



Canada debates induced-death practices

Between a bill in Parliament to legalize both euthanasia and assisted suicide and a proposal by the Quebec College of Physicians (QCP) to allow euthanasia for suffering patients, debate over induced-death practices has intensified in Canada.

Bill C-384 is MP Francine Lalonde's third attempt since 2005 to legalize euthanasia and assisted suicide. It is the first one to make it to a second reading in Parliament. Under the provisions of the loosely worded bill, anyone 18 or older who is terminally ill or has "severe physical or mental pain" would qualify for an induced death. The person need not be competent, but rather only needs to "appear to be lucid" at the time he or she requests death. [Bill C-384, §222 (7)] Since the bill has no residency requirement, it could make Canada a destination for death seekers from other countries, especially from the U.S.

While C-384 has advanced farther than Lalonde's previous two bills, its chances for passage are slim. On October 2, the bill received its first hour debate. Only about 20 MPs attended and, of the eight speeches delivered, only two favored the bill. The second hour debate will be in November, after which a vote will be taken. Should it pass then, it would be taken up by the Commons Justice Committee and studied further.

Also in November, the QCP released its anticipated report urging the federal government to amend the Criminal Code to allow euthanasia as "appropriate end-of-life care." [QCP Press Release, 11/3/09] According to Right to Die Society of Canada's president, Ruth von Fuchs, what the QCP "is trying to say is that death is sometimes a benefit. It's sometimes a form of care. It's the most practical, most sensible and most honest kind of care." [Globe & Mail, 7/17/09] But an open letter to the Quebec media, signed by five doctors and backed by 100 more, argued, "Killing would then become a therapeutic possibility..." [Canwest News, 9/24/09] ■

Organized efforts continue to target states for legalized assisted suicide

*"The team is coming together. The timeline is coming together. The plan is coming together... **And now the time has come.**"*

The above quote is from a recent Death with Dignity National Center (DWDNC) fundraising appeal. The group wants financial support for its efforts to identify the next state most likely to pass a voter initiative to legalize assisted suicide. It was the DWDNC, along with Compassion & Choices (the former Hemlock Society), who spearheaded the successful 2008 initiative campaign to legalize assisted suicide in Washington State. It was a victory that the then desperate, assisted-suicide advocates absolutely needed. It had been 14 years since Oregon had passed its initiative, and all subsequent efforts to legalize assisted suicide by ballot or in state legislatures across the country had failed, sometimes miserably.

Emboldened by the Washington State victory, groups like DWDNC and Compassion & Choices (C&C) are again targeting states they see as most vulnerable to their agenda. In addition to pursuing another voter initiative, advocates are filing lawsuits and pushing legislative bills in the hope of achieving what they would spin as a national consensus in favor of assisted suicide.

Pending lawsuits

Baxter v. Montana

On December 5, 2008, barely one month after Washington legalized medical killing, Montana District Court Judge Dorothy McCarter ruled in favor of C&C's constitutional challenge of that state's law banning assisted suicide. The suit, orchestrated by C&C's legal director Kathryn Tucker, argued that physician "aid-in-dying" (a euphemism for assisted suicide) is a right under the Montana Constitution, the only state constitution in the country to guarantee a right to dignity in addition to privacy. McCarter's ruling immediately legalized the practice. The state then appealed her decision to the Montana Supreme Court.

Oral arguments before the seven-member high court took place on September 2, 2009. Assistant Attorney General Anthony Johnstone, representing the state, argued that, when the people of Montana adopted the constitution,

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they did not include the issue of physician-assisted suicide nor did they exempt it from the homicide laws that draw a bright line against intentional killing. Any decision to change the law and public policy to allow assisted suicide, he argued, should be the job of the state legislature, not the courts. What C&C and the other plaintiffs want, he explained, is an absolute autonomy right. If the court were to establish such a broad right, it could not be limited to just the able-bodied, terminally ill who can self-administer lethal medication.

Mark Connell, C&C's local legal counsel from Missoula, argued that there is little difference between the current palliative care practice of a doctor increasing morphine to keep up with a patient's pain—knowing that the higher dosage could also hasten death—and physician "aid-in-dying." "Is there a conceivable state interest," Connell asked, "in forcing a dying, suffering patient to remain alive against his will simply so he can suffer a little longer, if the end result will be the same?" He then answered his own question: No, the state's interest in preserving a person's life diminishes as death approaches and suffering increases.

The court's ruling in the case is pending.

Blick v. Connecticut

On October 7, 2009, C&C along with two Connecticut doctors filed a lawsuit in Hartford Superior Court challenging the state's statute banning assisted suicide. But the rationale behind this C&C lawsuit differs significantly from the group's Montana case in that it is not a challenge based on any rights guaranteed by the state's constitution. Instead, C&C, under Kathryn Tucker's direction, is attempting to verbally engineer the definition of "suicide"—the act of intentionally taking one's own life—to exclude any self-killing by terminally-ill patients if they were helped by a doctor.

Connecticut law expressly states, "A person is guilty of manslaughter in the second degree when:...(2) he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide." [Conn. Gen. Stat. §53a-56 (a)] But according to C&C's complaint filed with the court, Connecticut's assisted-suicide statute "does not provide a valid statutory basis to prosecute any licensed physician for providing aid in dying because the choice of a mentally competent terminally-ill individual for a peaceful death as an alternative to enduring a dying process the patient finds unbearable does not constitute 'suicide'...." [*Blick v. Connecticut*, Verified Complaint, 9/20/09, pp. 8-9] In other words, when a terminally-ill patient intentionally ingests lethal drugs prescribed by a doctor, that patient is not committing "suicide," so the prescribing doctor is not assisting a "suicide." He is simply providing "aid in dying" and cannot be prosecuted under the assisted-suicide statute.

Tucker told a Hartford reporter that, if C&C's suit is successful, it could be used as a model for challenging assisted-

suicide statutes in other states with similarly worded laws. [*Hartford Courant*, 10/7/09]

2009 assisted-suicide bills

In 2009, bills were introduced in Connecticut, Hawaii, Massachusetts, Montana, New Hampshire, New Mexico, Pennsylvania, and Vermont. The New Hampshire and Pennsylvania bills remain technically "alive." All the others failed.

New Hampshire - HB 304

New Hampshire is a state with a history of failed bills intended to legalize assisted suicide. HB 304, introduced earlier this year under the title "Death with Dignity Act," is the fourth Oregon-style bill since 1996 to attempt to transform the crime of assisted suicide into a medical treatment. Rep. Charles Weed (D-Keene), the measure's lead sponsor, has amended the measure twice in the hope of getting it passed by the House Judiciary Committee. Thus far, he has not been successful. On February 3, the Judiciary held a public hearing, but never called for a vote. It was decided instead to hold the bill for study and bring it back for consideration next year. But, a committee work session on September 24 failed to reach any consensus. A new Judiciary executive session is scheduled for November 10 to vote on a recommendation to the full House to submit the bill for further interim study.

Pennsylvania - SB 404

Another assisted-suicide bill based on the Oregon model, Pennsylvania's SB 404, was introduced last March by Sen. Daylin Leach (D-Montgomery County). He sponsored a similar measure when he served in the House, but it died without even a hearing. SB 404 is his first attempt in the Senate to legalize assisted suicide. On March 5, the bill was referred to the Senate Judiciary Committee, but, so far, there has been no hearing or vote scheduled. While the bill is technically still alive, it doesn't appear that the Judiciary Committee is in any hurry to hear it. ■

Washington assisted suicides mounting

As of November 3, 2009, the Washington State Department of Health (WADH) has received 27 "After Death Reporting Forms" from attending physicians who prescribed lethal drugs to their now deceased patients since the Washington assisted-suicide law was enacted last March. A total of 47 patients have submitted a written request for life-ending drugs, but the WADH has received only 3 reporting forms from psychiatric/psychological consultants. That low number likely indicates that the doctors involved in the assisted-suicide process are only referring a fraction of the death-requesting patients for a psychological assessment. The WADH has also received 46 "Pharmacy Dispensing" forms indicating that patients have been dispensed lethal drugs. [<http://www.doh.wa.gov/dwda/formsreceived.htm>] ■

Recent developments point to emerging death culture in the U.K.

It could be argued that no country has debated the issues of legalized euthanasia and assisted suicide more than the United Kingdom. However, what is occurring now has gone well beyond mere debate. Some have termed it an emerging culture of death—the evidence of which can be seen in the Crown’s newly issued prosecutorial guidelines for the crime of assisted suicide and in a National Health Service (NHS) palliative care protocol gone bad.

Prosecution guidelines for assisted suicide

On September 23, 2009, Britain’s Director of Public Prosecutions (DPP), Keir Starmer, issued interim guidelines for England and Wales that outline the key factors used to decide whether an assisted-suicide case warrants prosecution. Currently, aiding, abetting, counseling, or procuring the suicide of another is illegal under Britain’s Suicide Act of 1961, and offenders could face 14 years in prison.

Starmer was ordered to issue the guidelines by a July House of Lords court ruling in the Debbie Purdy case. The panel of five Lords—sympathetic to the 46-year-old woman with multiple sclerosis who wanted assurance that her husband would not be prosecuted if he accompanied her to the Swiss suicide clinic Dignitas—essentially reversed two lower court rulings that denied her assurance request. [*R (on the application of Purdy) v. the Director of Public Prosecutions* [2009] UKHL 44]

The guidelines apply to aided suicides occurring both at home and abroad. It lists 16 “interest factors” favoring prosecution. Among them are:

- The victim lacked the capacity to make an informed suicide decision;
- The victim did not ask personally for suicide assistance;
- The person assisting the suicide (called “the suspect”) was not “wholly motivated by compassion,” but rather stood to gain from the victim’s death; and
- The suspect “persuaded, pressured or maliciously encouraged the victim to commit suicide.” [DPP, “Interim Policy for Prosecutors in respect of Cases of Assisted Suicide,” 9/09, pp. 3-4. Hereafter cited as Policy.]

Included in the 13 listed factors *against* prosecution are:

- The victim had a “terminal illness or a severe and incurable physical disability or a severe degenerative physical condition from which there was no possibility of recovery”; and
- The suspect was a spouse, partner, close relative or friend with a long-term relationship with the victim. [Policy, pp. 4-5]

While Britain’s law against assisted suicide technically remains unchanged, the DPP’s policy effectively removes anyone who is terminally ill or permanently disabled from the protection of that law. If a person has an incurable condition (such as MS, cerebral palsy, paralysis, etc.), yet the person has many years left to live, the individual is still presumed to

be eligible for assisted suicide. Further, barring any blatant factors in favor of prosecution, the one who helps the person die will most likely *not* be prosecuted.

Essentially, the policy is similar to the Swiss assisted-suicide law that allows the practice as long as the suicide assister has no “selfish motives.” But many of the DPP’s policy factors are virtually impossible to prove since any investigation would be postmortem. The victim—often the only one who knew whether he or she was pressured to die or if the assister had ulterior motives—is dead and, obviously, not able to testify. Alluding to the policy as a how-not-to-get-caught check-off list, Dr. Peter Saunders of Britain’s Care Not Killing wrote, “The guidelines are thereby a recipe for elder abuse and abuse of people with disabilities, chronic illnesses and terminal illnesses by unscrupulous individuals who can tick the right boxes.” [Personal e-mail, 9/27/09]

The DPP has invited public comment on the policy until December 16. A final version will be issued in Spring 2010.

Liverpool Care Pathway to death

The original intent of the Liverpool Care Pathway (LCP) was laudable: to reduce the suffering of the immanently dying. Developed by the Marie Curie Palliative Care Institute in the late 1990s for its Liverpool hospice, the Pathway protocol was intended for only terminal cancer patients. Now—after it has been adopted nationwide by the NHS and used in over 300 hospitals, 130 hospices, and 560 nursing homes—patients with a wide range of conditions are put on the Pathway. Approximately 20,000 patients a year die while on the LCP. A National Care of the Dying Audit found that in 28% (over one in four) of those cases, the patient’s family was never told that their loved one had been placed on the death Pathway. [*Telegraph*, 9/2/09; 9/14/09; *Times*, 9/14/09]

The LCP made headlines after six palliative care experts wrote an open letter to the *Daily Telegraph* exposing LCP’s use of continuous terminal sedation with the removal of food and fluids and drugs, such as antibiotics, “without regard to the fact that the diagnosis could be wrong.” “Forecasting death is an inexact science,” they wrote. “If you tick all the right boxes in the [LCP], the inevitable outcome of the consequent treatment is death.” Dr. Peter Hargreaves, one of the experts, explained that patients who are dehydrated and given painkillers often become confused and can be put on the LCP mistakenly. “[I]t can become a self-fulfilling prophecy,” he said. Doctors do not always check the patient often enough so they miss signs that the patient is improving and not dying. [*Telegraph*, 9/2/09, 9/3/09]

Soon after the experts’ letter was published, family members of patients who had wrongly been placed on LCP began telling their tragic stories to the media. Page 4 of this *Update* contains an article by ITF consultant Wesley J. Smith, who discusses three of those personal stories. ■



Hazardous Pathway: The road to euthanasia

by Wesley J. Smith

The United Kingdom continues to provide vivid warnings about the dangers of centralized health-care planning—a real possibility under Obamacare. Within the last few years, the U.K.'s notorious rationing board, the National Institute for Health and Clinical Excellence (NICE), urged hospitals, nursing homes, and hospices to follow an end-of-life protocol known as the Liverpool Care Pathway. The Pathway's guidelines instruct doctors to put patients thought to be near death into a drug-induced coma, after which all food and fluids, as well as medical treatments such as antibiotics, are withdrawn until death.

The problem with such a protocol is that no matter how well motivated—and undoubtedly, the Pathway's creators had good intentions—follow-the-dots medical protocols often lead to patients being treated as members of a category rather than as individuals. At that point, nuance often goes out the door, and mistakes, neglect, and even oppression frequently follow.

That seems to be precisely what has happened with the Pathway as it has been applied in hospitals, nursing homes, and hospices throughout the U.K. Angry family members are beginning to come forward, charging that their loved ones have been sedated and had food and water withdrawn—whether their symptoms warranted these measures or not. Indeed, some have alleged that their deceased relatives would have lived but for having been put on the Pathway to death. These stories have all the early hallmarks of a full-fledged medical scandal.

The problems with the Pathway, at least as sometimes applied, first came to light in an open letter in the *Daily Telegraph*, signed by palliative physicians and others:

Just as, in the financial world, so-called algorithmic banking has caused problems by blindly following a

computer model, so a similar tick-box approach to the management of death is causing a national crisis in care. The government is rolling out a new treatment pattern of palliative care into hospitals, nursing homes, and residential homes. It is based on experience in a Liverpool hospice. If you tick all the right boxes in the Liverpool Care Pathway, the inevitable outcome of the consequent treatment is death. ["Dying Patients," *Daily Telegraph*, 9/3/09]

A concurrent *Telegraph* story reported that 16.5 percent of patients who died in 2007–08 expired while under "continuous deep sedation," i.e., an artificial coma. [*Daily Telegraph*, 9/3/09] That figure struck me as exceedingly high. I have spoken to several hospice professionals about "palliative sedation," as it is sometimes called, and all claimed that it is rarely necessary to treat pain or to relieve other distressing symptoms. And in those few cases in which a patient must be rendered unconscious, the measure is undertaken so late in the disease process that it is generally not the cause of death.

In this regard, Dr. Eric Chevlen, a pain-control expert and former hospice medical director, told me, "In close to 30 years of practicing oncology and palliative care, I have treated hundreds of patients with opioids to relieve pain, accepting some level of sedation as an unavoidable side effect rather than the goal of therapy. But I can recall only a handful of times in which I felt that the best way I could reduce the patient's suffering was to intentionally diminish his level of consciousness."

This raises the suspicion that more dying patients are rendered unconscious in the U.K. due to the Pathway than would be warranted if each patient were treated based on his symptoms. If so, the Pathway protocols may be being applied in some cases without regard to proper

proportionality of dosing based on each patient's need, and without adhering to Hippocratic standards of individualized care—both of which are important ethical concerns. Indeed, this practice raises the suspicion that the Liverpool Care Pathway may have become a platform for backdoor euthanasia. Tellingly, the *Telegraph* reported that twice as many patients in the U.K. die while under deep sedation as do in the Netherlands—a country where terminal sedation sometimes serves as a substitute for active euthanasia.

After the doctors' letter was published, Pathway supporters fought back, claiming that family members were actually quite satisfied with the treatment their loved ones had received, and had been relieved that the protocol allowed all to die in peace, without pain. That seemed to be the end of the matter—but then, the horror stories began to come to light.

On September 8, the *Daily Telegraph* carried a story in which one Rosemary Munkenbeck charged that after her father was hospitalized with a stroke, he was quickly deprived of fluids and medications. She further claimed that doctors wanted to sedate him with morphine until he died, under the Pathway protocols, but the family refused. Munkenbeck's father went five days until sustenance was restored, but the family isn't hopeful. "We believe that he has been forced down this route," she told the *Telegraph*. "By withdrawing fluids he is now very weak and there's no going back from it."

Soon, the *Times* of London reported another case:

An 80-year-old grandmother who doctors identified as terminally ill and left to starve to death has recovered after her outraged daughter intervened. Hazel Fenton, from East Sussex, is alive nine months after medics ruled she had only days to

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News briefs from home & abroad . . .

- On the eve of his first ever North American Tour of how-to-kill-yourself workshops, Australia's Dr. Death, Philip Nitschke, has announced his latest creation: a single death-producing pill he calls the Exit Pill. Nitschke, the director of the euthanasia advocacy group Exit International, explained why he developed the deadly pill. "Exit believes that ALL seniors of sound mind should have the option of a peaceful death at the time of THEIR choosing should this be their wish—this Exit Pill will go some way to ensuring this," he said.

The pill is made from an inert form of Nembutal, a drug outlawed in Australia and New Zealand for human use. In order to be used as Nitschke intends, the pill must be reconstituted in liquid form. The "activation kit," with the chemicals needed for reconstitution, is still being developed, but Nitschke anticipates that it will be available for purchase in 2010.

In the meantime, Nitschke will promote his new Exit Pill during his November speaking tour in Vancouver (BC), Bellingham (WA), San Francisco (CA), Anaheim (CA). "I think it is a way of keeping people accurately informed and allows them to make viable choices," he said. "The provision of this information is, I think, con-

sistent with good medical practice." [Voxy.co.nz, 10/30/09, ABC News, 10/30/09]

- The Swiss Federal Council, a seven-member cabinet that heads the government, announced two proposed measures to curb the increasing numbers of people traveling to Switzerland to die with the help of assisted-suicide groups. "As a country, we aren't interested in attracting suicide tourism," Justice Minister Eveline Widmer-Schlumpf said. "Today somebody can come to Switzerland and already the next day can have an assisted suicide through one of the so-called assisted suicide organizations," she added. "This should not be possible."

One of the proposed measures would restrict assisted-suicide practice, the other would ban it altogether. The government prefers the first measure which would require documentation from two independent doctors that the patient is terminally ill with only months to live and that the patient is capable of making an informed decision to die. There would be a minimum waiting period required before death could be induced, the length of which would depend on the individual case. Suicide groups would also have to prove that they are not making

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live, withdrew her antibiotics and denied her artificial feeding. The former school matron had been placed on a controversial care plan intended to ease the last days of dying patients. Doctors say Fenton is an example of patients who have been condemned to death on the Liverpool care pathway plan. They argue that while it is suitable for patients who do have only days to live, it is being used more widely in the NHS, denying treatment to elderly patients who are not dying. [Sunday Times, 10/11/09]

Fenton lived to tell the tale. Not so for 76-year-old Jack Jones. Jones was hospitalized in the belief that his previous cancer had recurred and was now terminal. The family claimed he was soon denied food and water and put into deep sedation. But his autopsy showed that *he did not have cancer at all*, but actually had a treatable infection. The hospice

denied wrongdoing but paid £18,000 to Jones's widow. [Daily Mail, 10/14/09]

This is precisely the paint-by-the-numbers medical approach that Obamacare threatens to bring across the pond to our shores. Former senator Tom Daschle—whom the *New York Times* called the most influential adviser to the president in the health-care debate—has long urged that America adopt NICE-style centralized medical planning. Indeed, according to Scott Gottlieb, writing in the *Wall Street Journal*, Daschle "argues that the only way to reduce spending is by allocating medical products based on 'cost effectiveness.' He's also called for a 'federal health board' modeled on the Federal Reserve to rate medical products and create central controls on access." [WSJ, 1/20/09]

Chillingly, current Obamacare plans call for the creation of many cost/benefit/best-practices boards, the full power of which won't be fully known until the

bureaucrats promulgate tens of thousands of pages of regulations between now and 2013, when the law would go into effect. Making matters more alarming, these boards would not only govern treatment provided in any public-option health plan, but would also be empowered to set the standards of care paid for by private insurance. Unless the final version of Obamacare is amended explicitly to prohibit such centralized health planning, don't be surprised if an American version of the Liverpool Care Pathway comes soon to a hospital or nursing home near you. ■

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a profit from clients' deaths. Dignitas director Ludwig Minelli, who has been accused of profiting financially from his suicide business, is not happy about the government's plans. "By cutting off assisted suicide for chronically or psychologically ill people who are capable of informed choice," he warned, "the government will promote lonely suicides on train tracks, from high bridges and by other inhuman methods." The government's proposals are open for public comment until March 1, 2010. A draft law will then be sent to the Swiss Parliament for consideration. [SwissInfo, 10/28/09; AP, 10/28/09; eturbonews.com, 10/31/09]

- A British study, recently published in the journal *Social Science and Medicine*, found that doctors who actively favor assisted-suicide legalization are 40% more likely to withhold or withdraw

treatment from their dying patients. Seven percent (7%) of the 3,000 doctors surveyed said they had withdrawn medications and food and fluids with the intention of hastening the patient's death. Doctors who oppose assisted suicide or who have strong religious beliefs were far less likely to intentionally cause death. [*Times*, 10/26/09]

- A study on patients in vegetative states, published in *Nature Neuroscience*, found that some patients are capable of simple learning, indicating consciousness in those patients who had failed traditional cognitive tests. This finding means that these patients have the potential for some degree of recovery. Past research indicates that the vegetative state is misdiagnosed 40% of the time. A patient's accurate prognosis can mean the difference between life and death. [*Scientific American*, 9/10/09] ■

The International Task Force on Euthanasia & Assisted Suicide is a human rights group formed in 1987 to meet the urgent need for individuals and organizations who oppose euthanasia to work together to: provide information on euthanasia and related issues; promote and defend the right of all persons to be treated with respect, dignity and compassion; resist attitudes, programs and policies which threaten the lives of those who are medically vulnerable.

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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