



# Euthanasia Prevention Coalition

Newsletter #80

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## Information and service available

**E**very month the Euthanasia Prevention Coalition receives several calls requesting information or wishing to discuss issues related to end-of-life care decisions.

These calls are often complex because they are related to actual medical decisions for people who are personally part of their lives.

It is important to plan ahead to protect yourself when you are unable to speak for yourself.

We offer the *Life Protecting Power of Attorney for Personal Care* for this purpose. This is a document that is designed to protect you by ensuring that the person whom you have appointed to make decisions for you has

- a) received adequate direction and
- b) has the legal support to uphold your wishes.

You can purchase *The Life-Protecting Power of Attorney for Personal Care* for \$25. It is a legal document that already protects more than 1,700 people in Canada.

If you have any questions concerning medical decisions or information please call us at: 1-877-439-3348.

Please visit our redesigned website at: [www.epcc.ca](http://www.epcc.ca)

The website contains our previous newsletters, information about upcoming events such as the International Symposium and other information about educational materials such as our DVD *Turning the Tide*.

We have sold more than 1,075 copies of *Turning the Tide*. We have just received another 1,000 copies of this popular DVD. It is available for purchase.

## Current Issues ⇒ Future Directions

### *The First-International Symposium on Euthanasia and Assisted Suicide:*

**When: Friday, Nov 30<sup>th</sup>, Saturday, Dec 1, 2007.**

**Where: Four Points by Sheraton - Toronto Airport Hotel.**

Hotel rate is \$109/night. Reserve by calling 1-800-368-7764

Indicate that your room is for the: **Euthanasia Symposium.**

*Registration Cost:* \$189.00 - regular, \$100.00 - students or people with disabilities. Registration includes: **Friday** (lunch & dinner), and **Saturday** (lunch)

Co-Sponsored by: *Euthanasia Prevention Coalition, NOT DEAD YET - USA, Compassionate Healthcare Network - Canada, Physicians for Compassionate Care - USA, Vermont Alliance for Ethical Healthcare - Vermont, Care NOT Killing*

*Alliance - UK, No Less Human, UK, and the Roman Catholic Archdiocese of Toronto*

The program begins on Friday, Nov. 30<sup>th</sup> at 9:30 am, with closing celebration on Saturday, Dec. 1 at 5:30 pm.

The Friday night dinner speaker is Professor Margaret Somerville founding director of the McGill Centre for Medicine, Ethics and Law.

Some of the important speakers include: Dr. Bill Toffler, Oregon, Dr. Bob Orr, Vermont, Rita Marker, USA, Bert Dorenbos, Netherlands, Dr. Peter Saunders and Alison Davis, UK, Diane Coleman & Stephen Drake, *Not Dead Yet.*, Wesley Smith, USA, Hugh Scher, Canada.

More than 220 registrations have already been received. Total registrations cannot exceed 270.

For more information about registering and hotel reservation please call us at: 1-877-439-3348 or go to the link on our website at: [www.epcc.ca](http://www.epcc.ca).

**Euthanasia Prevention Coalition • P.O. Box 25033 London ON N6C 6A8**

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## Suicide lessons from Oregon

# After ten years and 300 deaths, what is there to learn from America's assisted suicide frontier?

By Kenneth R Stevens,  
Oct 26, 2007

Oregon during fall rivals states more famous for the beauty of their dying foliage, according to the north-west state's official website. That claim may be contentious, but in one thing Oregon is definitely unique in the American landscape: it has a law that allows doctors to help people kill themselves.

Next month marks the tenth anniversary of the state's physician-assisted suicide (PAS) law. Although Oregon's Death with Dignity Act was initially approved by state voters in 1994, legal proceedings kept it from becoming operational until November 1997. The first recorded legal assisted suicide deaths began at the start of 1998. According to the Oregon Department of Human Services, which monitors the Act, in the nine years from 1998 through 2006 there were 292 such deaths. Information regarding the 2007 calendar year will be released in March 2008.

The assisted suicide movement itself has acknowledged that physical pain is not the main reason for ending life. Oregon assisted suicide patients have been described by their doctors as being fiercely independent and controlling people. They fear dependency. Control and choice are the key words now used in the promotion of assisted suicide.

In the first four years (1998 to 2001) there were 91 deaths or about 23 a year. In the last five years (2002 to 2006) there were 201 deaths or about 40 a year. In 2006 there were 46 deaths; there were 65 prescriptions for lethal doses of secobarbital or pentobarbital written by 40 doctors. Currently about one in 700 deaths in Oregon is from assisted suicide.

Why have these Oregonians chosen to end their lives? Although the sponsors of the PAS law claimed that uncontrolled physical pain was the primary reason for legalizing assisted suicide, we have since learned that pain is not the main reason that some Oregonians have chosen it. The assisted suicide movement itself has acknowledged that physical pain is not the main reason for ending life. Oregon assisted suicide patients have been described by their doctors as being fiercely independent and controlling people. They fear dependency. Control and choice are the key words now used in the promotion of assisted suicide. *Less incentive to care*

The arrival of "death with dignity" in Oregon has not created a health paradise. The national organization, Last Acts, issued a "report card" in November 2002 to states

regarding their end-of-life care. Oregon was given a D grade for hospice care and an E grade for palliative care programs. There are concerns regarding pain management in Oregon. After four years of assisted suicide, an Oregon medical university study reported that there were almost twice as many dying patients in moderate or severe pain or distress as there had been prior to the law change.

Once a patient has the means to take his or her life, there is less incentive to care for the patient's symptoms and needs. A detailed report in the American Journal of Psychiatry in 2005 told of a depressed lung cancer patient in Oregon who had been committed to a mental hospital unit. During planning for his discharge, a palliative care consultant wrote that he probably needed attendant care at home, but providing for that additional care might be a "moot point" because he already had "life-ending medication" at home. His assisted suicide doctor did nothing for his pain and palliative care needs, but did offer to sit with him while he took the overdose. This seriously physically and mentally ill patient received poor medical advice and care because he had been prescribed lethal drugs.

### *An excuse for rationing care*

Legitimising suicide for some can create danger for others. At a time of rising health costs administrators may build assisted suicide into their calculations. For instance, Oregon Medicaid covers the cost of assisted suicide, but not the cost of curative or local medical treatment for patients with cancer who have a less than a five per cent chance of living five years, even when that treatment can prolong valuable life. In 2003 Medicaid stopped paying for medicines for 10,000 poor Oregonians; this included patients with AIDS, those needing bone marrow transplants, people who are mentally ill and those with seizure disorders. In 2004 and the first half of 2005, an additional 75,000 Oregonians were cut from the health plan to keep the state budget balanced.

Even if an Oregon patient has Medicare or Medicaid coverage, there is limited access to health care. Sixty per cent of Oregon physicians limit or do not see Medicaid patients, and 40 per cent do not see Medicare patients. Seventeen per cent of Oregonians are without health insurance, and the share of Oregonians without health insurance has grown faster than in any other state over the past four years.

**Abuse of the law**

The so-called "safeguards" in Oregon's law are meant to limit access. It is to be expected, however, that when controlling-type people -- as PAS patients in Oregon allegedly are -- come up against the requirements of the law, something has to give, and so the boundaries around assisted suicide in Oregon have stretched.

Some of the legal requirements are: being an Oregon resident, being mentally capable, being diagnosed with a terminal illness that will lead to death within six months, and self-administering the prescribed medication. Predictably, there are reported instances of these rules not being followed. In any case, there is no protection for the depressed or mentally ill: in recent years, only five per cent of those dying from assisted suicide had a mental health consultation. In 2006, only two of the 46 patients dying from assisted suicide were referred for psychiatric evaluation, yet depression is the most common cause of suicidal thoughts.

There are published reports about a patient diagnosed by a psychiatrist as having dementia, who still received a prescription for lethal drugs. The drug is supposed to be self-administered and ingested, and yet we have media reports of cases where that has not occurred because the patient was not capable of doing it. Other reports concern two patients whose lethal medication entered the body via a feeding tube, one of them a PEG tube (feeding straight into the stomach) placed for the sole purpose of taking the lethal medication. Terminally ill people are reportedly moving to Oregon from other states because of Oregon's assisted suicide law.

Many doctors are writing prescriptions for lethal drugs to patients for whom they have not previously cared and some appear to be making it their specialty. Dr Peter Rasmussen reported that 75 per cent of the patients who come to him regarding assisted suicide are people he has never seen before. In the past four years, one doctor each year has written between six and eight prescriptions.

One thing Oregon's PAS law has not done: it has not reduced other suicides. Between 1999 and 2002 the state had a rate of suicide (not counting deaths from assisted suicide) among those 65 years of age and older that was sixth highest in the nation and one and a half times the national average.

At the same time there is no real monitoring of Oregon's assisted suicides. In the last three years the prescribing doctor was present at the time the patient took the lethal dose of sleeping drugs in only 29 of the 121 deaths. Knowledge of

complications for the other 92 patients is obtained second- or third-hand. Following David Prueitt's failed assisted suicide attempt in January 2005, the state Department of Human Services (DHS) publicly stated that they had "not authority to investigate individual Death with Dignity cases -- the law neither requires or authorizes investigations from DHS."

**An isolated anomaly - for now**

With majorities voting twice -- in 1994 and 1997 -- in favor of legalization, it is unlikely that Oregon will repudiate assisted suicide in the near future. However, the north-west state has failed to be the predicted harbinger of assisted suicide spreading to other states. In keeping with its geographic fringe location, Oregon represents a solitary anomaly in legalizing assisted suicide. Voter referendums and legislative bills similar to Oregon's assisted suicide law have failed in Alaska, Arizona, California, Hawaii, Maine, Michigan, Washington and Wisconsin. The failure of assisted suicide extended across the Atlantic where an Oregon-type assisted suicide bill was rejected in the British House of Lords in 2006. In early October 2007 the Washington State Medical Association rejected a proposal to be neutral in this area and strengthened its policy of opposition to PAS.

Why have PAS bills failed in other states? Because of the concern of a broad coalition of health care professionals, hospice workers, disability rights advocates, minority groups, pro-life advocates, and various moral and ethical leaders who have vigorously opposed the legalization of assisted suicides in these political jurisdictions.

They are concerned about the impossibility of containing assisted suicide once it starts; about the financial inequalities in society and about fair access to medical care by the disadvantaged. Above all, they worry that the so-called "safeguards" of Oregon's assisted suicide law are being disregarded.

*Kenneth R. Stevens Jr, MD, is Vice-President of the Physicians for Compassionate Care Education Foundation. The foundation promotes compassionate care for severely-ill patients without sanctioning or assisting their suicide. Members affirm that all human life is inherently valuable and that the physician's roles are to heal illness, alleviate suffering, and provide comfort for the sick and dying.*

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## Awakenings: The Schiavo case revisited



By Wesley J. Smith

*Weekly Standard, Oct 30, 2007 Volume 013, Issue 08*

**O**n October 19, only months after being nearly dehydrated to death when his feeding tube was removed, Jesse Ramirez walked out of the Barrow Neurological Institute in Phoenix on his own two legs. He is lucky to be alive. Early last June, a mere one week after a serious auto accident left him unconscious, his wife Rebecca and doctors decided he would never recover and pulled his feeding tube. He went without food and water for five days. But then his mother Theresa successfully took Rebecca to court demanding a change of guardianship on the grounds that Rebecca and Jesse's allegedly rocky marriage disqualified her for the role.

The judge ordered that Jesse be temporarily re-hydrated and nourished. Then he regained consciousness. Now, instead of dying by dehydration, he will receive rehabilitation and get on with his life—all because his mother rejected the reigning cultural paradigm that a life with profound cognitive dysfunction is not worth living.

Ramirez is only the latest instance of an unconscious patient waking up after being consigned to death by dehydration. Take the disturbing case of 12-year-old Haleigh Poutre in Massachusetts. Only eight days after she was hospitalized in the wake of a beating, the Massachusetts Department of Public Social Services, acting on doctors' solemn assurances that she was "virtually brain dead," requested permission to remove her respirator and feeding tube. This request was approved by the Massachusetts Supreme Court.

But the doctors, social workers, and judges were wrong about Haleigh's prospects. Just before her life support was withdrawn, she began to exhibit signs of awareness, leading to a last-minute reprieve. Today, according to some media reports, she is awake and aware and able to eat some foods.

Beyond these and other unexpected spontaneous awakenings, there is the news that some patients diagnosed with persistent vegetative state (PVS) may actually be cognizant. This discovery stunned the scientific community after doctors conducted a sophisticated brain scan upon a supposedly deeply unconscious British woman. Unexpectedly, the scan looked, well, normally reactive to stimuli.

Even though the woman remains physically unable to react, she is clearly cognizant.

In other medical developments, a few unconscious patients have been awakened by medication (paradoxically,

the sleeping agent that goes by the brand name Ambien). In a few cases, people who have been unresponsive for years have become responsive while the medication is active in their systems.

Looming over all this good news like the proverbial elephant in the living room is the Terri Schiavo debacle. Almost every story reporting these hopeful events emphasizes that the Schiavo case was "different." Maybe the writers are experiencing subliminal guilt over the part their biased and misleading reporting played in the wrong that was done to Schiavo.

Indeed, in the wake of polls showing the public supported her 2005 dehydration, the media have portrayed the effort by Republicans in Congress to pass a law to save her life as an attempt to impose their religious views on a private family.

This political revisionism about the Terri Schiavo case coincides with a panicked retreat among many who once robustly opposed dehydrating the cognitively disabled. Emboldened are those who seek to supplant the equal sanctity of human life with a "quality of life" value system that accords to those who are profoundly cognitively impaired less value than to the rest of us. This cultural tide now endangers thousands of people whose lives depend on how they are perceived by doctors, family members, and society.

Increasingly, we hear about sustenance being withdrawn within days of a serious brain injury. And now that these helpless people are deemed dehydratable, there is a growing clamor in the professional journals to transform them into natural resources to be exploited like a corn crop as sources of vital organs and subjects for experimentation. To show how far this line of thinking has already gone, bioethicists writing in the *Journal of Medical Ethics* recently advocated transplanting pig organs into people diagnosed with PVS to determine the safety and efficacy of xenotransplantation (the transplantation of animal organs into human patients).

A serious cultural consequence of the Terri Schiavo drama has been the devaluation of the weakest among us into a disposable and exploitable caste. But Jesse Ramirez, Haleigh Poutre, and the groundbreaking research into the treatment of serious brain injury are powerful reminders that where there is life, there is hope.

It is not too late to reverse the tide.

*Wesley J. Smith is a senior fellow at the Discovery Institute, an attorney for the International Task Force on Euthanasia and Assisted Suicide, and a special consultant to the Center for Bioethics and Culture.*

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