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Death is inevitable – suffering need not be.

A Chaplain's

*By Rev. Kevin Bradley, MDiv,
Minister, United Church of Christ*

View Of the Right to Die

I routinely ask my patients whether they are afraid of either death or the dying process. There is usually no fear of death, but there is often fear of suffering, of being a burden, or of the loss of autonomy and dignity. Hospice staff can provide some pain relief and ease the burden on family, but they can't do much about the loss of autonomy beyond honoring advance directives. They may try to explain the changes the body will undergo, but nothing can really be done about those changes. "It's natural," they will say, as if that makes the process more dignified. Family members are often comforted by that sentiment; patients are not.

Opponents of the right to die often cite religious reasons. Frequent objections are that suicide breaks the sixth commandment and is a mortal sin, that life is sacred and must be preserved at all costs, that only God can decide when and how our lives end, and that Christians are supposed to suffer because it allows them to empathize with Jesus' suffering.

Ending one's own life was deemed a mortal sin partly due to a bad translation of the sixth commandment. I learned it as thou shall not kill, but it's actually thou shall not murder. In the original Hebrew, murder is "the deliberate taking of another's life, with malice." The key words are taking and malice.

CHAPLAIN
continued on page 2

CONTENTS

SILENCE IN FLORIDA.....	3
IT DIDN'T HAVE TO END THIS WAY	5
OREGON'S SUCCESS	7
DEPRESSION PROGNOSIS... ..	8
REMEMBERING THE KAVANAUGHS	10
DENYING DEATH.....	11

VIOLENT DEATH IN A PARK VS. QUIET DEATH AT HOME

By Ruthanne Johnson

It was a warm, sunny, late afternoon, and I had turned 75 just two days earlier. I waited in our living room for the police to arrive and tell me that Frank, my beloved husband of 49 years, was dead from his handgun. I sat watching out the window when an unfamiliar car pulled into the driveway followed by a police car.

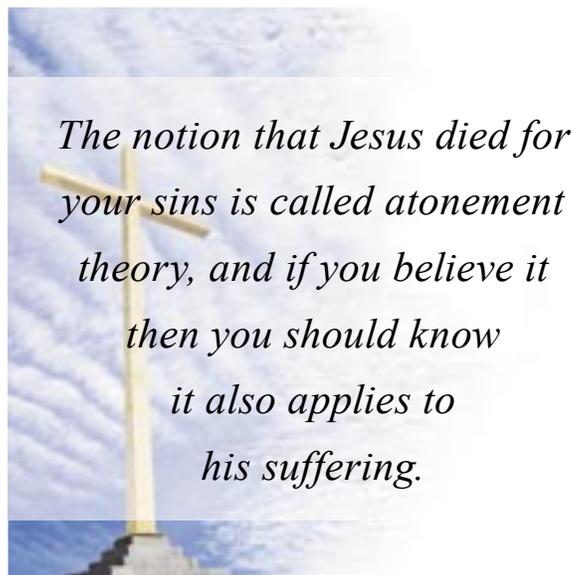
When my good friend Amy came to the door first, I asked “How did you know?” and I soon learned that my Frank had slipped her address and phone number in his pocket before he took his own life in a violent but sure way in a local park. I only wish he could have done it in a quiet way in our home with me at his side, holding him in my arms as he slipped away in death from a lethal medication which he could have administered. But, because of our law in Illinois, that option was not available for us.

Even though I knew what he was going to do to escape a probable nursing home stay or hospice care which he vehemently requested that I not let happen, it was a most heart-breaking time for me. We wanted to be together at the final moment.

Frank had an inquiring mind, and was a powerful tennis player until being diagnosed with multiple myeloma at age 80. The suggested treatment was unacceptable to Frank and would not cure the disease; hence, his decision to leave this life on his own terms.

Three of his last words to me before he drove to the park were, as I put my arms around him, “Don’t hug me!” The pain was so great, he didn’t want me to embrace him. His pain medication caused him to sleep so he couldn’t use it when he had a necessary task.

Why can’t we have a law that allows us to end our lives on our own terms when pain is so great, there is no cure in the near future for the illness, and being cared for like a baby is definitely not desired? ■



The notion that Jesus died for your sins is called atonement theory, and if you believe it then you should know it also applies to his suffering.

Chaplain continued from page 1

You cannot “take” something that is freely given; you can only receive it. If I ask you to help me end my life, you are not “taking” it, you are only allowing it to be given, and there is certainly no malice. You are merely honoring my request to help me end my suffering.

The notion that Jesus died for your sins is called atonement theory, and if you believe it then you should know it also applies to his suffering. If Jesus died for you, then he also suffered for you. Allowing or—God forbid—encouraging someone to suffer is not pious; it’s sadistic.

I could make similar arguments against the other objections, but that debate is a distraction because it focuses on human life, which is, believe it or not, beside the point. From a chaplain’s perspective, you are more than a human being—you are a spiritual being having a human experience. The death of your body is not the end of your life. When your Earthly purpose is fulfilled, your body is supposed to shut down and allow you to return to your true spirit form. My patients understand that and appreciate my saying it out loud.

But sometimes the body gets damaged and is unable to shut down on its own. Just as people in a bad car accident must be freed from their metal prison using the Jaws of Life, you may need help being freed from a body that has become a prison. You have the right to physically die because you have the right to be free.

Death is inevitable—suffering need not be. ■

As Other States Move Ahead, Florida is Silent on Physician-Assisted Death

By John Romano

Condensed from a column that appeared in the Tampa Bay Times – October 10, 2015

“They come up with these silly, boogey-man arguments so it sounds like a secular issue instead of the real reason, which is they’re forcing their personal, religious beliefs on everyone else.”



Rick Rivas, brother of FEN’s general counsel Robert Rivas, with his niece and nephew, Cecilia and Alex, on the water in Florida.

Sometimes, when the music feels right and the crowd is buzzing, Rick Rivas can ignore his impending death. Standing on a cramped barroom stage and tapping out Aretha Franklin on a bass, the 61-year-old salesman gets lost in the moment and the memories.

The meds keep him steady. His band mates keep him smiling. And the pain tickling his bones keeps him cognizant of the cancer that has metastasized from spine to skull.

It’s no way for a man to live, but Rivas is making the most of the time he has left. He’s about four months into what doctors tell him will be the final 12 to 24 months of his life.

So he plans vacations with family. He tries to make sure the lives of his three children are in order. He pauses to take pleasure in something as mundane as mowing the lawn.

And, far too often, he frets about something beyond his control:

The state of Florida will not allow Rivas to choose when it’s his time to die.

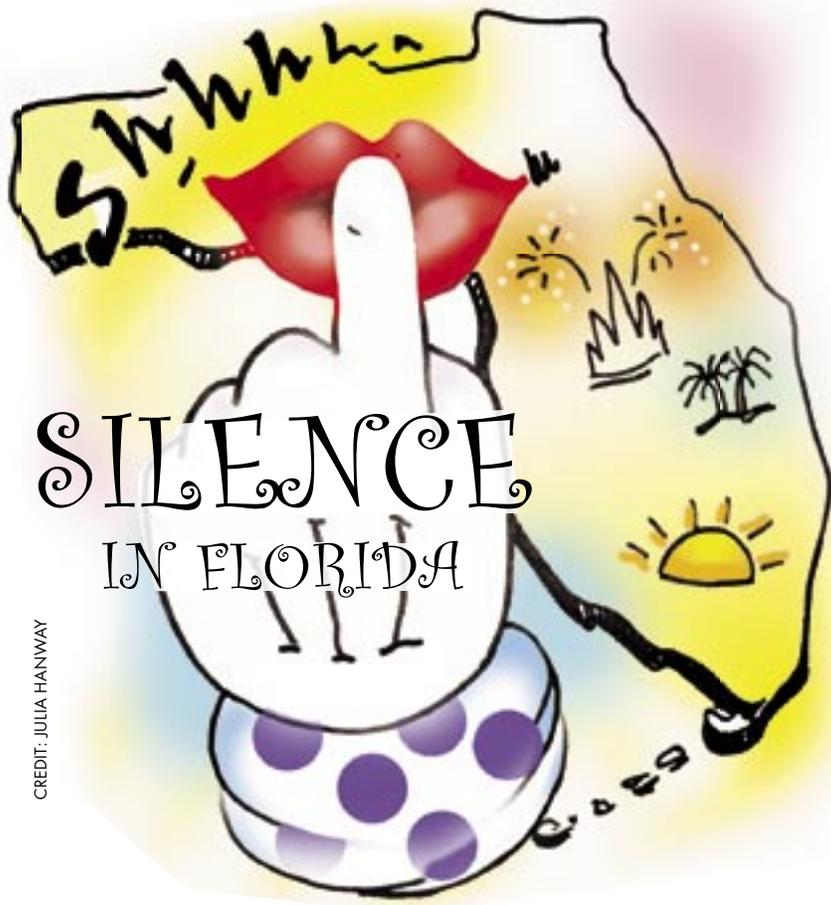
“My life has been my own responsibility on a day-to-day basis for as long as I can remember. And now when I’m about to finish my life, you want to take that responsibility away from me?”

Back in 1997, months before Oregon would pass the nation’s first national death law, a Florida judge ruled a Citrus County man with AIDS had the right to choose the time of his death with a physician’s help. The man’s attorney had successfully argued that the privacy provision in the Florida Constitution protected the relationship between a patient and a physician.

The attorney? Rick Rivas’ younger brother Robert. *[Robert is also Final Exit Network’s general counsel. Ed]*

Five months later, the state Supreme Court overturned the ruling, saying such matters were best left

FLORIDA continued on page 4



SILENCE IN FLORIDA

In a state that seniors flock to for easy living, the Florida legislature recently met in Tallahassee.

State lawmakers are mum on Death With Dignity laws in a state where more seniors reside than in any other state. Led by Republican governor Rick Scott, legislators were far more interested in the entertainment industry, gaming, and attracting new residents and industry.

This year, POLST (Physician Orders for Life-Sustaining Treatment) bills were filed in both the House and the Senate, but the bills never made it out of legislative committee for a vote.

Florida continued from page 3

for the legislature to decide.

We have endless debates about the most humane way to carry out executions, and yet we essentially sentence innocent people to horrible deaths with archaic end-of-life laws.

Robert Rivas, who has represented the Final Exit Network in several high-profile suicide cases, says “When opponents talk about aid-in-dying laws, they have to struggle to think up convincing arguments against it,” said Robert Rivas. “They come up with these silly, boogey-man arguments so it sounds like a secular issue instead of the real reason, which is they’re forcing their personal, religious beliefs on everyone else.”

The Oregon law, which has been mimicked in the other states, has safeguards that have prevented abuses. The typical patient in Oregon is a well-educated, 71-year-old with up-to-date health insurance who is suffering from terminal cancer.

Roughly 50 patients per year, on average, have exercised their right to die in Oregon, and another 27 patients annually get prescriptions but do not take the

drugs. Supporters say those people were comforted in knowing they had the option to end their lives if they so chose.

Rick Rivas has not yet decided what direction he will take when the end is near. Mostly, Rivas is hoping the pain can be managed and his death will be relatively swift. The point, he says, is the choice should be his. If the end is imminent, why is the method an issue?

The data shows assisted-death cases haven’t negatively impacted society, which turns it into a question of individual liberty. And that should be a cause conservatives and liberals alike can rally around.

Really, it boils down to a simple question: In what universe does it make sense for a government to insist that a person suffer in front of their loved ones, when a compassionate alternative is available?

“Those people who want to make their stupid-a**, slippery slope arguments are welcome to die in agony if they want,” Rick Rivas said. “They can have their high principles, but don’t force your principles on me. I no longer have the time for that foolishness.” ■

It Didn't Have to End That Way

The following testimony on the End of Life Options Bill was presented to the Colorado Senate Committee by Mr. Whitey Powers on Feb. 3, 2016

My wife, Janis, was diagnosed with an incurable lung disease in 2007 that caused her to endure many complications, including perforated colon, broken vertebrae on three different occasions, vomiting nearly every day for a year and half, brain damage, and numerous infections.

In 2010 Janis developed cancer, which resulted in two operations and many more complications. Between 2007 and 2011, I took her to the hospital 240 times. In the summer of 2011 she said she wanted to die and went off her medications with the consent of her doctors. During her third week of hospice care my daughter and I were informed that she had a week to live. At that time, my wife pleaded with the hospice nurse to give her something to hasten her death. The nurse said, "I really want to help you but I can't. It's not legal." That was a heart-wrenching scene. Her last wish on this earth was to be free of pain, and it was denied.

Earlier that evening my wife aspirated and breathing became very difficult for her, a loud crackling sound resonating from her lungs each time she took a breath. Before the nurse left for the day she instructed my daughter and me to give her morphine periodically to control her pain and help keep her asleep and comfortable. The next morning I entered her room about 6:30am and her chart indicated that it was time to give her morphine, which I did. I observed her for a while. She seemed to be agitated and was laboring with her breathing. Thinking she was struggling with pain, I gave her more morphine. I continued to observe her for another 10 or 15 minutes and she was grimacing and started to open her eyes. I gave her the rest of the morphine. It was 7am and she died a few minutes later.

I later learned that giving her that amount of morphine in such a short period time may have caused my wife's death. Even though she wanted to

The nurse said, "I really want to help you but I can't. It's not legal."

That was a heart-wrenching scene. Her last wish on this earth was to be free of pain, and it was denied.

COLORADO continued on page 6

How Doctors Die

By Jacquelyn Corley, M.D., neurological surgery resident at Duke University Medical Center

We often hear that medical professionals are reluctant to abide by the end-of-life wishes of their patients. In this article, the author says the opposite: patients often do not accept the treatments that doctors do. Following is a condensation of “Why doctors choose to die differently,” an opinion piece posted online by CNN. —Ed. Note

One problem with medicine today is that it is too good. People live longer than ever before, and many patients are able to recover from deadly illnesses the world knew nothing about when my grandparents were children. Doctors can keep people alive in ways once thought impossible.

There comes a time for every person when his or her identity is gone, and the quality of life should be valued more than the mere presence of it.

This is a common viewpoint for many in the health care community, but it seems to be in opposition to the beliefs held by the general public. Families are suddenly forced to make weighty decisions for loved ones, often erring on the side of caution. “Do everything you can for him, Doc” is a phrase with far-reaching implications. Doctors, nurses and others who devote their lives to taking care of very sick patients see it happen all the time. A patient’s time has come, but the family just can’t let go.

Studies show there is a dichotomy between how health care workers view end-of-life care and how the rest of the world does. To illustrate this, a recent report [Jan. 19, 2016] published in the Journal of the American Medical Association describes data that was obtained from death records from Massachusetts, Michigan, Utah and Vermont from 2004 to 2011.

It revealed that compared to the general popula-

tion, doctors were less likely to die in a hospital, less likely to undergo surgery at the end of their lives, and less likely to be admitted to an intensive care unit. Similarly, a study published in Plos One by doctors at Stanford University in 2014 found 88.3% of 1,081 physicians surveyed for the study designated “do not resuscitate” as their advance directive.

It is a painful truth that doctors are often asked to continue the kind of intensive measures they would never wish for themselves or a loved one. For those in the health care community, death is not an abstraction, but a daily reality. We know how precious life is, and we understand how difficult it is to watch family members lose people they love. But we also know in modern medicine, dying with dignity is a luxury more people should enjoy. ■

Colorado continued from page 5

die and probably was close to it, I didn’t want to be the person who may have contributed to her death. It didn’t have to end that way. If the End of Life Options Act had been in effect, my wife and I could have avoided that final and difficult chapter of her life.

In 2011, I purchased a revolver. I’m 77 years old and determined that, if I become terminally ill, I will do whatever I have to in order to avoid the unnecessary suffering that so many terminally ill people go through when dying. If I choose to end my suffering on my own with a revolver because there are no other options, then I will. My seeking aid in dying as a medical treatment would absolutely be my preference.

No other person or government should deny a terminally ill person their individual freedom and basic right to direct their own dying process. ■

Join the conversation

FACEBOOK:



Go to <http://www.facebook.com/groups/finalexitnetwork/>

Final Exit Network’s facebook page has over 1,000 participants on our moderated forum. Join our group and talk to us about what’s on your mind or post news about the death with dignity movement. We enjoy hearing from new participants and we welcome all to join.

Oregon Shows that Assisted Suicide Can Work Sensibly and Fairly

By Thaddeus Mason Pope, Director
Health Law Institute at Hamline University

[During the 17 years following enactment of Oregon's Death with Dignity Act in 1997,] more than 1,100 people have obtained life-ending prescriptions, and about 750 used them. Most were dying of cancer. And most feared a loss of autonomy, dignity and decreasing ability to participate in activities that made life enjoyable.

Safeguards ensure that patients who are terminally ill make voluntary, informed decisions. There is no evidence of exploitation.

These and other statistics on Oregon's experience are available, because of neutral data collection and reporting. This has permitted legislatures and courts



Thaddeus Pope, Director

around the world to assess Oregon's experience. Overwhelmingly, they have found it worthwhile.

In significant part, this is due to many safeguards in Oregon's law, which only allows participation by defined categories of patients. Patients must be mentally healthy residents of Oregon, 18 or older, who have had two physicians determine that they have no more than six months to live.

The safeguards also ensure that patients are making a voluntary and informed decision. A physician must educate the patient about all options, including palliative care, pain management and hospice. The patient must make three separate requests (two oral

"In short, the Oregon law has been a success."

and one written). The oral requests must be separated by at least 15 days, and the written request must be independently witnessed by two people. The patient can rescind these requests at any time. Finally, to further ensure that patients remain in full control of the process, they must administer the medication themselves.

These safeguards work. There is no evidence of an inordinate impact on vulnerable populations. Indeed, over 97% of the patients who died from ingesting a lethal dose of medication were white. Over 98% had health insurance, over 90% were enrolled in hospice and over 72% had gone to college. Nor does available research show any negative impact on the availability of palliative care or on the physician-patient relationship. Today Oregon is a universally recognized leader in end-of-life care across the entire continuum of options. In short, the Oregon law has been a success.

While once widely rejected, assisted suicide is receiving — and surely will continue to receive — increased recognition as an appropriate response to the suffering of patients at the end of life. This is due in large part to Oregon's proven safe and effective implementation. ■



DEPRESSION

PROGNOSIS

IS NOT ROSY

By Lowrey R. Brown

There is a common misconception, which appears in Final Exit Network's May 2016 Newsletter, that major depression is "treatable," and, therefore, those suffering from depression should not be considered for assisted suicide. In his article, the late Dr. M. John Rowe III stated, "I believe in assisted death. Not assisted suicide for depression. Depression is a treatable, reversible condition." Dr. Rowe is not alone in mistaking the availability of treatments for the availability of effective treatments, and this misapprehension often leads to the blithe dismissal from death-with-dignity discussions of those suffering from depression.

It is becoming increasingly clear that current treatments for depression are failing many, if not most, patients. Those with depression suffer incredibly, often despite treatment, and sweeping them away with an off-hand, "go see a doctor," adds further insult and isolation to an already-crippling affliction.

If we, as death-with-dignity advocates, currently find it too complex or too

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politically thorny to describe or define the conditions under which those suffering with depression may be supported in end-of-life choices, okay. Practical and social realities exist; the suffering understand this all too well. However, in being ignorant of modern medicine's lackluster performance in treating depression, in suggesting that those who suffer from depression do so voluntarily because they could simply seek treatment, we further marginalize an already misunderstood and often relegated population.

Consider the efficacy of antidepressant medication, usually the first-line of treatment for depression, and, for many patients, the only treatment. In published research articles describing antidepressant medication efficacy, the response rates were never great, but a 2008 study (*The New England Journal of Medicine* 358:252–60) of publication bias (positive results are more likely to be published than neutral or negative ones) for antidepressant medication trials “showed that the increase in effect size ranged from 11 to 69% for individual drugs and was 32% overall.”

Further, a 2002 study (*Prevention & Treatment*, Volume 5, Article 23) of antidepressant medication efficacy found that

when including unpublished trials, “the mean difference between drug and placebo was approximately 2 points on the 17-item (50-point) and 21-item (62-point) Hamilton Depression Scale,” a clinically negligible amount. Trial duration is also problematic. Depression can ebb and surge unpredictably, over days or years. A 2009 study (*Lancet* 373: 746–58) examining 117 antidepressant medication trials found a mean trial duration of only 8.1 weeks.

This cursory discussion doesn't address nuances, such as initial severity, or other treatments, such as psychotherapy. What I want to make clear is that modern medicine is often unable to successfully treat those with depression, and their suffering is real and excruciating. The death-with-dignity community may not be practically, politically, or philosophically ready to include this population in the current mission, and that is understandable. Let us be honest with ourselves and others about these difficulties, however, and cease excluding those with depression on the basis that their suffering could simply be alleviated with treatment. It is a position that is both false and hurtful. ■

Artwork by Aurora Mazzoldi, Creative Commons Attribution-Share Alike 3.0

REMEMBERING THE KAVANAUGHS

By Janis Landis

Being president of the Final Exit Network means I deal with end of life issues on a daily basis. But that still didn't prepare me for the phone call informing me that a reporter wanted to interview me about the death of Frank Kavanaugh and his wife Barbara. A murder-suicide by gun was the official verdict.

He was the consummate speaker with an incredible ability to engage his audience.

Frank was a long-time activist in many causes but FEN was fortunate to be his primary focus since our founding. With Frank, you had the embodiment of everything we stand for: personal autonomy, human dignity, deep compassion, and a determination to reduce needless suffering.

Frank was my mentor when I first became active in FEN. He was the consummate speaker with an incredible ability to engage his audience. He taught me so much about media outreach and marketing. He was open to any and all options: including his legendary hiring of airplanes trailing FEN banners over Florida beaches, billboards to reach folks in their cars, and patiently mastering a few Yiddish phrases I taught him so he could surprise his audience at synagogues.

But at his core, Frank was a family man and devoted husband. And when his beloved wife Barbara was diagnosed with a degenerative

brain disease, she became his focus. Recently, Barbara needed full time care. Frank sat with her at the nursing home every day. Until April 19 when he brought a gun to the facility.

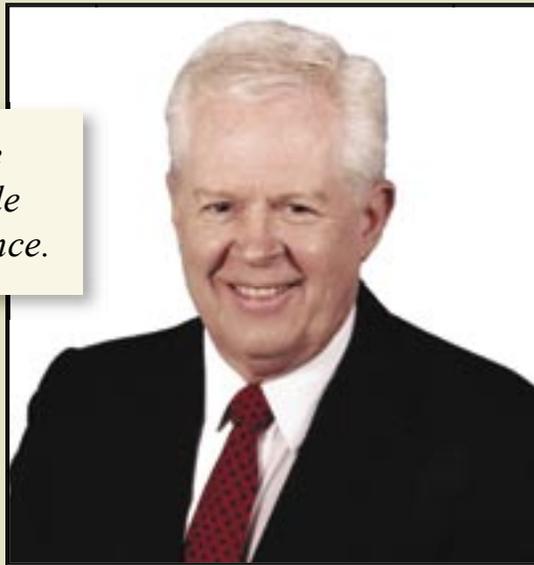
Two questions inevitably arise. First, why that day? We can only speculate, but from what we know it seems probable that Frank's own deteriorating health left him and his wife fearful that he might not be able to be with her when she chose to end her own life.

And secondly, why a gun? Because with caretakers present, the current law leaves no other option for couples in such a situation. A couple that wants to complete their life together before illness robs them of their identity and each other often find that gentler methods are not feasible.

There's so much more to say about Frank, and over the next few weeks I and his many other friends and colleagues will shift our focus from his death to the much more important part: his life and legacy and how we can best honor it.

I ask each of you with a story or remembrance you want to share to send us your comments. Send them to hdevenzio@charter.net. We'll include them in a future issue, paying due tribute to a life lived with kindness, integrity, and commitment.

It's an old-fashioned term for such a forward-thinking guy but, to those who knew him, the word that comes to mind is gentleman. ■



Frank Kavanaugh, PhD

When a patient's end is near and suffering becomes intolerable, what's the point of continuing that suffering?

Denying Someone a Peaceful Death Can Be Unethical

John M. Grohol, Psy.D.

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Sometimes it can be hard to let go. Nowhere do we see that more clearly than when it comes to a person's right to die with dignity at the end of their life. But perversely, sometimes the difficulty in letting go isn't expressed by the person with a terminal disease. Instead it's expressed by their doctor. Doctors often fall back on medical ethics to defend their stance against euthanasia or assisted suicide. Some doctors believe that since their primary responsibility is to heal, helping someone along to a quickened death is contradictory to their oath.

When doctors equate healing with quantity of life, they ignore the quality of life. If suffering is intolerable, it is inhumane not to end it.

But when doctors confuse or equate healing with the length of life, they ignore the importance of a person's quality of life. When a patient's end is near and suffering becomes intolerable, what's the point of continuing that suffering?

Instead, it appears incredibly inhumane, insensitive and disrespectful of a person's free will to deny them an end to their misery. It's old-school medical paternalism at its worst: "I'm the doctor, and I know what's best for you"—even when the patient may only have a few weeks left to live.

The doctors who rationalize and minimize such suffering—explaining that it can be “managed” with even greater doses of opioid medications—miss the point. If one of our doctors' primary jobs is to relieve suffering, they're abdicating responsibility at this crucial moment. Doctors regularly undertreat pain complaints because they're afraid to prescribe opioids at the levels necessary.

At the end of life, when medicine cannot help a person live any longer or stop a terminal disease, it seems in keeping with a physician's ethics to help an individual maintain their dignity and choose the date of their own death. Indignity and loss of independence can be viewed as forms of pain, even if they're not traditionally seen in that light. Ask any prisoner whether being imprisoned is a painful life experience, and I'm pretty certain what their answer will be. The same could be said for when we age—we can become prisoners of our own failing bodies.

If the mind is healthy (something mental status examinations by psychiatrists can determine) why not allow an individual the freedom of this one last, important choice? ■



John M. Grohol, Psy.D.

How They Do It in Arizona

The Arizona Affiliate group/team has had noteworthy success with the local community and might serve as a model for groups in other areas. We work as a cooperative team, making decision by consensus, developing and providing advocacy training classes, deliberating life-completion information, hosting small social discussion gatherings, and organizing one or two yearly informative programs to spread the FEN mission to its members and the larger community.

As of early 2016, we had about 350 FEN member households in Arizona, 35 of which are in Green Valley and 178 in Tucson. In addition to members, we have about 265 households receiving emails or phone calls who want to be informed about our programs, ideas, and national FEN news.

For examples of our programs, we had 283 people at our November general meeting, 50 people at two introductory meeting in February 2016, 30 people at two helium demonstrations in March 2016, and 34 people at our Advocacy

Training classes in February and March 2016. We have been doing these programs yearly for about four years, and this year we are organizing at least two informal social events for members to simply discuss FEN issues among like-minded comrades.

Our team leader, John Abraham, has worked tirelessly to give presentations, teach classes, keep the individuals on the email list and phone tree informed, recruit volunteers, manage our finances, keep in touch with national FEN, and more. He also maintains a regular presence with OLLI (The University of Arizona Adult Education Program) and speaks about FEN with civic groups like Rotary and Democrats of Great Tucson, and at numerous retirement communities. John is knowledgeable in thanatology as well as in the practical aspects of end of life, that we feel honored and grateful to have him work with our local group.

— Submitted by AZ FEN Leadership Team:
Jack, Jerry, J'Fleur, Mary



RTD Debate Draws Medical Crowd

Martin (Marty) Seidenfeld, PhD, board member, represented FEN at a conference of health care professionals working with patients undergoing bone marrow transplants. This is a high-risk procedure, with only about half of the recipients surviving three years beyond the operation.

The conference, held in Honolulu in February, drew nearly 4000 attendees. About 300 attended the “Hot Topics” debate over “The Right to Die” for transplant patients. Marty reported that program managers were surprised by the degree of interest in the session.

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Dr. Martin Seidenfeld presented to health care professionals meeting in Honolulu. A robust discussion followed his presentation to specialists in the bone marrow transplant field.

The program included a debate between Dr. Seidenfeld and Matthew L. Ulrickson, M.D., a bone marrow transplant specialist. The debate was specifically designed to allow attendees to hear current evidence to help guide them in clinical practice when dealing with these tough issues. Dr. Ulrickson did not disagree that doctors see death as the enemy, but he feared that if more people choose to hasten their deaths, there might be fewer willing to participate in experimental trials of new medicines.

Marty says that the audience was mostly sympathetic to patients who wanted to avoid ongoing pain. A large majority of those attending, close to 80%, believed that their patients should be informed of their right to die and favored physician-assisted suicide.

Canadian Parliamentary Committee Makes 21 Recommendations

By the time you read this, other items may have been proposed and/or enacted in Canada. Nonetheless, these recommendations of a special parliamentary committee reveal progressive political thinking that has not appeared in many places.

Following a decision of Canada's Supreme Court declaring that a ban on assisted suicide was unconstitutional, a multi-party committee was established to guide development of appropriate legislation. The committee recommended that the federal government make doctor-assisted dying immediately available to all adults with "grievous and irremediable" medical conditions—including mental illnesses—and eventually allow minors to also end their lives.

The committee wants its 21 recommendations to be implemented in two stages. The first would apply immediately to those over 18 experiencing "intolerable" physical or mental suffering. The second stage would extend it to "competent mature minors."

Credit Where Due, Belatedly

In our last issue we failed to recognize two worthy contributors.

The cover story about talking over end-of-life plans with your children did not write itself. The unnamed author of its useful suggestions was the late Frank Kavanaugh.

Also unnamed was the creator of last issue's cartoon. Chris Allison gave us permission to reprint his cartoon and, we hope, will do so in the future.

Patients would be evaluated by two doctors to ensure that each patient has the capacity to provide informed consent. The committee called for regular monitoring of assisted deaths and periodic review of the legislation to determine if adjustments are needed.

The report also recommended that allowance be made for health professionals who object to aid in dying. Governments, working with medical regulatory bodies, should establish ways to respect both these professionals' consciences and the needs of patients, the report said.

Endorsement of the report was not unanimous; three dissenters objected that some recommendations posed serious risks while one member felt it did not help people with longer-term diseases like ALS and dementia.

Coast to Coast Presentations

Among presentations made recently by FEN personnel:

Diane Carlin and Fran Schindler spoke to an audience of 45 members of the Unitarian Universalist Fellowship of Marion County, Summerfield, FL in March, and Dick MacDonald addressed a similar number at a March meeting of the Alliance for Support and Education in Dying and Death in Chico, CA. The presenters report that their audiences were very interested and feedback was notably positive. ■

Good Endings Book Club



If there is adequate interest, this newsletter will include a section called the “Good Endings Book Club,” a compilation of reviews, ratings, and recommendations (and anti-recommendations) on books dealing with end-of-life issues. If you have read a thought-provoking book, or read a book you disliked, send your comments to hdevenzio@charter.net. The Club also welcomes debates and discussions among contributors.

I’ll try to get things started.....

Being Mortal by Atul Gawande

(Comment from Huck DeVenzio)

An acclaimed book with more than 4,000 reviews on Amazon, this work appeared on several prestigious lists of the best books of 2014. Although it mentions physician-assisted death only in passing, it strongly urges greater discussion between doctors and patients and more consideration to what is important at the end of life rather than extending the end. Highly recommended, especially for healthcare professionals.

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**FINAL EXIT
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SUPPORTING THE HUMAN RIGHT TO A DEATH WITH DIGNITY

Sum by David Eagleman

(Comment from Huck DeVenzio)

Subtitled “Forty Tales from the Afterlives,” this compact and imaginative book describes a variety of lives after death in which simple scenarios usually lead to unexpected consequences. Among my favorites are “Perpetuity” where there is no afterlife for the righteous but eternal continuation for those who a bitter, immortal God dislikes, and “Egalitaire” where God finds good and evil too simplistic so She allows everyone into Heaven which turns it into Hell. Sum may not help you as a guide to life after death, but it provides insights that could affect your view of life before death.

On My Own by Diane Rehm

(Review from Huck DeVenzio)

Recently published, this is the personal introspective of Diane Rehm, host of her widely acclaimed show on National Public Radio. The book is a heartfelt and frank account of the relationship between Ms. Rehm and her husband, John, who died in 2014, ten days after refusing food, liquids, and medications. He suffered from Parkinson’s disease. It is a soul-searching look – including marital strains as well as many warm, loving moments – in which the author recalls her past and ponders her future.

Her book is replete with questions, musings, and speculations on loneliness, love, afterlife, regrets, parenting, hopes, careers, and death with dignity.

Ms. Rehm has become a vocal advocate of end-of-life options. She writes, “That is what I fear: that my desire to take control of my life and end my own suffering that will not be honored... Why should someone who may have a totally different set of beliefs and values from my own have the legal authority to decide whether I should continue to live and suffer or to die peacefully?”

The book suggests that the Rehms did not realize that a physician in their state could not administer drugs to hasten the desired end. “When Dr. Fried explained that he was unable to carry out John’s wishes [for an assisted end], that he was prohibited from committing such an act in the state of Maryland, John became very angry. He said, ‘I feel betrayed.’” It is surprising to me that a couple so intelligent and so informed could be unaware of this. Apparently we have a lot of educating to do – or maybe a lot of miserable deaths to endure – before there is enough support to enact death-with-dignity legislation. ■

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