



SPECIAL REPORT

Health Care Law: New Words, Same Meaning

by Rita L. Marker

On March 23, 2010, President Obama signed HR 3590, the “Patient Protection and Affordable Care Act” (P.L. 111-148, 124 Stat. 119) which was drafted by the Senate. The following week, on March 30, 2010, he signed HR 4872, the “Health Care and Education Reconciliation Act of 2010” (P.L. 111-152, 124 Stat. 1029) as part of the budget reconciliation process, amending and modifying HR 3590. Together, they make up the new health care law that is often referred to as ObamaCare.

During the months leading up to passage of the health-care overhaul legislation, there was a lot of discussion—sometimes very heated discussion—about death panels, end-of-life consultations, and advance care planning.

But are those words in the new law?

The answer is “no.” In fact, the phrase, “death panel,” was never in any version of the law. It was used by many to describe what they believed would happen if the law passed. The reasons for that concern were provisions about end-of-life consultations and advance care planning that would be paid for under several early versions of health care reform. Heightening that concern was the fact that the assisted-suicide advocacy group Compassion & Choices (C&C)—previously known as the Hemlock Society—had openly acknowledged that it had played a major role in formulating and supporting the end-of-life and advance care planning portions of the early bills.

However, one can search the more than two thousand pages of the new law and not find the words “end-of-life options” or “advance care planning.” So, it would be tempting to breathe a sigh of relief and assume that the problems envisioned by earlier bills no longer exist.

Not so fast.

Assisted-suicide advocacy group claims victory

Advance care planning and consultations about end-of-life decisions *are* in the law. They’re just called something else. That this is the case, was confirmed by C&C soon after ObamaCare was signed into law. Describing its passage, C&C’s web site noted:

[A]s a result of Compassion & Choices advocacy efforts, together with Senator Ron Wyden of Oregon, the new law includes a provision to require health insurers in the so-called Public Exchange to offer enrollees information on resources available for advanced care planning....

In addition, Compassion & Choices, together with others, successfully prevented the inclusion of a measure that would have undermined aid-in-dying laws in Washington. [Note: “Aid-in-dying” is C&C’s preferred term for assisted suicide.]

Compassion & Choices’ talented advocacy team is determined to continue strategizing a way forward.

So what provisions in ObamaCare have buoyed C&C’s spirits, leading the organization to claim that advanced care planning is actually contained in the law?

And how do those provisions compare with the earlier proposals that caused such consternation in the months leading up to its passage?

Offensive phrases in earlier drafts

Last summer’s firestorm of controversy erupted over one particular section of HR 3200, the measure then under consideration. The catalyst for the label “death panels” was Sec. 1233 which would have paid practitioners (doctors, nurse practitioners, and physicians’ assistants) who provided “advance care planning consultations” to Medicare patients. Among the elements that would have been included in those consultations were discussions of decision-making documents such as living wills and durable powers of attorney for health care, orders regarding life-sustaining treatments, and an explanation of the continuum of end-of-life services.

Many people viewed this as a subtle pressure on elderly patients to decide that they will make a decision to forgo treatment for an, as yet, undiagnosed condition. In addition, the fact that, if such “advance care planning consultations” were to be paid for, a compulsory discussion about the “continuum of end-of-life services” was to be included. Since consultations about that continuum would have encompassed all legal options, they would have included discussions about the Physician Orders for Life-Sustaining Treatment (POLST) form, the voluntary stopping of eating and drinking (VSED), terminal sedation, and assisted suicide in those states where it is considered a medical treatment. (See box on page 2 for a discussion of these terms.)

However, Sec. 1233 did not make the final cut, and the offending words found in that section are nowhere to be found in the new law.

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Health Care Law: New Words, Same Meaning, continued from page 1**ObamaCare, the NHS and “NICE”**

Two sections, buried in the thousands of pages of the law, address the very same issues and provide for the same outcome as the earlier version of ObamaCare. Only the words have changed.

The first is Sec. 3201 which establishes a Center for Medicare and Medicaid Innovation (CMI) within the already existing Centers for Medicare & Medicaid Services (CMS).

Coincidentally, after ObamaCare passed, the president nominated Harvard professor Donald Berwick to head the CMS. Berwick is an avid supporter of Britain’s socialized health care system. In a 2008 address, he said, “I am a romantic about the National Health Service; I love it.” He has praised that country’s National Institute for Clinical Excellence— known by its Orwellian acronym, “NICE”—which is a panel of government selected experts who determine how funds for medical care should be allocated. NICE has been responsible for numerous Draconian measures, including denial of many cancer-treating drugs and placement of a monetary cap on the amount of money that can be spent on the last six months of a patient’s life.

In 2004, NICE urged all hospitals, hospice programs and nursing homes to institute a controversial “end of life care strategy” called the Liverpool Care Pathway. Under Pathway protocols, which are now implemented nationwide, all food and fluids are removed from seriously ill patients who are then put under continuous sedation until they die. According to researchers at the Barts and London School of Medicine and Dentistry, 16.5 percent of Britain’s deaths in just one year (2007-2008) resulted from this method.

Yet, Berwick praises the British health care system. And, if his nomination is confirmed, he will be heading up the very department that, under Sec. 3201 of ObamaCare, will determine health care models that, among other things, “test innovative payment and service delivery models to reduce program expenditures.”

Under Berwick, the CMI will have the role of “assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-

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Current medical decision-making terms and tools

POLST: stands for Physician’s Order for Life-Sustaining Treatment.

In some states it is called MOLST (medical orders for life-sustaining treatment) or similar names. A one page, two-sided form printed on brightly colored heavy paper, it is placed in the front of the patient’s medical chart and accompanies the patient when hospitalized or discharged. It gives health care providers immediate information about what interventions should or should not be undertaken.

Generally the form has boxes to check indicating whether the patient should have CPR (cardio-pulmonary resuscitation), antibiotics, tube feeding, etc. It is signed by the patient’s treating physician and by the patient or the patient’s decision maker.

However, with the exception of a decision that the patient should or should not be resuscitated, there is really no need for immediate access to other orders. In fact, checking boxes about other interventions essentially gives complete authority to health care providers and circumvents further discussion of what a patient may or may not want.

Patients or their decision makers are often pressured to have a POLST form, just as they are often led to believe that they must have an advance directive. Patients and their decision makers should be aware that it is illegal to compel them to sign such documents.

Terminal Sedation: refers to the “end of life strategy” which, in England, is called the Liverpool Care Pathway. A patient is placed under continuous sedation; all food and fluids are removed; and the patient dies of dehydration.

In the U.S., terminal sedation is often called “palliative sedation” and has been defined by assisted-suicide advocates as a process in which sedation is used to render the patient unaware and unconscious, while food and fluids are withheld.

However, true palliative sedation—used to alleviate a patient’s pain and suffering, such as extreme agitation, that does not respond to other interventions—is a technique in which the patient is sedated into unconsciousness but food and fluids are not withheld to cause death.

In a recent issue of the *American Journal of Nursing* (September 2009), other “options” were described as occurring “routinely in health care settings across the country.” The article by Judith K. Schwartz* discussed legal “clinical practices that hasten dying.” Those practices include:

VSED: stands for voluntarily stopping eating and drinking.

After a person, who need not be terminally ill, stops receiving any food and water, death occurs within five to twenty-one days. Schwartz explained that patients sometimes forget they have made a decision to stop all oral intake so, if they ask for food or water, “caregivers should gently remind the patient of the previously made decision to stop eating and drinking.”

This type of death has been described positively in medical journals, beginning with a 1994 *JAMA* article, “A piece of my mind: a conversation with my mother,” by Dr. David Eddy in which he told of helping his 84-year-old mother—who was not terminally ill—die in this manner.

C&C has unsuccessfully tried to require health care providers to offer VSED to all patients who have a predicted life expectancy of one year. (See: www.internationaltaskforce.org/iaa44.htm#17)

Physician-Assisted Dying: stands for physician-assisted suicide. It is the euphemism that assisted-suicide advocates use interchangeably with “aid in dying.” This occurs when a doctor prescribes an intentional lethal overdose of drugs that a patient takes to commit suicide.

Oregon and Washington have transformed the crime of assisted suicide into a “medical treatment” by voter initiative. In its December 31, 2009, *Baxter v. Montana* decision, the Montana Supreme Court declared that assisted suicide—which the court called “aid in dying”—is part of the “legal ethos of honoring the end-of-life decisions of the terminally ill.”

* It should come as no surprise that Judith K. Schwartz is a regional clinical coordinator of Compassion & Choices, listed on the organization’s web site as a speaker who addresses “end-of-life care.” ■

Canadian Parliament kills euthanasia/assisted-suicide bill

The Canadian House of Commons overwhelmingly defeated Bill C-384 by a vote of 228 to 59. The bill—officially titled “An act to amend the Criminal Code (the right to die with dignity)” —was MP Francine Lalonde’s third failed attempt since 2005 to convince Parliament to legalize both euthanasia and assisted suicide.

Lalonde originally introduced Bill C-384 in May 2009. Its first hour of debate was on October 2, 2009, with only about 20 members of Parliament in attendance and just two speeches in favor of the measure. Lalonde delayed the second hour of debate three times, apparently to buy time to secure more votes. But, on April 20, 2010, when the second hour of debate

was finally held, it became clear that the added support she sought had not materialized. The landslide vote against her bill followed the next day, on April 21.

While Bill C-384 advanced farther in Parliament than Lalonde’s two previous induced-death bills, it was as seriously flawed a measure as her earlier attempts. Under C-384’s provisions, anyone 18 or older who was terminally ill or had “severe physical or mental pain” would qualify for euthanasia or assisted suicide even if there were “appropriate treatments available,” but the suicidal patient had refused them. [Bill C-384, 2 (A)]

Moreover, there was no requirement that patients be capable of making in-

formed decisions regarding ending their lives, only that, when they provide the “medical practitioner” with the written death requests, they do so “while appearing to be lucid.” [Bill C-384, 2(B)(iii)] “Appearing to be lucid” is not the same thing as “being lucid.” Further, there was no mention of the need for lucidity or competency at the most crucial time just prior to patients’ induced deaths. The bill was an open invitation for abuse by greedy heirs and others to take advantage of vulnerable patients without any oversight.

Also, the bill had no residency requirement, making Canada open to death seekers from other countries, particularly from the U.S. ■

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support tools.” Those tools are meant to “improve applicable individual and caregiver understanding of medical treatment options.”

Thus, under Sec. 3201, providers of services (doctors, nurse practitioners, and physicians’ assistants) and suppliers (insurance companies) will be paid for conducting consultations for Medicare patients about health care decisions, including end-of-life options. In effect, the offending words of the early bill drafts have been replaced with different words, but the meaning is still the same.

There’s more. Unlike the earlier, seemingly more offensive language, the law will only pay for consultations if government approved “patient decision-support tools” are used.

“Entity” to formulate patient decision tools

Another section of ObamaCare (Sec. 3506) gives an indication about what these “patient decision-support tools” will look like. According to the new law, patient decision aids are intended to help patients and their health care providers decide what treatments are best for patients based on their treatment options. The law further stipulates that they “shall address health care decisions across the age span, including those affecting vulnerable populations.”

As in early versions of the health care bill, health care decisions which address the end-of-life continuum would be the subject of the government-paid consultations that are now referred to as “assisting applicable individuals in making informed health care choices.”

In addition, the government will “contract with an entity to establish standards and certify patient decision aids.” That entity will “develop and identify consensus-based standards to evaluate patient decision aids” and will “develop a certification process [to determine] whether patient decision aids meet the standards.”

Essentially, the law gives the outside “entity” control over what options are deemed appropriate for consideration by patients. And, after development of the patient decision aids, those which are certified by the “entity” will become the authorized

tools that will be available through government resource centers.

There’s a bit of a back story to the inclusion of “patient decision aids” and the provision that an “entity” under contract with the government will be empowered to design and certify those aids.

Beginning in mid-2009, various health care overhaul bills were proposed. Among these were several that were sponsored or co-sponsored by Senator Ron Wyden (D-OR) or Congressman Earl Blumenauer (D-OR), both of whom are publicly supportive of assisted suicide and Compassion & Choices. In the early bills, as in the law that passed, there were provisions for the development of patient decision aids. Those drafts, like the bill that passed, would have authorized the government to contract with an outside entity to develop such aids so that Medicare patients would have a better understanding of medical treatment options.

It’s almost a sure bet that first in line to become the outside “entity” to develop patient decisions aids under ObamaCare will be none other than Compassion & Choices or one of its affinity groups, since C&C has been working feverishly to position itself as a “patients’ rights” organization that has expertise in educating the medical profession about decision-making with particular emphasis on end-of-life care.

C&C’s description of end-of-life care is, indeed, all encompassing. In fact, Kathryn Tucker, the organization’s director of legal affairs, who will be addressing the Idaho Medical Association’s annual conference this summer, wrote a column for the ACLU of Idaho’s newsletter (Spring 2010) in which she issued an invitation to Idaho physicians to engage in assisted suicide “among other end of life options.”

There can be no question about the contents of patient decision aids if C&C is tapped to be the “entity” to design and oversee them. ■

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Oregon & Washington issue 2009 assisted-suicide reports

Both Oregon and Washington, the only two states to have passed ballot initiatives legalizing physician-assisted suicide (PAS), issued their mandated annual PAS reports on the very same day, March 3, 2010.

A coincidence? Not likely, since Washington, which passed its Death with Dignity Act in 2008, is in lockstep with Oregon and based its assisted-suicide reporting system almost entirely on Oregon's 12-year-old system. Moreover, Compassion & Choices (C&C), the advocacy group pushing assisted-suicide legalization nationally, considers itself the

“steward” of the PAS laws in both states and controls much of the information released for public consumption. In fact, the vast majority of reported assisted-suicide deaths in both states are facilitated by C&C (formerly the Hemlock Society). In 2009, C&C facilitated 97% of the reported PAS deaths in Oregon and 80% of the reported deaths in Washington. [K. Stevens, M.D., “Cornering the market on physician-assisted suicide,” *Oregonian*, 3/10/10; *Seattle Post-Intelligencer*, 3/4/10]

In 2008, Oregon's largest newspaper, *The Oregonian*, refused to endorse the

Washington ballot initiative to legalize Oregon-style assisted suicide, in part because of C&C's control over PAS information and practice. “Oregon's physician-assisted suicide program has not been sufficiently transparent,” the editorial board said. “Essentially, a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know....” [*Oregonian*, 9/20/08] The editorial board recognized that Washington's proposed assisted-suicide law would simply extend C&C's dominance over PAS deaths to another state.

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Reported Assisted-Suicide Deaths in Oregon & Washington State					
Report data supplied by lethally prescribing doctors, pharmacist reports, and death certificates. ¹					
Figures and percentages are those reported by the respective states.					
Oregon			Categories	Washington State	
1998 - 2008	2009	TOTAL		2009	TOTAL
401	59	460	Number of reported assisted-suicide deaths	36	36
629	95	724	Number of reported lethal prescriptions written	63	63
353	55	408	Number of reporting doctors who wrote lethal prescriptions in a given year	53	53
85 [26.4%]	3 [6.4%]	88 [23.8%]	Number of cases where prescribing doctor was present when lethal drugs taken	3 [8%]	3 [8%]
76 [23.5%]	1 [1.8%]	77 [20.3%]	Number of cases where prescribing doctor was present at the time of death	Not Reported	Not Reported
38 [9.6%]	0 [0.0%]	38 [8.4%]	Number of patients referred for psychiatric evaluation	3 [7%]	3 [7%]
			Patients' reasons for requesting assisted suicide:		
357 [89.9%]	57 [96.6%]	414 [90.8%]	Loss of autonomy	44 [100%]	44 [100%]
347 [87.4%]	51 [86.4%]	398 [87.3%]	Inability to do enjoyable activities	40 [91%]	40 [91%]
228 [83.8%]	54 [91.5%]	282 [85.2%]	Loss of dignity	36 [82%]	36 [82%]
233 [58.7%]	31 [52.5%]	264 [57.9%]	Lost control of bodily functions	18 [41%]	18 [41%]
152 [38.3%]	15 [25.4%]	167 [36.6%]	Being a burden	10 [23%]	10 [23%]
95 [23.9%]	6 [10.2%]	101 [22.1%]	Inadequate pain control or concern about it	11 [25%]	11 [25%]
11 [2.8%]	1 [1.7%]	12 [2.6%]	Financial implications of treatment	1 [2%]	1 [2%]
			Complications after lethal drugs were ingested:		
19 [4.9%]	1 [1.7%]	20 [4.5%]	Regurgitation	1 [3%]	1 [3%]
0 [0.0%]	0 [0.0%]	0 [0.0%]	Seizures	0 [0%]	0 [0%]
1 ²	0 [0.0%]	1 ²	Patient awakened	2 [5%]	2 [5%]
10 [2.5%]	1 [1.7%]	11 [2.4%]	Unknown	5 [14%]	5 [14%]
20	1	21	Reported incidents of physician non-compliance with the assisted-suicide law	Not Reported	Not Reported
0	0	0	Penalties imposed for non-compliance with the assisted-suicide law	Not Reported	Not Reported

Notes:

- The Oregon Department of Human Services, the agency responsible for overseeing assisted-suicide practice, has acknowledged that it has no way of knowing if data provided by prescribing doctors are accurate or complete. The Pharmacy Dispensing Report simply asks for general information (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. **Washington's system of assisted-suicide data retrieval is virtually identical to Oregon's.**
- According to Oregon's *Twelfth Annual Report*, “In 2005, one patient regained consciousness 65 hours after ingesting the medications, subsequently dying from their illness 14 days after awakening. The complication is recorded here but the patient is not otherwise included in the total number of PAS deaths.”

Sources:

Oregon Department of Human Services, *Twelfth Annual Report on Oregon's Death with Dignity Act*, 3/4/10. Available online at: <http://oregon.gov/DHS/ph/pas/docs/year12.pdf>.

Washington State Department of Health, *2009 Death with Dignity Act Report*, 3/4/10. Available online at: http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf.



News briefs from home & abroad . . .

- While the Swiss assisted-suicide clinic Dignitas touts the motto “Live with dignity, die with dignity,” it apparently isn’t at all concerned that its members are buried with dignity. The clinic, which specializes in offing foreigners, is currently under investigation for allegedly dumping hundreds of urns filled with the ashes of its deceased clientele into picturesque Lake Zurich.

Located about 30 feet below the surface at Trotte Bay on the lake’s Gold Coast, the pile of urns was accidentally discovered by divers. “At first we thought they were flower pots,” explained one diver. “When I realized that they contained the remains of people, I was horrified,” he said. “I do not know how many are down there, it could be hundreds.” [*Daily Mail*, 5/10/10]

This isn’t the first time Dignitas has been investigated for dumping human remains into the lake. In 2008, two of its employees were caught by a local property owner pouring ashes into the lake while on his land. At the time, even after hundreds of human bone fragments began to wash up on

shore, Dignitas was not charged, only warned to cease the dumping. But, after the recent gruesome discovery, Switzerland’s **Environment Agency** filed a criminal complaint pending the outcome of the investigation.

The urns found show no direct link to Dignitas, other than they all bear the imprint of the crematorium Dignitas always uses. Soraya Wernli, a former Dignitas employee, said that the clinic’s director, Ludwig Minelli, would pry off the nameplate on each urn and take the lid off before disposing of them in the lake. [*Daily Mail*, 4/27/10, 5/10/10]

While it will be almost impossible to determine the individual identities of the remains, there is ample evidence to point to Dignitas as the dumping culprit. Among that evidence is a profile published in the March 2010 issue of *The Atlantic*. According to the author, “Minelli told me he stores the urns until he has enough to fill his car. Then he drives, usually at night, to a quiet spot nestled among the multimillion-dollar houses on Lake Zurich, and tosses the

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Oregon’s 2009 PAS report

According to the Oregon Department of Human Services (ODHS), 95 prescriptions for intentionally lethal drugs were written by 55 doctors in 2009. Of the 95 patients for whom the prescriptions were written, 53 took the drugs and died, 30 opted not to take the drugs and died of their underlying illness, and 12 were still alive at the end of the year. Adding to the death toll for 2009 were six patients who had obtained their lethal drug prescriptions before the beginning of the year but took the drugs in 2009 and died. The total number of reported assisted-suicide deaths in 2009 is 59. The total of reported PAS deaths since the Oregon law took effect in October 1997 is 460.

It’s important to note, however, that only PAS deaths that were *reported* to the ODHS are included in the annual reports. The ODHS has repeatedly acknowledged in its earlier reports that it has no way to detect unreported PAS deaths and no way of knowing if data submitted by doctors in reported cases are even accurate or complete.

In 2009, there was only one reported case where the lethally prescribing doctor was present when the patient died. That means that the data which physicians reported to the state regarding the deaths of the other 58 was second-hand information

from someone who was present. Since C&C oversaw 97% of the 2009 assisted-suicide deaths, it’s very likely that C&C facilitators were present at the time patients took the lethal drugs and were the primary source of doctors’ second-hand reported death data.

Another disturbing statistic is that none of the 59 patients who opted for assisted suicide in 2009 had been referred for a psychiatric evaluation to rule out depression, other mental illnesses, dementia, coercive pressures, etc., as sources of the patient’s hastened death wish. [ODHS, *Twelfth Annual Report on Oregon’s Death with Dignity Act*, 3/4/10]

Washington’s 2009 PAS report

The Washington State Department of Health’s (WSDH) first annual PAS report revealed that, between March 5, 2009 (when the PAS law took effect) and December 31, 2009, 53 doctors wrote lethal drug prescriptions for 63 individuals. Of those, 47 died in 2009 (36 took the drugs and died; 7 did not take the drugs but died of their underlying illnesses; and, for the remaining four, the WSDH has no clue why or how they died). The state agency also has no knowledge of the “ingestion status” of another 16 people who obtained a lethal drug prescription in 2009 but did not die. In other words, the

WSDH lost track of 20 out of the 63 people who were dispensed fatal drugs.

The Washington report shares many similarities with Oregon’s PAS experience. Most of the people who opted for assisted suicide were white, married, had health insurance, and were college graduates with a baccalaureate or graduate degree. The vast majority in both states lived west of the Cascade Mountains. Most had cancer and were enrolled in hospice programs. Pain was not high on their lists of concerns. Fears of losing autonomy ranked the highest, closely followed by fears over the inability to engage in enjoyable activities, loss of dignity, lost control over bodily functions, and being a burden on their families or caregivers.

Assisted-suicide doctors in both states are apparently not interested in being present during the dying process. In fact, each state reported that the prescribing doctor was present in only three cases *when the patient ingested the drugs*. In Oregon, there was only one case where the doctor was present *at the time of death*. Washington didn’t even have that category in its report.

Following Oregon’s trend, Washington doctors referred only three patients for a psychiatric evaluation. [WSDH, *2009 Death with Dignity Act Report*, 3/4/10] ■

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remains into the water, urns and all.” [Falconer, “Death Becomes Him,” *The Atlantic*, 3/10]

“The terrible thing is that people’s last wishes weren’t respected,” Wernli said. “Women wanted to be buried next to their husbands, but instead Dignitas threw their ashes in the lake.” [*London Times*, 5/9/10]

- A new study, published in the *Canadian Medical Association Journal*, examines two categories of “physician-assisted deaths” currently being practiced in Belgium, a country that followed the Netherlands’ lead and legalized euthanasia and physician-assisted suicide in 2002. Also, like the Netherlands, Belgium categorizes euthanasia as cases where the patient voluntarily and explicitly requests death. If there has been no clear, voluntary request, the case is termed “the use of life-ending drugs without explicit patient request,” and considered totally distinct from euthanasia, even though the one doing the killing in both cases is a physician. Such non-voluntary deaths are

technically illegal under Belgium’s euthanasia law.

But, according to the study, ending a life without an explicit request occurs in 1.8% of the deaths in Flanders, Belgian’s predominately Dutch section, while legal euthanasia and assisted suicide account for only slightly more deaths (2.0%) in the same region. Researchers also found that euthanasia and assisted-suicide patients were predominantly under age 80, had cancer, and died at home, whereas the patients who did not ask to die were usually 80 or over, did not have cancer, and their lives were most often ended in the hospital. Doctors surveyed indicated that “the decision had not been discussed with the patient because the decision was in the patient’s best interest (17.0%) or because discussion would have been harmful (8.2%).” In some cases, the patient was comatose or had dementia. [Chambaere, et al., “Physician-assisted deaths under the euthanasia law in Belgium,” *CMAJ*, 5/17/10] ■

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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