

Newsletter #73

March 2007

Euthanasia Prevention Coalition co-sponsors International Euthanasia Symposium

The Euthanasia Prevention Coalition is organizing the first International Euthanasia Symposium for the weekend of November 30 - December 1, 2007 at the Toronto Airport Sheraton Hotel. Please mark this weekend on your calendar.

The *International Task Force on Euthanasia and Assisted Suicide*, the *Physicians for Compassionate Care* in Oregon, the *Vermont Alliance for Ethical Health Care*, and the *Care Not Killing Alliance* in the UK have agreed to co-sponsor the Symposium with the *Euthanasia Prevention Coalition*.

Confirmed Speakers:

- **Margaret Somerville** from the McGill Centre for Medicine, Ethics and Law.
- **Wesley Smith & Rita Marker**, *International Task Force on Euthanasia and Assisted Suicide*.
- **Alison Davis**, *No Less Human* in Britain.
- **Dr. Bill Toffler**, *Physicians for Compassionate Care*.
- **Dr. Bob Orr**, *Vermont Alliance for Ethical Health Care*.

More information will be available in the next newsletter.

Euthanasia Prevention Coalition Mails out Materials

The *Full-Report: expose* from the World Federation of Right to Die Societies Conference in Toronto last September is now being mailed out. The whole project became larger than originally planned.

The document contains information from every presentation at the Right to Die Conference. Many of the presentations include commentaries.

To order a copy of the Full Report: expose, just send a donation of \$25.00 or call toll-free: 1-877-439-3348..

The new video: *Turning the Tide: Fighting for our Lives* will be mailed out as soon as they arrive in the office. *Turning the Tide* will be sent out with a Discussion Format to be used for group presentations.

To order a copy of the video: *Turning the Tide*, just send a donation of \$50.00 or call toll free: 1-877-439-3348.

Sick Children's Hospital in Toronto withdraws hydration & nutrition from infants with disabilities

On January 18, 2007; Alex Schadenberg, and one other person, attended a seminar by the Bioethics Department of the Hospital for Sick Children in Toronto on the Withdrawal of Hydration and Nutrition (H & N) in the NICU

The seminar was presented by Dr. Jonathon Hellmann, professor of Paediatrics (U of T) and Clinical Director of the NICU (Hospital for Sick Children in Toronto).

The criteria from withdrawing (N & H) from infants with disabilities is:

- The parents must freely request that feeding be withdrawn. (Doctors may present it as an option to the parents.)
- The child must be "profoundly" disabled. (The criteria did not limit dehydration to children who were dying anyway.)
- The child must lack an ability to eat normally (lacks a sucking mechanism).

The Hospital for Sick Children in Toronto will permit infant children with disabilities to be intentionally dehydrated to death. **This is euthanasia by omission.** We were not given the *particular circumstances* that the Hospital for Sick Children in Toronto has applied its policy of withdrawal of H & N, only the general principles.

The Criminal Code of Canada states that: ***you must provide the basic necessities of life.*** This is an important provision in the Criminal Code because it protects vulnerable people from others who will deny them the basic necessities of life.

This is a form of eugenics. These children are being refused (H & N) not only because it is a benefit to them, but also because the infant is so profoundly disabled that the child is believed to be "better off dead." by the parents.

This also represents a form of medical abandonment. These children often lack an ability to feed normally because they are premature. This is often a temporary condition that can be rectified by good care and by being tube-fed.

Please refer to the letter in this mailing from our President, Dr. Barrie deVeber for our action plan on this matter.



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PRESS RELEASE

March 8, 2007

PHYSICIAN ASSISTED SUICIDE IN OREGON HAS BECOME AN UNSPEAKABLE ACT

Proponents of physician-assisted suicide manipulated Oregon Department of Human Services (DHS), through threat of litigation, to use vague and misleading language to cloud the debate on physician-assisted suicide. This year, rather than reporting on “physician-assisted suicide” as in prior years’ reports, DHS is now reporting on “those patients who participated in the Act”. Despite this euphemism for state-sanctioned medical killing in Oregon, we need to remember that this report is about physician-assisted suicide.

Physicians for Compassionate Care Education Foundation (PCCEF) is very concerned about the limited content of data in this year’s Department of Human Services Annual Report of physician-assisted suicide. The report issued today by Oregon’s DHS regarding the 2006-Year experience of physician-assisted suicide is amazingly brief and incomplete and much of the past narrative-type information is not present in this year’s report.

PCCEF is concerned with several areas of the report:

- This year’s report does not enumerate the number of prescriptions written by doctors, i.e. how many doctors wrote one, two, three, etc. prescriptions. This information was in prior reports.
- Only two of the 46 patients dying from assisted suicide in 2006 were referred for psychiatric evaluation, yet depression is the most common cause of suicidal ideation.
- The prescribing physician was present when medication was ingested for only 15 of the 46 deaths; knowledge of complications for the other 31 patients is obtained second or third-hand.
- Emergency medical services were called for a patient who had fallen, yet that fall was not listed as a complication of the lethal prescription for the physician-assisted suicide.
- The median duration of the patient-physician relationship was only 15 weeks, with a range from one to 767 weeks. We know that many of these patients are receiving prescriptions for lethal medications from doctors that are new to them, rather than from their usual doctor.
- The time between the first request and death ranged from 15 to 747 days. As we have previously noted, many non-terminal patients are dying from assisted suicide.
- The Summary statement reports that more patients were concerned about inadequate pain control, yet the details of Table 1 of the report identifies that category of End-of-Life Concerns as “inadequate pain control or concern about it”. We don’t know if this is “inadequate pain control” or fear of future inadequate pain control.

PCCEF believes that all human life has inherent value and that physician-assisted suicide:

- undermines trust in the patient-physician relationship
- changes the societal role of the physicians from healer to executioner,
- endangers the value that society places on life, specifically for those who are most vulnerable.

PCCEF members will continue to assist individual patients and their families to access excellent palliative care at the end of life.

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Physicians for Compassionate Care Educational Foundation

When Killing Yourself Isn't Suicide **Word games may win the day in the battle of physician-assisted suicide.**

By: Rita L. Marker & Wesley J. Smith
Nationalreview.com, March 5, 2007

The Vermont legislature has fast-tracked a bill to legalize physician-assisted suicide, and California may not be far behind. If the legislatures in these states do vote to redefine physician-assisted suicide as a legitimate and legal “medical treatment,” a large part of the blame, strange though it may sound, can be laid at the feet of postmodernism.

The deconstruction of language, with disregard for facts and accurate definitions, is infecting medical and health-care ethics and policies. Case in point: In order to further the legitimization of assisted suicide, the American Public Health Association (APHA) embraced the political advocacy of assisted-suicide supporters in November when it decided that “physician-assisted suicide”—an accurate and descriptive term—should be replaced with the euphemistic advocacy-phrase “aid in dying.” At its annual meeting, the organization approved an interim policy:

Urges health educators, policy-makers, journalists and health care providers to recognize that the choice of a mentally competent, terminally ill person to choose to self-administer medications to bring about a peaceful death is not “suicide,” nor is the prescribing of such medication by a physician “assisted suicide.” Urges terms such as “aid-in-dying” or “patient-directed dying” be used to describe such a choice.

This policy will become permanent if confirmed by the APHA’s governing council in 2007.

The stakes in this semantics game are high. At issue—and indeed, the whole point of this postmodernist exercise—is whether activists will be able to convince other states to join Oregon in redefining the crime of assisted suicide as a legitimate “medical treatment.” If that happens, funding of assisted suicide would soon follow, just as it has in Oregon, where the act of facilitating suicide is now deemed a state-funded form of “comfort care.”

In one sense, the opening of this new front in the assisted-suicide debate reveals that the movement, thought to be unstoppable when Oregon passed the nation’s first assisted-suicide law, understands that it has failed to convince America that suicide should be part of

medicine’s armamentarium. In the more than ten years since the passage of the Oregon law, state after state has considered legalizing assisted suicide. Each time, there was early support for the measure. Yet, in each instance, when the official vote was taken, support had evaporated and the proposal went down in defeat. This left assisted-suicide proponents, particularly Compassion & Choices (C & C) (formerly the Hemlock Society), which spearheaded most of these legislative proposals, searching for some way to improve their position.

So C & C commissioned research and polling. They found that people have a negative impression of the term “assisted suicide,” but, if euphemistic slogans like “death with dignity” or “end of life choices” were used to describe the same action, response was relatively positive. Likewise, poll respondents were more apt to approve letting doctors “end a patient’s life” than they were to approve giving doctors the right to “assist the patient to commit suicide.” According to one polling firm, the apparent conflict was a “consequence of mentioning, or not mentioning, the word ‘suicide.’”

As a result, assisted-suicide advocates concluded that the accurate word “suicide” had to go. They embarked on a crusade to erase and replace it with kinder, gentler language that masked the harsh reality of what was being discussed.

Their line of attack aimed at three target groups: the media, the state of Oregon, and major public-policy organizations. If those groups could be persuaded to adopt new language, opposition would supposedly disappear.

Accordingly, they issued press releases claiming that use of the term “assisted suicide” demonstrated insensitivity to dying patients and to the physicians who assisted them. In one C & C press release, Dr. Peter Goodwin, who has presided over a number of assisted-suicide deaths, said, “As a physician, I resent the term ‘physician-assisted suicide.’ I never felt I was assisting a suicidal patient, but rather aiding a patient with his or her end of life choice.”

Thus far, however, the press has, for the most part, not jumped on the name-change bandwagon. For example, the Associated Press bureau chief in Portland, Oregon, said, “We have thought about it and we feel ‘suicide’ describes the act of taking one’s life, so we’ll stick with

it – for the time being.” Likewise, the Register-Guard (Eugene, Oregon) will continue to use the terms “doctor-or physician-assisted suicide,” since they have chosen “to err on the side of plain English.”

The government of Oregon, however, is another story. The Oregon Department of Human Services (DHS) is the entity charged with compiling annual assisted-suicide statistics, and, since those statistics are inevitably part of any debate or discussion about new assisted-suicide measures, C & C needed the DHS to replace the offending “s-word” in the reports. To accomplish this, C & C first sent a formal request to the state agency, suggesting that the terms “aid-in-dying,” “directed dying,” or “assisted dying” be used in official state reports. Then the group upped the ante when it brought lawyers to a meeting with the DHS to discuss the language substitution and implied that, if it were not made, litigation might follow.

Rather than risk a legal wrangle (or, perhaps, out of sympathy for the cause), the state acquiesced. On October 16, state officials announced that, in the future, physician-assisted suicides in Oregon would be listed as “physician-assisted death.” However, this label was changed after a number of Oregonians objected to its ambiguity, since it could refer to anything from plumping a pillow or wiping a brow to intentionally giving an overdose of a lethal drug.

The state agency finally settled on the phrase it would use instead of “physician-assisted suicide.” In all future official communication, the state of Oregon will refer to patients who die from physician-assisted suicide as “persons who use the Oregon Death with Dignity Act.”

Assisted-suicide activists were ecstatic. According to Kathryn Tucker, C & C’s director of legal affairs, “This will be a sea change because how you speak of things strongly influences how you think of them.”

The victory in Oregon was equaled when the APHA announced that it would embrace the misleading language. With over 50,000 members from over 50 occupations in the public-health field, APHA has a long arm. According to its web site, “APHA has been influencing policies and setting priorities in public health for over 125 years.” Now it will give the media an excuse to shift from precise and accurate descriptive language about assisted suicide to the words of pure political

advocacy. Clearly, the APHA’s adoption of a policy intended to mask the reality of suicide and to legitimize its facilitation by describing it in innocuous terms constitutes thinly veiled support for passage of laws permitting physician-assisted suicide.

This is a big shift from 1999, when then-U.S. Surgeon General David Satcher declared, “Suicide is a serious public health problem,” and urged implementation of a comprehensive national strategy for suicide prevention. At the time, he did not recommend that those who had been diagnosed (or misdiagnosed) with a terminal illness be exempt from efforts at suicide prevention. But Satcher himself has now caught assisted-suicide fever. In 2006 (when he was no longer the surgeon general), he wrote a letter supporting a California bill that was identical to Oregon’s law. (The California bill failed.) In his letter, he referred to assisted suicide in Oregon as “legal aid in dying in Oregon.” Apparently, suicide is no longer a problem if it isn’t called “suicide.”

Let’s think about how this works: Take a patient who has been diagnosed with a terminal condition. If that patient asks her doctor for sleeping pills so she can sleep comfortably at night, and if the doctor prescribes them, but she takes all of the pills at once and dies, her death is called “suicide.”

But, if that same patient asks her doctor for sleeping pills so she can die, and if the doctor prescribes them for that purpose, and she takes all of the pills as directed and dies, her death is not called “physician-assisted suicide.”

Assisted-suicide advocates say that that’s proper, but really it’s just political correctness. By bringing postmodernism to health-care public-policy, they hope to drive their agenda to victory.

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<http://article.nationalreview.com/?q=NGYwNWM4Y2EwODRjOTViZjI4ZTJjZTQ0M2Q4NWRhZjI=>

Legislature has no role in end-of-life choice

Editorial – Burlington (Vermont) Free Press

Sunday, February 25, 2007

There's something unnerving about government legislating death. That's what the Legislature is considering in taking up bills on whether to allow doctors to prescribe lethal doses of medicine to terminally ill patients.

The bills are S.63 and H.44, both titled: "An Act Relating to Patient Choice and Control at End of Life." The hearings Friday in Montpelier continued a debate that has been going on in Vermont for at least a decade.

The latest poll, released Thursday, indicates overwhelming support among Vermonters — 81.5 percent — for allowing terminally ill patients, as former Lt. Gov. Barbara Snelling put it, "full choice and control at the ends of their lives."

But the result of the poll — conducted by Zogby International — is less adamant than it might first appear because of the way the survey was structured. The poll first asked participants to choose between two statements:

A: If I am terminally ill, within six months of dying and with no hope of recovery, the decision about when I should be able to bring a peaceful end to my suffering is mine to make in accordance with my wishes and in consultation with my family and loved ones;

B: Given the sacredness of human life, only God should decide when my life ends.

Then the survey asked, "Would you support or oppose legislation to allow a mentally competent adult, dying of a terminal disease, the choice to request and receive medication from a physician to peacefully end suffering and hasten death?"

The poll question links reducing suffering to doctor-assisted dying with no other options. Other polls, taken earlier, have shown that public support can fade when the act is called "suicide." All this underlines the fact that society is still deeply divided over the issue. After all, Vermont has no death penalty. Can we really stomach state-sanctioned suicide?

No one is against easing suffering for the dying or their families, but the focus should be on the kind of end-of-life care that manages pain, both physical and psychological. And those who don't want to prolong their lives already have the right to refuse treatment.

It's one thing to withhold treatment, but you make a leap over a vast moral chasm when you move to actively enabling

death. Allowing doctors to prescribe lethal doses of medicine for the terminally ill might be the right thing to do for our society, but there are too many questions that leave too many of us uneasy, unconvinced.

The debate is healthy and necessary, but without the absolute certainty, the Legislature should drop these bills. Proponents say this is about personal choice, and there is nothing more personal than one's own death. That's why the Legislature has no place in the decision. A death-with-dignity law implicates us all.

We're not ready for that, yet.

Studied Neutrality and Redefining Language

By: Alex Schadenberg

The American Academy of Hospice and Palliative Medicine (AAHPM) at their Board of Directors meeting on February 14, 2007 changed their position from opposing assisted suicide to that of "studied neutrality".

Last November, the Canadian Hospice Palliative Care Association (CHPCA) also moved from a position of opposing assisted suicide to that of "studied neutrality".

In 2005 the British Medical Association took a position of "studied neutrality". At their AGM in August 2006 the BMA members renewed their opposition to assisted suicide.

Like the CHPCA, the AAHPM has also changed their language. They now refer to Physician-Assisted suicide as Physician-Assisted Death. Once again, they have bought into the wording that is being pressured onto them by the national group Compassion & Choices, formerly the Hemlock Society. Compassion & Choices is a lobby group that works to legalize assisted suicide in the United States.

Last year I attended the World-Wide Federation of Right to Die Societies conference in Toronto. Compassion and Choices explained that they had two main focuses.

1. **To change the language.** Through polling and focus groups, they learned that the word suicide had negative connotations for many people.

2. To get leading medical associations to take a position of "**studied neutrality**".

Leaders of the Euthanasia Prevention Coalition are currently discussing a practical response to the new push by the euthanasia lobby. If the euthanasia lobby is successful, the lives of: vulnerable people, especially people with disabilities, the frail elderly and people who live with depression and mental illness will be put in direct risk.

Zurich Hospital Rejects Assisted Suicide

Swissinfo - March 8, 2007

Zurich University Hospital has revealed that a ban on assisted suicide on its premises has been in place since the beginning of February.

Leading Swiss hospitals have been debating whether to allow assisted suicide on their premises since Lausanne University Hospital decided in 2005 to allow assisted suicide under strict conditions from January 1, 2006.

Zurich hospital said on Thursday that the directive applied not only to hospital personnel but also to any visitors. However assisted suicide groups can still visit patients.

“The directive is intended to be robust and practical regarding everyday questions,” said Georg Bosshard, head of clinical ethics at Zurich University Hospital.

For example, when a patient's desire to end his or her life clashes with the hospital's fundamental job of curing patients, the directive is explicit in forbidding any form of assisted suicide within hospital walls. Those wanting to die may however leave the hospital.

Patients may still receive visits from assisted suicide groups such as Exit and Dignitas, and if they express a desire to die, they have the right ? like all patients ? to a report giving medical information such as their diagnosis and prognosis.

Christian Schwarzenegger from the Institute of Legal Medicine at Zurich University said such a report in no way constituted participation in suicide.

In those cases where a patient who wants to die is no longer capable of leaving the hospital, the hospital would try to find an individual solution, according to Urs:Martin Lütolf, head of the radiology: oncology clinic.

“The important thing is to reach a consensus with everyone involved,” he said.

Elsewhere

In 2005 Lausanne University Hospital took the decision to permit assisted suicide under strict conditions from January 1, 2006.

The hospital in western Switzerland said it would allow the voluntary euthanasia group, Exit, to help terminally ill patients who are unable to go home.

It said patients wishing to take their own lives must have expressed a persistent wish to die, be of sound mind, suffer from an incurable disease and carry out the final act themselves.

Lütolf pointed out that in the past six months six people had asked for help in assisted suicide at Lausanne University Hospital and only one had gone ahead with it? three had backed out and two were considered not of sound mind.

Geneva University Hospital has offered the same options to patients as Lausanne since 2006.

Pressure

Pressure for controls on assisted suicide have been mounting in recent years, partly because Switzerland has gained a reputation for “death tourism”.

In October 2006 a national ethics commission recommended that there should be more external controls in place for people using suicide assistance organisations to end their lives.

The Swiss National Advisory Commission on Biomedical Ethics said organised suicide assistance should only be permitted for people suffering from serious illnesses.

The commission noted that since there was a legal framework for assisted suicide, it was important to make sure that organisations carrying out the practice were properly controlled.

In June 2006 the Swiss government said legislation governing assisted suicide in Switzerland was sufficient and it had no plans to tighten the rules.

Book Banned in Australia

Radio Australia - February 26, 2007

The Australian government has banned a book by euthanasia advocate Dr Phillip Nitschke that gives advice about suicide options. The Classification Review Board voted unanimously to ban “The Peaceful Pill Handbook” by Dr Nitschke and Dr Fiona Stewart.

The book cannot be sold, displayed or imported into Australia.

A spokeswoman for the Board says Dr Nitschke's book gives detailed but incomplete instruction in the manufacturing of barbiturates. It was reviewed after a complaint by the Attorney General Phillip Ruddock.