other means, such as designating us as a beneficiary of your IRA, pension plan, life insurance policies or assets held in a trust.

Please contact us for more information on leaving a lasting legacy for the continued work of the Patients Rights Council.

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and Wales. Since that time, the DPP has decided not to prosecute well over 20 people suspected of aiding another's suicide, a crime punishable by up to 14 years in prison. Those opposed to legalizing assisted suicide have charged that the DPP has essentially changed the law, putting vulnerable people at risk. [*Daily Mail*, 12/15/10]

Those who want assisted suicide legalized aren't happy either—even though, at the time the guidelines were released, Sarah Wooton, executive director of the advocacy group Dignity in Dying, called them “a victory for common sense and compassion.” What advocates want is to formally change the law so assisted suicide is no longer a punishable crime.

Lord Falconer, a longtime assisted-suicide supporter, has formed the Commission on Assisted Dying, to objectively determine, he said, whether the law should be changed and, if so, what would be the best way to do it. His commission consists of 12 members, nine of whom are on record favoring assisted-suicide legalization. The idea for the commission came from Dignity in Dying, and the commission is funded in part by novelist Terry Pratchett, another avid supporter of legalization. The commission is currently hearing testimony from both assisted-suicide proponents and opponents. [*British Medical Journal*, 1/24/11; *This is London*, 1/19/11; *Guardian*, 11/30/10; pjsaunders.blogspot.com. 11/30/10] ■

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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