Euthanasia Prevention Coalition

NEWSLETTER

Number 85 May 2008

Oregon Death With Dignity Act Annual Report for 2007

By Alex Schadenberg

Once again, the Oregon Death With Dignity Act is more about numbers than actual information. It is important to note that there are no case reports connected to the annual report and there is no guarantee that all the cases have been reported.

The number of reported deaths has risen in 2007 to 49 from 46 reported deaths in 2006. More interesting was the fact that the number of lethal prescriptions rose to 85 in 2007 from 65 in 2006. 3 of the 49 deaths in 2007 received their prescription in 2006.

Out of the 85 lethal prescriptions in 2007, 46 died from assisted suicide, 26 died of their underlying disease, 13 were alive at the end of 2007.

The most frequently mentioned end-of-life concerns were: loss of autonomy (100%), decreased ability to participate in activities that made life enjoyable (86%), and loss of dignity (86%). (33%) stated that they were concerned about inadequate pain control in 2007, which is up from (26%) in 2006. It must be noted that their is no differentiation in the report between a patients lack of adequate pain control at the time of asking for the prescription from a patients fear of inadequate pain in the future.

Complication were reported in 3 patients who had regurgitated some of the drug. One person lived 3.5 days. The question is not answered as to how the complications were dealt with. We also question the total number of complications knowing that the physician was present 22% of the time at the death.

None of the people who died by assisted suicide were referred for a psychiatric or psychological evaluation in 2007. It appears that the "safeguards" in Oregon are either being ignored or every physician who prescribes death for their patients are also experts at treating depression.

Since 1997 - 341 patients have been reported to have died from assisted suicide in Oregon.

For a summary of the Oregon Death With Dignity Act Annual Report for 2007, issued March 18, 2008, go to: http://www.oregon.gov/DHS/ph/pas/docs/year10.pdf

(Comment posted March 19, 2008 on http://alexschadenberg.blogspot.com)

National Euthanasia Symposium in Winnipeg October 24-25, 2008

Theme: "Death Making"

Registration fee: $99 regular;
$69 students & people with disabilities.
More information will be in future editions of this Newsletter.

Advance registration: call Euthanasia Prevention Coalition, 1-877-439-4439.

Victoria Inn - Winnipeg Manitoba
1808 Wellington Ave
Phone: 1-877-842-4667
Room rate: $115 per night, $199 for a suite.
Book rooms under the title: "Euthanasia Prevention"

• Continued on page 2

Many assisted suicides seem to be needless

By Gayle Atteberry

Contrary to the March 22 editorial in *The Register-Guard* (Eugene, Ore, newspaper) the Oregon Health Department's recent release of the 2007 report concerning Oregon's Death with Dignity Act proves one thing: Oregon's assisted suicide experiment does not work as voters were led to believe it would.

Last year's deaths by doctor-assisted suicide are three times the number of deaths in 1997, the year Oregon's law became functional. While proponents of the law say that only three more patients killed themselves under the law last year than the year before, that is a misleading picture of how dramatically suicides have increased. The number of lethal prescriptions written also has skyrocketed.

The most frightening figure, however, is zero the number of patients seeking physician-assisted suicide who were referred for psychiatric exams in 2007.

The Register Guard's absurd and unsubstantiated statement that "physician assisted death ... is a conscious, deliberate choice made by mentally sound individuals" flies in the face of all reality. It is a substantiated fact that clinical depression is the No. 1 cause of suicide. Yet last year, not one single patient seeking to end his or her life by means of the assisted suicide law was referred to a professional counselor because of depression!

When surveyed a few years ago, a majority of Oregon physicians admitted they could not recognize clinical depression in their patients. There are at least two

• Continued on page 2

EUTHANASIA PREVENTION COALITION • P.O. BOX 25033 LONDON ON N6C 6A8
EUTHANASIA PREVENTION COALITION INTERNATIONAL • P.O. BOX 611309 PORT HURON MI 48061-1309
Tel 1-877-439-3348 / 519-439-3348 • Fax 519-439-7053 • info@epcc.ca • www.epcc.ca

Many assisted suicides seem to be needless

(continued from page 1)

documented cases of mentally incapable patients receiving lethal prescriptions under Oregon's Death with Dignity Act.

"Pain or fear of pain" continued to be the least-used reason for those requesting suicide. Supporters of assisted suicide long have maintained that assisted suicide is necessary for those suffering from intractable pain; however, there has been no documented case of assisted suicide being used for untreatable pain.

Dr. Linda Ganzini, professor of psychiatry at Oregon Health & Science University, surveyed family members of 83 Oregon patients who requested assisted suicide. Published by the Journal of General Internal Medicine in February of this year, the study by Ganzini et al emphasizes this truth:

"No physical symptoms experienced at the time of the request were rated higher than 2 on a 1 to 5 scale. In most cases, future concerns about physical symptoms were rated as more important than physical symptoms present at the time of the request."

Ganzini concludes, "Our data suggests that when talking with a patient requesting (assisted suicide), clinicians should focus on eliciting and addressing worries and apprehensions about the future with the goal of reducing anxiety about the dying process.

"Some Oregon clinicians have expressed surprise at the paucity of suffering at the time of the request among these patients. Addressing patient concerns with concrete interventions that help maintain control, independence and self-care, all in the home environment, may be an effective way to address requests for (assisted suicide) and improve quality of remaining life."

Ganzini's study confirms that instead of having their fears and concerns ministered to, many patients are being abandoned at their critical time of need and left to indulge their fears by succumbing to a needless suicide.

The facts are now conclusive: Oregon's assisted suicide experiment has failed the very patients it was intended to serve.

Gayle Atteberry is Executive Director, Oregon Right to Life

National Euthanasia Symposium

(Continued from page 1)

Speakers include:
Diane Coleman & **Stephen Drake** from *Not Dead Yet*
Rhonda Wiebe, *Manitoba League of Persons with Disabilities*
Jim Derksen, *Council of Canadians with Disabilities*
Dr Mark Mostert, Virginia Beach VA - *Institute for the study of Disability & Bioethics*
Neil Kraveski, Winnipeg - Lawyer for Samuel Golubchuk
Hugh Scher, Toronto - Legal Counsel, *Euthanasia Prevention Coalition*
Alex Schadenberg - *Euthanasia Prevention Coalition*
Dr Margaret Cottle, Vancouver BC. Palliative care physician
Dr John Scott, Ottawa ON. Palliative care physician.

End-of-life decision-making Conference

On June 9, 2008 the Vulnerable Persons New Emerging Team (VP-NET) are sponsoring a conference to explore the ethical frameworks of the Manitoba College of Physicians and Surgeons - Statement on Withholding and Withdrawing Life-Sustaining Treatment.
It will be held at the Brodie Centre, Faculty of Medicine, University of Manitoba (North Campus) in Winnipeg.
Time: June 9, 2008 from 9 am - 4 pm.
The conference features legal expert: **Jocelyn Downie** - Canada Research Chair in Health, Law and Policy from Dalhousie University in Halifax N.S. and other legal, medical, ethical, and disability experts.
Contact **Rhonda Wiebe** rew@shaw.ca

Deep sedation is often "slow euthanasia"

By Alex Schadenberg

It was recently reported that deaths associated with Deep Sedation have risen from 5.6% in 2001 to 7.1% of all deaths in 2005. The question of the use of deep sedation in the Netherlands as an alternative form of euthanasia is an important question.

In the case of deep sedation, a person is sedated and usually fluids and food are then withdrawn resulting in an intentional death by dehydration or "slow euthanasia"

Intentionally killing someone by injection (or as Dignitas Clinic in Switzerland now use, a plastic bag and helium) usually takes several minutes but not more than one hour. To intentionally kill someone by dehydration usually takes 10 - 14 days.

The problem with the moral assessment of deep sedation is that not all acts of deep sedation are for the purpose of intentionally killing the person (euthanasia). Sometimes, a person is very near to death and experiencing intractable pain. The person is sedated and dies within a few days. This is not euthanasia but good palliative care.

Deep sedation can also be used in cases when someone is not near to death but experiencing uncontrollable pain. These people are then sedated for several days, fluids and food should be continued, and after the short period of time the person is brought out of the sedated state. These people can sometimes feel relaxed from their time of sedation and then be effectively treated for pain and symptom management without re-sedating them.

The point is: deep sedation can be used as a form of "slow euthanasia" or it can be effectively used as a form of good palliative care.

We must point out that when deep sedation is used as a form of euthanasia that this is an abuse of medical ethics and often an imposed death, whereby the family is not informed that the reason for the deep sedation is to cause the death of their family member.

When used as euthanasia, deep sedation can be abused and it is a direct threat to the lives of the most vulnerable people in our society who are often not given the care and respect that is due a human person.

(Comment posted March 25, 2008, on http://alexschadenberg.blogspot.com)

Washington campaign to legalize assisted-suicide seeks to sell voters on death

By Joel Connelly
Seattle P-I Columnist

If you are campaigning for the "right" of people to kill themselves, the first challenge is finding a nonlethal definition: Soft, reassuring terms must be substituted for the off-putting phrase "assisted suicide."

"Death with dignity is not suicide: Nor is assisted suicide, or physician-assisted suicide," proclaims ex-Gov. Booth Gardner in a fundraising letter for Initiative 1000, which would allow terminally ill adults to request and administer lethal medication prescribed by a doctor.

Gardner is seeking to raise $1 million for a signaturegathering campaign to get the initiative on the November ballot. The campaign has already collected $405,000.

Apparently Gardner and political consultants advising him never met Derek Humphrey, plain-spoken co-founder of the Hemlock Society.

"As the author of four books on the right to choose to die, including 'Final Exit,' I find the vacillation by (Oregon's) Department of Human Services on how to describe the act of a physician helping a terminally ill person to die by handing them a lethal overdose -- which they can choose to drink (or not) -- an affront to the English language," Humphrey wrote to The Register Guard newspaper in Eugene, Ore.

" 'Physician' means a licensed M.D.; 'assisted' means helping; and 'suicide' means deliberately ending life.

"The department's cop-out choice of the words 'death with dignity' is wildly ambiguous and means anything you want. Let's stick to the English language and in this matter call a spade a spade."

The advice is likely to be ignored by a campaign that seeks to sell voters on death.

"He who controls the language wins the debate: Hence, phrases like 'aid in dying' are used because they do well in polls," said Wesley Smith, a lawyer, a former collaborator in Ralph Nader's consumer crusades and a critic of assisted suicide.

Among local political consultants, I-1000 is becoming a cause to die for. The Yes-on-1000 Committee has shelled out more than $333,000, in increments of $10,000 to $50,000, to 12 consulting firms and consultants.

Prominent Democratic consultants are on the receiving end. J. Blair Butterworth, chief political adviser to former Gov. Gary Locke, has received $15,000. And Northwest Passage Consulting, headed by Sen. Maria Cantwell's former campaign aide Christian Sinderman, has received $21,789.

The list is growing.

"Signature Gatherers Needed Immediately. Great $$$!" read an ad on Craigslist.com last week. A company, National Ballot Access, seeks paid signaturegatherers for assisted suicide, promising 75 cents for each voter that signs the petition.

Gardner and his supporters need 224,880 valid voter signatures to win I-1000 a spot on the November ballot.

A slightly broader assisted-suicide measure, Initiative 119, made it onto the 1991 ballot, but failed with 46 percent of the vote.

Only one state, Oregon, has legalized assisted suicide, and that happened 10 years ago. Opposition has since grown, especially with groups representing disabled Americans.

The cause has faced dissent from some social activists, who fear patients who are poor will be pressured not to be a "burden" on their family or insurers.

A win in Washington would bring the cause of assisted suicide back to life. "In 49 states, that right does not exist: With your support, it will, in one more -- and a national movement will begin," pledges Gardner.

And Gardner recently told The New York Times Magazine that enacting I-1000 is a first step, and that the "right" can later be expanded. The former governor, who suffers from Parkinson's disease, would not be able to kill himself under I-1000. His condition is not terminal.

"We have assembled an outstanding team of campaign professionals skilled in educating and motivating the public," Gardner said in his letter.

Voters approached by Gardner's signature mercenaries, or hit up for donations, ought to pose some critical questions.

If this is a first step, what will be the next step, and the next? The Netherlands, which long ago allowed assisted suicide, has moved steadily toward legalizing euthanasia (mercy killing).

Gardner talks about taking one's own life as a "fundamental human right."

Says who? Our nation's Founding Fathers spoke of the Creator endowing all of us with the inalienable right to "life, liberty and the pursuit of happiness."

The right is life. Where does death fit in, or is it part of the "pursuit of happiness?"

My questions stem from my father's struggle with prostate cancer. He was in his 80s when he found that he had cancer. He was depressed and frightened of the treatment, didn't want to be a "burden" on my mother and myself and initially wanted to "go and go quietly."

Under I-1000, there is no requirement that one's family be notified when a request is made for a lethal prescription.

The initiative requires that patients be "informed" of alternatives such as hospice care and pain control.

Why, however, is there no referral to a mental health professional to help the depressed and scared?

The I-1000 campaign plans to peddle "death with dignity" on TV and in print advertising. An adoring press is focused on Gardner's "last campaign."

Still, critical questions must not be enveloped in gauzy language or poll-tested slogans.

We are, after all, talking about matters of life and death.

http://seattlepi.nwsource.com/connelly/357023_joel31.html
Reprinted with permission of the author

Chantal Sébire's refusal of effective medical treatment

By Alex Schadenberg

When I first heard about the case of Chantal Sébire, I was mystified that her condition was so extreme. Since I was not informed of her personal condition I assumed that her tumors were inoperable.

Now I learn that Sébire had constantly refused treatment for her condition that would have likely returned her to a healthy condition. Nearing the end of her life, Sébire was suffering from significantly painful conditions but she continued to even refuse treatment for pain. Morphine would have effectively controlled most of her painful symptoms.

Sébire had the right to refuse medical treatment, and I would never argue otherwise, but it is disingenuous to refuse effective medical treatment or care and then claim to the public that you need to die by euthanasia because there was nothing that could be done for you.

Similar issues were central to the Latimer case. Robert said that the only way to stop Tracy Latimer's suffering was to kill her. In fact, Robert had a phobia with medical treatment. This may be why the Latimers refused to have a feeding tube for Tracy and the reason why Robert finally refused surgery on Tracy's hip by gassing her to death in his pick-up truck.

Just the facts.

See article "French Euthanasia Case Rumbles On", by Bruce Crumley - Paris France (April 1, 2008). www.time.com/time/world/article/0,8599,1726787,00.html

(Comment posted April 2, 2008 on http://alexschadenberg.blogspot.com)

We need to care for people — not kill them

After the case of Chantal Sébire, who ended her life on 20 March after being denied the right to euthanasia, another woman is taking up the euthanasia cause. Clara Blanc, 31, who suffers from d'Ehlers Danlos syndrome, a degenerative disease of the connective tissue, has written to French President Nicolas Sarkozy and the French Health Minister, calling on the country to bring the question of euthanasia into open debate, and to hold a referendum on the issue.

By Alex Schadenberg

The cases of Chantal Sebire and Clara Blanc will naturally affect the emotions of every person. One may say that, if euthanasia were legal, these would be cases that many people would feel qualify for the act.

The question we need to ask is: "What does it mean to be a human person?"

I contend that a human person is not merely a physical being. Our dignity and quality of life is not determined by our physical characteristics alone.

Intentionally and directly causing the death of people by euthanasia or assisted suicide, even for the most difficult cases, results in a change within our social fabric that will only lead to furthering the social conditions that lead to the hopelessness and despair that is connected to calls for euthanasia.

What we really need is to change our attitudes by becoming a more caring society. People need to care for others, in such a way as to eliminate the abandonment that exists within society that leads people to consider euthanasia.

Whether it be the health care system, or people of good-will extending themselves to others, we need to create a culture that encourages people to care for others.

Clara Blanc should be experiencing true dignity by being cared for by her friends, family, and community. She should feel that her community values her even when she is living with a rare genetic condition.

As a society we need to develop new and better methods of controlling physical pain but we primarily need to recognize that the human person is a social, psychological, emotional and spiritual being.

The most effective way to care for the other is by "being with" the other. It is when we feel alone, abandoned and unwanted that we experience depression and loneliness that directly create the demand for euthanasia.

We need to care for people and not kill them.

See article "France: Another "Chantal" case -- sufferer asks to die" (AGI) - Paris, April 1, 2008. Find the article at: http://www.agi.it:80/world/news/200804011833-cro-ren0081-art.html

(Comment posted April 2, 2008 on http://alexschadenberg.blogspot.com)

Check out our new blog

http://alexschadenberg.blogspot.com

Alex Schadenberg, executive director of the Euthanasia Prevention Coalition of Canada, has begun posting commentaries at: Commentaries are published several times per week to enable supporters and news services to access information on issues related to euthanasia and assisted suicide immediately. Alex was the first person to publish a comment on the 2007 Oregon assisted suicide report.

There's a link to the blog at our website **www.euthanasiaprevention.on.ca**