



Suicide advocates advertise to lure members

Is there such a thing as a “safe suicide”? There is, if you believe the promotional material distributed by Dr. Philip Nitschke (Australia’s Dr. Death) to drum up business for his do-it-yourself “Safe Suicide” workshops he conducts in various countries. But Nitschke’s workshop flyers and e-mails only generate limited interest, mostly among the elderly.

In order to attend the how-to workshop, new participants are required to pay a sizable fee to also join Nitschke’s organization, Exit International. The more participants there are, the more Exit members he can claim and the more fees he can collect. So to better promote his cause, Nitschke hired an ad agency to produce a 45-second TV ad depicting a gaunt actor in pajamas saying,

I chose to marry Tina, have two great kids. I chose to always drive a Ford. I chose this shirt. I even chose this haircut. What I didn’t choose is being terminally ill. I didn’t choose to starve to death because eating is like swallowing razor blades. I certainly didn’t choose to have to watch my family go through it with me. I’ve made my final choice. I just need the government to listen.

But Australian authorities banned the ad nationally because it did not comply with the Commercial Television Code of Practice regarding the “promotion or encouragement of suicide.” Canada soon followed suit after Nitschke wanted to run the TV ad to promote his recent workshop tour there. The ad, however, will air in New Zealand and Italy. [AAP, 9/10/10; *Toronto Sun*, 9/27/10; Exit International E-mail, 11/17/10]

Nitschke has also turned to billboard advertising. Soon, he said, there will be billboards in Melbourne and Brisbane that will say, “85 percent of Australians support voluntary euthanasia, our government doesn’t! Make them listen.” [Express, 10/5/10]

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It’s official: Vermont next state targeted for assisted-suicide bill in 2011

“The stars in Vermont are finally aligning,” declared Dick Walters, president of Vermont’s newly consolidated, assisted-suicide advocacy group Patient Choices at End of Life. After years of failed attempts to pass “Death with Dignity” legislation, advocates began sensing the possibility of change in Vermont. [deathwithdignity.org, 9/29/10]

Though cautiously optimistic, advocates remained tentative about launching another legislative campaign—that is, until Peter Shumlin, the Vermont gubernatorial candidate who declared himself staunchly pro-assisted suicide, was victorious on election day, November 2, 2010.

Then, Peg Sandeen, executive director of the Oregon-based Death with Dignity National Center (DWDNC), emboldened by the Shumlin victory, shot off a press release officially announcing Vermont as the next targeted state and laying the groundwork for future doctor-prescribed suicide initiative campaigns in other New England states:

After years of working in collaboration with supporters in Vermont, we’re ready to publicly proclaim the high chance of success in the Green Mountain State.... Our extensive research and polling demonstrates several states in New England are on the cusp of passing Death with Dignity laws. Passing a new law in 2011 will establish a foothold in New England and set the stage for a successful 2012 ballot initiative campaign. [DWDNC Press Release, 11/3/10]

This is not the first time the DWDNC determined which state had a “high chance of success” for legalizing doctor-prescribed death. In 2007, this group along with Compassion & Choices (the former Hemlock Society) targeted Washington as the state most likely to follow Oregon’s lead and pass a measure to legalize assisted suicide. In 2008, these extremely well-funded groups convinced voters to do just that.

While Oregon and Washington passed assisted-suicide ballot initiatives, no state has ever passed a legislative bill to legalize the practice, despite there being over 110 such attempts in 24 states since 1994. But in Vermont, as Sandeen explains, “...all of the appropriate pieces of the [legislative] model will be in place: a supportive governor, an organized grassroots structure, model legislation tested in other states, and a supportive constituency.” [deathwithdignity.org, 9/29/10] ■

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Compassion & Choices' role in official suicide reports confirmed

During September and early October 2010, a Scottish parliamentary committee conducted hearings on a bill authored by MSP Margo MacDonald that would legalize both euthanasia and assisted suicide in Scotland. (See page 5 for information on the committee's findings.)

On September 7th, the committee questioned two experts on Oregon's 13-year-old assisted-suicide law via a video-conference link from Portland, Oregon. The experts were Dr. Linda Ganzini, a professor of psychiatry and medicine at the Oregon Health and Science University who has conducted a number of studies on the law and the people who use it to die, and Deborah Whiting Jaques, executive director of the Oregon Hospice Association. Their testimony confirms that the doctor-prescribed suicide advocacy group Compassion & Choices essentially controls the information contained in both Oregon's and Washington State's annual assisted-suicide reports. Moreover, the testimony substantiates concerns that doctors who do not comply with Oregon's assisted-suicide law are not being penalized in any way.

When the committee asked the two women to describe Oregon's official doctor-assisted suicide oversight and monitoring procedures, Jaques replied:

We do not have a monitoring committee approach. Physicians are responsible for reporting death with dignity to the Department of Human Services. The *Compassion & Choices of Oregon* agency produces the reports, collects the data and provides them to the state of Oregon, which ensures that the data are published and made publicly available on an annual basis. The *state of Washington* has implemented similar monitoring processes after passing legislation last year. [Emphasis added.]

Ganzini then added:

...If the [health] division is concerned that the correct law has not been followed, it will look into the case and will refer the physician to the Oregon Medical Board, which is the licensing and disciplinary board that deals with such concerns. That has happened. It usually happens if there are issues around witnessing and other criteria.... *No physician has lost their license or their ability to practice because of a problem around the law.* [Emphasis added.]

Jaques ended their joint response by saying, "I am not aware that there has even been disciplinary action surrounding a death with dignity event."

Subsequently, Ganzini was asked if any doctor-prescribed deaths went unreported. She replied, "It would be very difficult to know whether that is happening..." [Transcript, End of Life Assistance (Scotland) Bill Committee Hearing, 9/7/10] ■

Oregon hospices say no to assisted-suicide participation

A study published in the *Hastings Center Report* found that all the Oregon hospice programs surveyed prohibited their staff members from helping patients obtain and self-administer lethal drug overdoses, which is legal since Oregon enacted its Death with Dignity law in 1997.

Researchers received documents representing 56 hospice programs (amounting to 86% of the state's hospice programs). Virtually every program had a policy statement that read, "Hospice [name] will not provide, pay for, deliver, administer, or assist with medications intended for [physician-assisted suicide/physician-assisted death]." The study's authors concluded that hospice assisted-suicide policies and guidelines reflect an attempt "to be faithful to the historically formative values of hospice care"—values held by the nonreligious hospice programs (45 programs) as well as those with a religious affiliation (11 programs).

If patients ask for information about assisted suicide, most hospices require that staff members take a position of neutrality. Some do not provide any information at all and ask patients to respect their position. Some will refer patients to their attending physicians for information, since they are the only providers legally allowed to assist a patient's suicide. If hospice, with its team approach to patient care, were involved, the patient's death would be hospice-assisted instead of doctor-assisted suicide.

The job of arranging for an assisted suicide rests with the patient or his/her family, not with hospice. Researchers found that the assisted-suicide advocacy group Compassion & Choices of Oregon often gets involved to facilitate the process. [*Hastings Center Report*, September-October, 2010] (For more on this, see page 3.) ■

Suicide advocates blitz Montana

Compassion and Choices (C&C) has ramped up its campaign to mount public pressure for the passage of a bill to explicitly legalize doctor-prescribed suicide during Montana's 2011 legislative session. To that end, C&C has sent a constant stream of speakers to address even small audiences in local library meeting rooms, to write op-ed pieces in local newspapers, and to appear on local radio talk shows.

Recent speakers have included Ann Jackson (former Oregon Hospice Association head and a C&C donor), Barbara Glidewell (billed as a "death with dignity expert and bioethicist") and Dr. Tom Preston (medical director of C&C of Washington). Preston's 10-day speaking tour included a talk at Montana State University. [*Billings Gazette*, 7/17/10 & 10/25/10; *Havre Daily News*, 9/17/10]

Bills to expressly ban doctor-assisted suicide will also be introduced during the 2011 legislative session. ■



Oregon hospices right not to cooperate with assisted suicide

by Wesley J. Smith

I am rarely encouraged by news out of Oregon about assisted suicide, where doctors may legally prescribe a lethal overdose to patients they diagnose as terminally ill. Over the years, the number of assisted suicides has increased, while the media studiously ignored studies demonstrating that abuses abound. For example, a major study in the *Michigan Law Review* by Dr. Kathleen Foley—perhaps the country’s most respected palliative care physician—and suicide prevention expert, Dr. Herbert Hendin, found that the so-called protective guidelines are often violated with legal impunity. Further, the study found that the bureaucrats in charge of overseeing the law “do not collect the information [they] would need to effectively monitor the law” and worse, that “in its actions and publications [they] act as the defender of the law rather than as the protector of the welfare of terminally ill patients.”

I have also been distressed by assisted-suicide advocates bragging that most people who receive doctor-prescribed death were in hospice when they died—as if that made it all okay. But now a study published by the Hastings Center shows that the assisted-suicide agenda has not yet corrupted the state’s hospices. To the contrary: Most Oregon hospices do not actively participate in Oregon assisted suicide. From a *Hastings Center Report* study:

During 2009, in order to assess the extent to which Oregon hospice programs participate in physician-assisted death, we requested policy statements, program guidelines, and staff education materials that had been developed by sixty-four hospice programs affiliated with the Oregon Hospice Association to address patient inquiries about the Death with Dignity Act. We received forty documents representing fifty-six programs. Our examination of these documents suggests that individual hospice programs generally assume a minor role in the decision-making process of patients who exercise their rights to physician-assisted death—a role largely confined to providing information about the law in a “neutral” manner. Moreover, hospices claim they will not assist with providing the medications necessary to hasten a patient’s death. This limited role indicates that questions of legal compliance and moral complicity inhibit hospice collaboration with patients seeking physician-assisted death.

I hope the actual reason is more fundamental, that hospice workers in Oregon understand that facilitating assisted suicide is directly contrary to the hospice philosophy. Indeed, rather than facilitating doctor-prescribed death, hospice professionals are supposed to prevent the suicides of their patients by intervening to

provide services or treatments the patient might be lacking, so that they no longer want to die immediately.

I can personally attest to how seriously this obligation is taken by hospice administrators. I was trained as a hospice volunteer, and I was told in no uncertain terms that if I even suspected that a patient was suicidal, I was to immediately inform the multidisciplinary team so they could provide preventive mental health and other services—just as the medical profession would for any other suicidal person.

This raises an important question: Why does hospice philosophy oppose assisted suicide? According to the late Dame Cecily Saunders—the creator of the modern hospice concept and one of the great medical humanitarians of the 20th Century—doctor-prescribed suicide denies the equal dignity of hospice patients. As she wrote in the 2002 book, *The Case Against Assisted Suicide* (chapter, “The Hospice Perspective”), hospice asserts on behalf of the dying patient his or her “common humanity and personal importance” to the moment of natural death.

The well-known American hospice physician, Ira Byock, is similarly opposed to assisted suicide, writing in the *Journal of Palliative Care*, “The hospice focus is on life and the alleviation of suffering,” whereas “the goal of assisted suicide and euthanasia is death.” Moreover, if a hospice cooperated in doctor-prescribed death, it would abandon that patient to his or her worst fears—that they will die in agony, that they are a burden, that their lives truly are no longer worth living.

Thus, when assisted-suicide facilitators in Oregon brag that they have assisted the suicides of hospice patients, they are actually admitting that they interfered with the proper medical care of these patients. Indeed, boasting of helping hospice patients kill themselves is akin to patting themselves on the back for helping the patient die after denying them proper pain control—another crucial hospice medical service.

This is the bottom line: Hemlock (if you will) and Hospice cannot occupy the same philosophical space. That is why I am very pleased that Oregon hospices are generally keeping assisted suicide at arm’s length. Legal or not, doctor-prescribed death has no place in proper end-of-life care. ■

Wesley J. Smith is an ITF legal consultant, a senior fellow in The Discovery Institute, and a Center for Bioethics and Culture special consultant. He is also the author of many books including Forced Exit, The Culture of Death, and co-author of Power over Pain (published by the ITF).

Euthanasia & assisted suicide hotly debated in Australia & Canada

Senator Bob Brown, Australia's Green Party leader, has reignited the euthanasia debate by calling for the Federal Parliament to pass his bill, the Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010. The measure's title is somewhat misleading because, if passed, it would not legalize euthanasia as such. Rather, it would restore the rights of the legislative assemblies of the Northern Territory (NT), the Australian Capital Territory (ACT), and Norfolk Island to legalize euthanasia if they so choose. The bill would repeal the Euthanasia Laws Act 1997, a measure passed by the Federal Parliament to overturn a euthanasia law enacted by the NT Parliament in 1996, making the NT the first jurisdiction in the world to legalize the practice.

Prime Minister Julia Gillard said any parliament vote on Brown's bill would be a conscience vote, but she also indicated that she is "conflicted" on the euthanasia issue since it is "almost impossible" to create real safeguards against abuse.

Even if Brown's bill were to pass, it is doubtful that the current NT Parliament would legalize euthanasia. NT Chief Minister Paul Henderson indicated it is not a priority issue. Even euthanasia advocate Dr. Philip Nitschke doubts that NT politicians will vote for legalization. But Brown's Green Party has made euthanasia legalization a top priority for Australia's

five states as well as its territories. [NT News, 9/13/10; The Age, 9/20/10, 9/27/10; Sydney Morning Herald, 10/29/10]

During the fall in Quebec, Canada, the government-formed Select Committee on Dying with Dignity conducted public hearings in 11 communities throughout the very liberal province to determine the public sentiment on euthanasia and assisted-suicide legalization. What became apparent, however, was that a consensus on those issues would be highly unlikely due to the diversity of the strong opinions voiced. [CTV News, 9/7/10]

When representatives from various professional health care groups testified that what was needed was more and better palliative care services, not euthanasia or assisted suicide, H el ene Bolduc, president of the Right to Die with Dignity Association, charged that the hearings were being sidetracked by these calls for better care. "It's not because I don't believe in this type of care," she said, "but palliative care shouldn't be practiced with dogged determination." [CBC News, 9/8/10]

But Gyslaine Desrosiers, president of a professional nurses' order that represents over 71,000 nurses, testified that better palliative care should be developed. She told the committee, "We don't want to live in a society where it is easier to die than to be cared for." [Montreal Gazette, 9/29/10] ■

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It's likely that Nitschke got the billboard idea from the U.S. assisted-suicide group Final Exit Network (FEN). Last summer, FEN paid for billboards to be placed in high-traffic areas in San Francisco and New Jersey. The billboards read, "My Life My Death My Choice" followed by "FinalExitNetwork.org." Because the ads drew strong criticism for encouraging suicide, FEN changed the message for a billboard in South Florida. The new message makes clear FEN's goal to recruit new members: "Irreversible illness? Unbearable Pain? Die with Dignity... Join Final Exit Network." FEN's billboards are being funded by tax-deductible donations.

According to a FEN press release, during the last two weekends in October, the group planned for a helicopter with a huge lighted grid to fly across the night sky over Baltimore and Washington with the scrolling message: "Die with Dignity" followed by FEN's contact information. [FEN Press Release, 10/18/10] ■

Dignitas director calls for assisted suicide for relatives

Once again, Ludwig Minelli, director of the Swiss assisted-suicide clinic Dignitas, has been in the news. Referring to a tragic case (involving a 64-year-old man who, after caring for his 73-year-old wife with Alzheimer's for 7 years, strangled her and then laid beside her corpse for several days), Minelli said that the relatives of those who opt for an assisted suicide should be offered suicide assistance as well, particularly if they are grieving over the family member's death. "Relatives, should also be allowed to have a prescription for suicide drugs even when they are not terminally ill," Minelli told the Swiss newspaper *Blick*. "The government is required to give dementia sufferers and their families more opportunities," he added.

Birgitta Martensson, the director of the Alzheimer's Association Switzerland, called Minelli's comments about family members "grotesque." However, she agreed that Alzheimer's patients who still have the ability to discern should have the assisted-suicide option. The original *Blick* newspaper article even credited Minelli for speaking to "a real public health problem" since there are currently over 100,000 people with dementia in the country.

A *Blick* survey accompanying the article on Minelli posed the question: Should assisted death be offered to the relatives of seriously ill people?

42.64% said "No, this is going too far."

41.79% said "Yes, family members may also suffer."

15.57% said "Prohibit assisted death. We must not play God."

[*Blick.ch*, 10/17/10; *Daily Mail* (London), 10/18/10; *24 Heures*, 10/19/10; GenevaLunch.com, 10/19/10] ■



News briefs from home & abroad . . .

- A parliamentary committee in **Scotland**, convened to study a bill to decriminalize euthanasia and assisted suicide, has strongly recommended that Parliament reject the measure. After months of gathering written and oral testimony from, among others, experts experienced with both death practices in other countries as well as specialists in palliative care, the **End of Life Assistance (Scotland) Bill Committee** concluded:

Overall, the majority of the Committee was not persuaded that the case had been made to decriminalise the law of homicide as it applies to assisted suicide and voluntary euthanasia, termed ‘end-of-life assistance’ in the Bill, and, accordingly, does not recommend the general principles of the Bill to the Parliament. [www.scottish.parliament.uk/s3/committees/endLifeAsstBill/reports-10/ela10-01-vol1.htm#67]

The bill’s author, independent **MSP Margo MacDonald**, charged the committee with ignoring the evidence presented to them because of their “known hostility” to doctor-prescribed death. [*Herald Scotland*, 11/19/10] But the committee’s report listed realistic concerns over what it called “flaws” in the bill (i.e., the use of ambiguous and misleading language, heightened risks to disabled people and the poor, provisions with inequitable and dangerous applications, lack of a conscience clause for health care professionals to opt out, etc.)

The **British Medical Association Scotland** welcomed the committee’s rejection of the bill, as did the coalition **Care Not Killing**. [*Press & Journal*, 11/19/10]
- A recent Canadian survey, conducted by **Environics Research**, indicates that support for euthanasia legalization has fallen in all regions in **Canada** within the last year. The poll found that 59% of the 2,025 people surveyed supported legalization (with only 22% voicing strong support), down from 61% support (with 25% strongly supporting legalization) last year. Of particular note, this year’s poll found that more Canadians are concerned about the adverse effects euthanasia legalization would have on vulnerable patients: 63% felt patients would feel pressured to die in order to lower health care costs and 78% worried that sick, disabled, or elderly people would be euthanized without their consent. 71% said that the government should improve palliative care rather than legalize euthanasia. The survey was conducted September 15-22, and has a margin of error of +/- 2.2%. [Press Release, Euthanasia Prevention Coalition (Canada), 11/8/10]
- In September, **Montreal, Canada**, hosted the **First International Pain Summit**, where delegates from 84 countries came together and issued the historic document, “**The Declaration of Montreal**.” The document declares that access to pain management is a fundamental human right and that treatment for acute pain is inadequate for more than 50% of people in developed countries and 90% of those in developing countries. The declaration also calls for pain assessment to be accepted by health care providers as the “fifth vital sign” in patient

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We’re changing our name...

Those familiar with the work of the International Task Force know that we’re committed to providing documented research and information on euthanasia and doctor-prescribed suicide, practices that abandon patients when they are most vulnerable.

But the actual scope of our work is even broader than that. It encompasses all end-of-life issues—from the withholding of food and fluids from incompetent patients to the denial of wanted, life-saving treatment deemed futile by health care providers; from the creation and dissemination of our state-specific, health care advance directive (the Protective Medical Decisions Document) to the publication of our book *Power over Pain: How to Get the Pain Control You Need*.

What all these efforts have in common is our strong commitment to protecting patients’ rights. That’s why, starting in January 2011, the name International Task Force on Euthanasia & Assisted Suicide will change to **Patients Rights Council**. Nothing else will change—just our name. ■

Will your legacy live on?

Planned giving is a great way to support the **Patients Rights Council** (formerly International Task Force). It can be as simple as leaving us a bequest in your will, or using one of the many tax-advantaged strategies available under the law. You can be assured we’ll use your gift wisely, in keeping with our mission of advocating for compassionate care for all.

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News briefs from home & abroad, *continued from page 5*

care and recorded as such. According to **Margaret Somerville**, director of **McGill University's Centre for Medicine, Ethics, and Law**, the Declaration of Montreal "is not just a piece of paper; it's what we call a 'verbal act,' that is, its words will change reality, just as a judge's verdict is not just words, but changes reality." [Press Release, International Association for the Study of Pain, 9/3/10; *Ottawa Citizen*, 9/4/10]

- In a recent issue of the *Final Exit Network Newsletter*, Jerry Dincin, president of **Final Exit Network (FEN)**, reported on the organization's recent board of directors' meeting. He related the various projects and proposals discussed by board members, including distribut-

ing the explicit how-to-commit-suicide manual *Final Exit* to public libraries and encouraging more assisted-suicide test cases (to test laws and legal systems). "Some suggested," he wrote, "we make the human-rights aspect of our work more prominent, perhaps thereby encouraging more youth to join." [*Final Exit Network Newsletter*, Summer 2010, p. 3]

FEN is a national network of volunteers who travel around the country to assist the suicides of its members. Currently, FEN's medical director, **Dr. Lawrence Egbert**, and several of the volunteer "**Exit Guides**" are under indictment in **Georgia** and **Arizona** in connection with the deaths of two non-terminally ill members. ■

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.

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