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# Update

## Massachusetts voters reject assisted-suicide initiative in stunning upset

Until very recently, all the polls reflected overwhelming public support for Massachusetts Ballot Question 2, an initiative that would have legalized Oregon-style doctor-prescribed suicide in the Bay State. But the measure’s supporters were in for a shock on election day, November 6, when opponents overcame a 48–point polling deficit to defeat the measure 51 to 49 percent. Incredibly, the final tabulation showed the “No” side on top by 63,000 votes.

“The turnaround on this campaign was remarkable,” said Tim Rosales, campaign strategist for Massachusetts Against Doctor-Prescribed Suicide - No On 2. “Generally, when you see support for a ballot question in the high sixties it should be a slam dunk,” he explained. [No On 2 Press Release, 11/7/12]

And, indeed, the national assisted-suicide advocacy groups backing Question 2—Compassion & Choices and the Death with Dignity National Center, both old Hemlock Society spin-off groups—were confident that the polls foretold a major victory for them. Even very late in the campaign, Michael Clarke, campaign director for Dignity 2012, the group pushing for the initiative’s passage, sent an email message enthusiastically telling supporters about a new *Boston Globe* poll showing they had a 47 to 37 percent lead over opponents. “With just 5 days before the election, we can pass Death with Dignity,” he wrote. [Dignity 2012 letter, 11/1/12]

But if opponents have learned anything from previous state assisted-suicide initiative campaigns it is that

polls often reflect the public’s knee-jerk support for something they really don’t know much about, something made to sound desirable in carefully crafted and often deceptive poll questions. In the case of assisted-suicide, once people find out what the measure really means, support dramatically evaporates.

Due in large part to the efforts of state opposition groups like Massachusetts Against Doctor Prescribed Suicide, the disability group Second Thoughts, and the Committee Against Physician-Assisted Suicide, voters learned that Question 2 was badly written, seriously flawed, and wide open to the abuse of society’s most vulnerable patients.

Many other prominent groups also opposed the measure. They included

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## Outrage escalates over abuse of UK’s end-of-life care pathway

It’s called the Liverpool Care Pathway (LCP), and it’s extremely controversial. Laudably, it was created in the late 1990s by Liverpool’s Marie Curie Hospice and the Royal Liverpool University Hospital to reduce the suffering of imminently dying patients whose specialized needs would not be met if they were placed in the hospital’s general patient population. The LCP was so successful that Great Britain’s socialized health system, the National Health Service (NHS), adopted its use nationwide in most of its hospitals, hospices, and nursing homes in 2006.

But, in 2009, six palliative care experts wrote an open letter to London’s *Daily Telegraph* stating that some LCP patients were being deeply sedated while all their food and fluids as well as antibiotics and other drugs were being withheld, directly causing their deaths. This was happening, the experts

wrote, “without regard to the fact that the diagnosis could be wrong.” [Daily Telegraph, 9/2/09, 9/3/09]

While this revelation generated some protests and calls for reform, they were mild compared to what happened after Dr. Patrick Pullicino, a noted neurologist consultant at East Kent Hospital and professor of clinical neurosciences at Kent University, addressed the Royal Society of Medicine’s Medical Ethics Alliance conference last June.

Pullicino told those in attendance that UK doctors were turning the LCP into a euthanasia program for the elderly and seriously ill patients by prematurely ending their lives if they were difficult to manage or the hospital needed to free up beds for other patients. He explained that the LCP is supposed to be used only if the doctor thinks that there

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## Minnesota judge rules guardians cannot end life support

In a landmark Minnesota case, Hennepin County District Judge Jay Quam ruled that appointed guardians in the state cannot order the removal of life support from their wards.

While the judge acknowledged that state law gives guardians the power to allow or withhold medical care, he pointed out that it does not specifically empower guardians to terminate life support. Only judges and the patient's legally authorized surrogate have that power.

"Simply stated," the judge wrote, "if the Legislature intended to give a guardian the power to end the ward's life, it would have explicitly done so."

The case involved Jeffers Tschumy, a 57-year-old mentally disabled man who lived in a group home and had been under guardianship since 2008. Last April, he choked on food, but could not be revived so oxygen could not reach his brain. He was declared severely brain damaged with little hope of recovery.

Since Tschumy had no advance health care directive and no family member could be found, his health care provider, Allina Health System, filed a petition asking the judge to allow the removal of Tschumy's life support either by ruling that his guardian, Joseph Vogel, had the power to make that decision or by a direct ruling from the court authorizing the

the cessation of life-sustaining treatment. In May, Judge Quam did the latter and ordered the removal of Tschumy's life support, but rejected the guardian's petition for sole power to issue such an order.

"The Court does not believe that the Legislature intended a subtle inference in a statute to bestow on 12,000 guardians around the state the most awesome power imaginable over the life of another," the judge ruled.

Tschumy's court appointed attorney—responsible for safeguarding the patient's best interests—favored the removal of life support, which resulted in Tschumy's death. [*Star Tribune*, 10/18/12] ■

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the Massachusetts Medical Society, Hospice & Palliative Care Federation of Massachusetts, Massachusetts Academy of Family Physicians, American Medical Association, American College of Physicians, Western Massachusetts Pharmacists Association, National Spinal Cord Injury Association, National Council on Disability, Autistic Self Advocacy Network, American Nurses Association, American Society for Pain Management Nursing, American Society of Anesthesiologists, and National Hospice & Palliative Care Organization, to name a few.

Dignity 2012 garnered endorsements from two medical groups: the American Medical Women's Association and the American Medical Student Association. High-profile individuals who declared support for the prescribed-suicide measure included Dr. Marcia Angell, former editor of the *New England Journal of Medicine* and one of the initiative's original petitioners, and actor Leonard Nimoy, best known for playing Dr. Spock on the TV series "Star Trek." [Death with Dignity National Center Blog, 10/31/12]

On the other side, Victoria Kennedy, an attorney, health care advocate, and the widow of the popular former Massachusetts senator, Ted Kennedy, made public her strong stance against the ballot measure. In an opinion piece titled,

"Question 2 insults Kennedy's memory," she wrote,

"My late husband Sen. Edward Kennedy called quality, affordable health care for all the cause of his life. Question 2 turns his vision of health care for all on its head by asking us to endorse patient suicide—not patient care—as our public policy for dealing with pain and the financial burdens of care at the end of life. We're better than that." [*Cape Cod Online*, 10/27/12]

On the same day Victoria Kennedy's article was published, another op-ed ran in the *New York Times* that could have also influenced the Massachusetts vote. It was by Dr. Ezekiel Emanuel, the Obama administration's former special advisor for health policy, who wrote that the four main arguments used for legalizing assisted suicide are "falsehoods":

- Assisted suicide is not about ending severe physical pain. It's about escaping "psychological distress" driven by "depression, hopelessness and fear of loss of autonomy and control."
- The future prospect of being hooked up to undignified, advanced medical technology is not why people want to end their lives early. It's "the rise of individualistic strains of thought that glorify personal choice" that is to blame.

- Assisted suicide will not improve everyone's end-of-life care. "[T]he poor, poorly educated, dying patients who pose a burden to their relatives" will suffer abuse.

- Assisted suicide is not a guaranteed quick and painless way to die. "Nothing in medicine—not even simple blood draws—is without complications."

"The appeal of physician-assisted suicide is based on a fantasy," Emanuel concluded. "The real goal should be a good death for all dying patients." [*NY Times*, 10/27/12]

#### Advocates plan for the future

While the unexpected loss in Massachusetts was a huge defeat for prescribed-death activists, Compassion & Choices (C&C) will continue to carry out its strategic campaign—called "Critical Mass" before the defeat—to "build a base of popular support for end-of-life liberty across New England and into New York." [C&C emailed letter, 10/9/12]

But C&C has designs on other states as well. In a defeat follow-up letter to supporters, C&C President Barbara Coombs Lee wrote, "Together we travel onward in Hawaii, Connecticut, New Mexico, Vermont, Montana, New York and California. We have quite a year ahead." [C&C letter, 11/7/12] ■

## Lawsuit filed against NY Organ Donation Network for lethal violations

A lawsuit filed on September 26, 2012, accuses the New York Organ Donation Network (NYODN), a non-profit, federally designated organ procurement organization, of coercing doctors to declare living patients brain dead and using pressure tactics on unsuspecting members of the patients' families to get their consent to surgically harvest the patients' organs.

The suit was brought by former NYODN employee Patrick McMahon, 50, who worked for the organization from July 2011 until he was fired in November of the same year. McMahon—an experienced Air Force Flight Nurse and a nurse practitioner who saw action in Iraq and Afghanistan—was hired as a transplant coordinator by NYODN, a job that required him to work in many hospitals around the state.

His duties included making sure that NYODN adhered to the NY State Department of Health's transplant guidelines as well as all state laws and individual hospital rules regulating the determination of brain death. If the patient responded to even one of twelve required neurological tests, if those tests were not done or done incorrectly, or if test results were ignored, then it was McMahon's responsibility to stop the organ retrieval.

According to the court complaint, McMahon witnessed firsthand "NYODN employees declaring patients brain dead even though they would respond to neurological tests and show signs of brain activity." NYODN would then end the patients' lives by harvesting their organs, often without a proper brain death diagnosis or consent from families.

The complaint lists four cases in which NYODN violated state guidelines:

- A 19-year-old was admitted to Nassau County Medical Center in critical condition. Since young donors are a "high priority," NYODN aggressively sought the family's permission for harvesting, despite the fact that the patient responded to the neurological pain stimuli test and showed other signs of brain activity. NYODN held a conference call

between its employees at the hospital, including McMahon, and NYODN director Michael Goldstein. It was during this call that Goldstein allegedly exclaimed, "This kid is dead, you got that?" He then ordered the employees to ramp up efforts to get the family's permission and the doctor's signed brain death diagnosis (called "the Note"). They succeeded.

- The second case occurred at St. Barnabas Medical Center. The neurological tests showed that the female patient responded repeatedly to both the pain stimuli and reflex tests, indicating definite brain activity—a conclusion shared by several resident physicians. But NYODN disregarded the test results, got "the Note" from a cooperating neurologist, and quickly harvested the patient's organs.
- A male patient at Kings County Hospital Center responded to the pain stimuli test by moving his shoulder, but NYODN went ahead and took his organs anyway. McMahon's NYODN co-worker justified the harvesting by saying, "[W]hat kind of life would he have anyway?"
- The last case happened at Staten Island University Hospital shortly before McMahon was fired. NYODN told its employees to keep McMahon's involvement to a minimum since they considered him a "troublemaker." But McMahon noticed

that the female patient, who was scheduled for a "full organ harvest," had been given an injection of vecuronium, a drug that causes paralysis but does not kill pain. When McMahon questioned the anesthesiologist, he was told that the surgeon had ordered the drug because the patient was moving and jerking when the surgeon made the incision on her chest—a clear sign that she was not brain dead and likely experiencing severe pain. Despite McMahon's vehement objections, NYODN went ahead with the organ retrieval and directly caused the patient's premature death.

During a meeting with NYODN President and CEO Helen Irving, McMahon told her that "one in five patients declared brain dead show signs of brain activity at the time the Note is issued." Initially, Irving tried to discredit that allegation, but later said that "this is how things are done." [*McMahon v. New York Organ Donor Network*, Complaint, No. 156669, N.Y. Sup. Ct., filed Sept. 25, 2012]

"I have been in Desert Storm, Iraq, and Afghanistan in combat," McMahon told the *NY Post*. "I worked on massive brain injuries, trauma, gunshot wounds, IEDs. I have seen worse cases than [these] and the victims recover." [*NY Post*, 9/26/12] ■

## Belgium euthanizes patients by harvesting organs

On September 29, 2012, participants at a Brussels conference on euthanasia and organ retrieval were told that, since 2007, nine patients have been euthanized by having their useable organs harvested for transplantation.

Dr. Dirk Van Raemdonck a leading Belgian organ transplant specialist, told those in attendance that the lungs from four voluntarily euthanized patients were successfully transplanted by a team of doctors at a hospital in Leuven between 2007 and 2009. He further explained that the euthanasia deaths of another five patients over the last three years resulted in more successful organ donations.

According to a posting on the website of VRT, the Flemish public broadcasting company, Dr. Van Raemdonck said that Belgium is the world leader in organ harvesting after euthanasia. The Netherlands has performed the procedure only once. [[demaakbarenens.org](http://demaakbarenens.org), 9/30/12; BioEdge, 10/5/12]

Only organs from about 20 percent of all euthanasia cases can be transplanted. The highest quality organs come from euthanized patients with neuromuscular disorders. [See *Update*, 2011, No. 1]

In 2011, there were 1,133 reported euthanasia deaths in Belgium. The number of unreported cases is unknown. ■

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is no possibility of recovery and the patient will die within hours or days. Currently, many patients are dying of dehydration on the LCP, but that is because all their food and fluids are being withheld needlessly. Approximately 29 percent of patients who die in hospitals or under NHS care—estimated to be 130,000 per year—are on the LCP. Pullicino called it a “self-fulfilling prophecy” for death.

He also said that he had personally saved the life of a 71-year-old patient who had pneumonia and epilepsy. A doctor on the weekend shift had put the patient on the LCP without his family's knowledge and consent. When Pullicino returned to duty, he took the patient off the LCP after facing considerable resistance. “[The patient's] seizures came under control,” Pullicino said, “and four weeks later he was discharged home to his family.” The LCP has become an “assisted death pathway” instead of a “care pathway,” he told the conference participants. [*Daily Mail*, 6/20/12; *Daily Telegraph*, 6/20/12]

Pullicino's comments became the fodder for heated debate in the months that followed. A “Consensus Statement,” signed by more than twenty organizations all of which supported the LCP, was issued; a British Medical Association spokesperson called the LCP “the best-known tool to manage the care of dying adults”; and the renowned *British Medical Journal (BMJ)* ran a number of articles in support of the LCP. [“Consensus Statement,” 9/12; *Herald Scotland*, 10/12/12; *BMJ*, 10/3/12, 10/30/12]

The debate would have eventually died out if it had not been for numerous families coming forward to tell the media their horrific personal stories about non-dying loved ones being placed on the LCP. Here are some samples:

- The family of 48-year-old Andy Flanagan was told that he was imminently dying from organ failure after a cardiac arrest left him severely brain damaged. He was placed on the LCP and his fluids were withdrawn so he could “slip away.” When his sister, a nurse, tried to move him, he began to talk in such a way that she realized that his brain was not severely damaged after all. Fearing that the doctors wanted him dead, the family kept a round the clock vigil and gave him drops of water every ten minutes. He recovered, returned home, and lived for another month with his family by his side. [*Daily Mail*, 10/12/12]
- Olive Goom, 85, was admitted to the hospital after she fell and broke a bone in her upper arm. She died alone in an isolated room after hospital staff neglected to tell her niece, her only relative, that she had been placed on the LCP with no food or fluids. When her niece called the hospital only hours before her aunt died, she was told that there was no urgent need for her to visit her aunt. The niece was not even notified when Goom died. [*Daily Mail*, 10/15/12]
- A doctor put Patricia Greenwood, 82, on the LCP with no food and fluids, but her family gave her water against the his orders. She recovered and is now planning to go on a world cruise. [*Daily Mail*, 10/29/12]

- Thomas James, 90, was placed on the LCP in his own home by a district nurse without ever consulting his family. She gave him the sedative midazolam. Its boxed warning states that the drug is associated with “respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings.” [www.drugs.com] James' daughter demanded he be taken off the drug, but he died of pneumonia days later on October 8. Tragically, he was planning on attending his granddaughter's wedding in December and had even picked out a red tie so he could match the bridesmaids. [*Daily Mail*, 10/30/12]

It has also come to light that hospitals are being given financial incentives to place patients on the LCP. According to figures obtained under the Freedom of Information Act, 85 percent of NHS' trusts have adopted the LCP. Six out of 10 of those trusts have received or are soon to receive financial rewards totaling to at least £12 million, but the actual cash rewards over the past two to three years could be closer to £20 million. NHS commissioners pay trusts for putting a target number of patients on the LCP. The payments are, they say, to “reward excellence” in health care under a program called “Commissioning for Quality and Innovation.” One government spokesman told the press, “The Department of Health does not centrally fund any payments for the use of the Liverpool Care Pathway, but local areas may choose to do so in order to improve the care and support given to people in their last days.” Critics, however, say getting patients to die sooner rather than later saves the budget conscious NHS a considerable amount of money. Often more than 50 percent of the patients who die in a UK hospital have been placed on the LCP. [*Daily Telegraph*, 10/31/12]

In response to all the negative press, UK Health Secretary Jeremy Hunt announced plans to revise the NHS constitution. One of the proposed changes, he said, will be that health trusts who neglect to consult with patients and their families prior to initiating the LCP can be sued, and doctors who ignore their wishes “face being struck off.” [*Huffington Press UK*, 11/3/12]

Liberal Democrat Care Minister Norman Lamb has also vowed to prevent a repeat of the kind of cases that have been reported in the press. “I want to hear where things have gone wrong,” he said, “and I want to make sure we address that, absolutely...” [*Daily Telegraph*, 11/1/12] But just two weeks prior to making that statement, Lamb launched a “toolkit” to help doctors select one out of every 100 of their patients to be placed on a list of those who are likely to die within the year. He said, “[O]lder people are a priority to consider.” Patients on the death list will receive “end-of-life care.” The scheme could potentially save the NHS over £1 billion a year. [*Daily Mail*, 10/17/12; *Daily Telegraph*, 10/17/12]

“There is a warning here for us under Obamacare,” cautioned PRC legal consultant Wesley J. Smith. [Blog, *National Review Online*, 11/1/12] ■



# Research in review

## ■ Witnessing a loved one's legal assisted suicide can be detrimental to a person's mental health

A first-of-its-kind study, published in the journal *European Psychiatry*, found that witnessing a loved one's assisted-suicide death significantly impacts the subsequent mental health of family members and friends.

Researchers from the University of Zurich in Switzerland, and University Hospitals in Zurich and Leipzig, Germany, surveyed 85 family members and close friends of people who had died with the help of the Swiss assisted-suicide organization Exit Deutsche Schweiz.

Unlike Dignitas, the assisted-suicide clinic on the outskirts of Zurich that specializes in ending the lives of foreigners, Exit accepts only Swiss residents as members, and most of its facilitated deaths occur in the member's home. There, an Exit volunteer hands the member the lethal cocktail to drink. If the member has difficulty swallowing, the barbiturate overdose can be self-administered by the member intravenously or through a gastrostomy tube.

Researchers found that approximately 20 percent of the 85 assisted-suicide witnesses surveyed experienced full or partial post-traumatic stress disorder (PTSD), and 16% had clear symptoms of depression approximately 19 months after the assisted suicide.

"Witnessing the unnatural death of a significant person," researchers wrote, "thus seems to have a strong impact on the bereaved, which may lead to severe mental health problems at 14 to 24 months post-loss." [B. Wagner, J. Müller, and A. Maercker, "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," *European Psychiatry*, October 2012]

Often PTSD is the result of war and other dangerous or threatening situations, but that isn't always the case. According to the National Institute of Mental Health, "Some people get PTSD after a friend or family member experiences danger or is harmed." [NIMH, "Post-Traumatic Stress Disorder," Publication No. 08 6388. Available at: [www.nimh.nih.gov](http://www.nimh.nih.gov)]

## ■ DNRs increase post-surgical deaths

A new study, presented at the American Surgical Association's 132nd annual conference, found that elderly patients who sign preoperative do-not-resuscitate (DNR)

orders are more likely to die from surgical complications because the DNRs effectively prevent the aggressive treatment of their complications. Dr. John E. Scarborough, the study's lead author and assistant professor of trauma and surgical critical care at Duke University Medical Center, calls this a "failure to pursue rescue."

Based on data collected by the American College of Surgeons National Surgical Quality Improvement Program between 2005 and 2010, investigators found that 57% of the DNR patients who developed major postoperative complications died within 30 days of the surgery. That was 18 percentage points higher than the mortality rate for surgical patients without DNR orders. In addition, DNR patients were less likely to undergo a second surgery following the first one. Just 8% had a second, follow-up operation, compared to 12% in the non-DNR group.

According to Dr. Ronnie A. Rosenthal, professor of surgery at Yale University School of Medicine, there may be an ethical dilemma for the surgeon when a DNR patient develops a complication. "The ethical dilemma is that the surgeon may well feel that rescue from the complication is possible—which the study supports since mortality following a complication in the matched non-DNR patients is lower while the complication rate is the same—but patient autonomy demands the respect for the patient's right to stop further treatment." [*General Surgery News*, July 2012]

## ■ Doctors' beliefs influence which end-of-life care options are offered to family members

Research conducted in five intensive care units (ICUs) at two academic hospitals in San Francisco, CA, found that, in cases involving critically-ill patients with a high mortality rate, physicians neglected to inform family members about the option of comfort-oriented care in about half of the doctor-family conferences. Physicians who strongly believed that the goal of care was to prolong life were less likely to inform the patients' decision makers about comfort care as an end-of-life treatment option, whereas doctors who felt strongly that life support should be withdrawn from patients were more likely to offer comfort care as an option and list the benefits of such care.

Researchers studied 72 audio taped family meetings with doctors. One hundred sixty-nine (169) family members and 54 physicians participated in the study. The ICU patients

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were at high risk for death or “severe functional impairment.” Researchers indicated that they used a “broad definition” of comfort care: the “withdrawal of life-sustaining treatment and/or a plan of care focused primarily on maximizing patient comfort rather than prolonging life.” [Schenker et al., “Association between physicians’ beliefs and the option of comfort care for critically ill patients,” *Intensive Care Medicine*, August 11, 2012]

**Note:** *Some health care providers interpret comfort care to include the withholding of all food and fluids from the patient.*

### ■ Study finds making doctors’ notes available to patients clinically beneficial

A study, published in the *Annals of Internal Medicine*, found that allowing patients to read their doctors’ notes on their office visits can benefit both doctors and patients.

Referred to as “OpenNotes,” the study involved more than 100 primary care physicians who invited over 20,000 of their patients to go online to review the notes the doctor wrote and signed after patients’ office visits. The doctors had practices at either Beth Israel Deaconess Medical Center in Massachusetts, Geisinger Health Systems in Pennsylvania, or Harborview Medical Center in Washington State. After 12 to 19 months of open note experience, the study’s participants were surveyed in the fall of 2011.

“The study findings suggest that open notes may be a powerful intervention for improving the health of patients,” the researchers wrote. They found that 99% of the participating patients were enthusiastic and wanted the open-note practice to continue. Patients reported a greater sense of control and an increased understanding of their medical issues and plans for care. They also felt better prepared for their future office visits. “Perhaps most important clinically,” researchers observed, “a remarkable number reported becoming more likely to take medications as prescribed. In contrast to the fears of many doctors, few patients reported being confused, worried, or offended by what they read.”

As for the doctors, there was far less of an impact on their work load than was anticipated. By the end of the year-long study period, none of the participating doctors chose to discontinue the open-note practice. [Delbanco et al., “Inviting Patients to Read Their Doctors’ Notes: A Quasi-experimental Study and a Look Ahead,” *Annals of Internal Medicine*, October 2, 2012]

“The study is very important because it shows [OpenNotes] did not create a significant burden for doctors, and it helps patients to understand better the diagno-

sis and the advice of the doctor,” said Rita Marker, executive director of the Patients Rights Council. “Patients feel empowered.” [*HealthDay News*, 10/1/12]

### ■ Making crisis medical decisions can emotionally affect health care surrogates

A systematic review of 40 studies with data on more than 2,800 health care surrogate decision makers —also called proxies—found that at least one-third of the surrogates who made treatment decisions for seriously-ill loved ones experienced negative emotional effects that were substantial and long-lasting. More than half of the surrogates were family members of patients incapable of making their own treatment decisions..

The most prevalent emotional effects cited by surrogates were stress, guilt over the treatment decision, and doubt about whether they made the correct decision. These emotional burdens often lasted for months and even years.

According to the researchers,

The type of negative effect that surrogates experience seems to vary depending on the patient’s circumstances and the nature of the decision in question. Surrogates who made treatment decisions express concern that they harmed the patient, whereas those who decided to place a family member in a nursing home or long-term care facility reported feelings of abandoning or betraying their loved one.

Often the decision-making experience is directly affected by how confident the surrogate is that he or she knows what the patient would have wanted. “When surrogates were confident that they knew which treatment the patient would have wanted,” the researchers wrote, “they sometimes described making treatment decisions as simply reporting or implementing the patient’s preferences, as opposed to deciding for the patient.” [Wendler & Rid, “Systematic Review: The Effect on Surrogates of Making Treatment Decisions for Others,” *Annals of Internal Medicine*, March 2011]

**Note:** *By executing a durable power of attorney for health-care—like the Patients Rights Council’s Protective Medical Decisions Document (PMDD)—people can reduce or eliminate any future emotional burdens on their designated decision makers by documenting their wishes and discussing them with their chosen surrogates. For information on obtaining state-specific or multi-state PMDDs, call the PRC’s head office (800-958-5678) or go to the PRC website: [www.patientsrightscouncil.org](http://www.patientsrightscouncil.org).* ■



## News briefs from home & abroad . . .

- **United States:** The American Nurses Association (ANA) has released a draft of its revised position policy on assisted suicide and euthanasia. It states,

“The American Nurses Association (ANA) is strongly opposed to nurses’ participation in assisted suicide and active euthanasia because these acts are in direct violation of *The Code of Ethics for Nurses with Interpretive Statements*, the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.”

The position statement has not yet been ratified. The ANA had requested comments from the public first. The deadline for submitting those comments was November 8. [*Nursing Insider News*, September, 2012]

- **Colombia:** A desperate Colombian man, who is tired of his health care provider’s refusal to provide him with the care he needs, has decided that death is preferable to a life of medical neglect. Claudio Cruz was left quadriplegic by an accident 28 years ago. His medical treatment needs were supposed to be met by the EPS, a system that sells health service packages to the public with the promise that it will arrange for the care to be provided by health care institutions. But that never happened, even after Cruz and his wife won a lawsuit against EPS in 2009. Now, Cruz and his family believe the only way out of his nightmarish existence is for him to be euthanized. It is estimated that 20 million

people in Colombia are without health care due to corruption in the EPS system. [*Colombia Reports*, 10/31/12]

In 1997, the Colombian Supreme Court decriminalized euthanasia but never stipulated any specific regulations, so the practice remained in limbo. Cruz’s request for euthanasia comes only two months after one Colombian Senate committee passed a bill to regulate the practice. That bill passed its first Congressional vote on October 9 by a 10-4 margin, but has not yet passed the full Colombian Congress. [*Colombia Reports*, 10/10/12]

- **United Kingdom:** A survey of 150 members of parliament (MPs) of all parties found that seven out of ten would refuse to support attempts to change current law prohibiting assisted suicide and euthanasia. Seventy-two percent (72%) said vulnerable patients could feel pressure to end their lives if it were legal for doctors to prescribe lethal drugs, and 60 percent felt that, given the current economy, the pressure on patients to die would increase since they would not want to be a costly burden on their families.

Over 77 percent of MPs said that legalizing assisted suicide is currently not a priority issue in parliament. However, at least one member of the House of Lords wants to make it a top priority. Lord Chancellor Charles Falconer—whose Commission on Assisted Dying issued a biased report in January 2012 calling for a change in the law—is expected to introduce an assisted-suicide bill next year. [*UK Press Association*, 9/15/12, *Daily Telegraph*, 9/15/12]

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### *The legacy you leave could save lives...*

**D**id you know that one of the most *effective* ways you can support the work of the Patients Rights Council is through a **planned gift**?

Many tax-advantaged financial tools can be used to support the PRC and its fight against euthanasia and doctor-prescribed suicide. At the same time, these tools can bring certain advantages to both you and your family. For instance, you could:

- Make a tax-free gift from your IRA.
- Gift appreciated securities to the PRC, which could cost you less than the tax deduction you would receive.
- Make the PRC a beneficiary of your will, revocable trust, or retirement plan—costing you nothing during your lifetime.

- Gift assets that you no longer need or want—perhaps a vacation home, land, or a life insurance policy.

Get creative—for example, by selling property to the PRC at a charitable discount, deeding your home to the PRC while you continue to live there, or even by making a gift that pays you income for the rest of your life.

If you believe in our mission and want to support us with a planned gift, please contact:

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- **Ireland:** Marie Fleming, 59, has advanced multiple sclerosis (MS). Because she is no longer physically capable of killing herself, she has asked the Irish High Court to rule that she has a constitutional right to end her life with help. She also asked the court for assurances that her partner and full-time caregiver would not be prosecuted if he assists her suicide, and a court order requiring the Irish Director of Prosecutions (DPP) to issue guidelines detailing the criteria used to determine whether a person will be prosecuted for suicide assistance. Assisted suicide is currently a serious criminal offense in Ireland, and carries a prison sentence of up to 14 years. A panel of three High Court justices will hear Fleming's case on December 4, 2012. [*Irish Independent*, 11/1/12]  
Fleming's court challenge is virtually identical to that of Debbie Purdy in

Great Britain. Purdy also has MS and uses a wheelchair. In 2008, she petitioned the courts to force Britain's DPP to issue prosecution guidelines on assisted suicide and to provide assurances that her husband would not be prosecuted if he helped her travel to Switzerland to die. While she was successful in getting the DPP to issue guidelines, the courts refused to reverse the law and assure her that her husband would not be prosecuted.

- **Canada:** Gloria Taylor, the ALS patient whose doctors were given legal immunity for one year by a British Columbia judge to assist her suicide, unexpectedly died of natural causes on October 4. After the judge issued her ruling last June (that also overturned Canada's assisted-suicide law starting next year), Taylor told reporters that she really wasn't ready to die yet. [*Globe & Mail*, 10/5/12; *Canadian Press*, 6/18/12] ■

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

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