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Euthanasia Paper receives incredible distribution

The Euthanasia Paper: ***How Will You Say Goodbye*** is a 12 page educational paper printed in newspaper format.

We printed an additional 100,000 copies of the paper in January to fill orders and to have copies available for distribution across Canada. Currently, we have distributed more than 170,000 copies of the paper.

The Euthanasia Paper features articles on palliative care, elder abuse, disability concerns, etc.

The paper is attractively designed to encourage average Canadians to read and be affected by the articles.

Order the Euthanasia Paper by calling: 1-877-439-3348.

• $25 per 100 copies for orders of less than 500 copies,

• $22 per 100 copies for more than 500 copies,

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• $18 per 100 copies for more than 5000 copies.

* Shipping and Handling costs are extra and will vary based on the size of the order and the location.

No Jail time for woman who helped son commit suicide

A 60-year-old woman in Montreal who helped her adult son commit suicide won't be going to jail.

On January 27, 2006, Marielle Houle was sentenced to three years' probation. She had pleaded guilty to a charge of assisting in a suicide.

Houle's son, Charles Fariala, a playwright and former nurse at a Montreal chronic-care centre, was diagnosed with multiple sclerosis in 2002 and believed the degenerative disease was advancing rapidly.

He decided to kill himself at age 36, using a method he found on the internet.

Fariala took a mixture of drugs and alcohol. His mother tied his hands, put a plastic bag over his head and stayed with him until he died. A short time later, she turned herself in to police.

The Criminal Code provides a 14-year maximum sentence for the offence. Houle's lawyer, Salvatore Mascial, argued that she acted out of compassion and should not be imprisoned. “This is actually the first case that I’ve seen charged this way. I’ve seen other cases where the charge is murder,” said Mascial.

The Crown left the decision to the judge. After the verdict, Houle smiled and said, “It’s truly a nice day.”

Marielle Houle case

Marielle Houle was given a sentence of 3 years probation for assisting her son Charles Fariala to die.
The Euthanasia Prevention Coalition will be asking the Minister of Justice of Quebec to review the sentence of Marielle Houle. We understand that extenuating circumstances exist for Houle, but are concerned that the current sentence provides no deterrent for others who may follow Houle's lead.
In fact, Houle should have been charged with second-degree murder or manslaughter. According to the evidence, Houle placed the plastic bag over her son's head and tied it tight. By doing so, she didn't simply assist the act but she committed the act, which is murder in the criminal code.
Fariala was experiencing the early stages of MS and according to his friends, seemed very depressed. Fariala needed positive emotional and psychological support from his mother, not death.

Legalizing assisted suicide would be a very risky decision

By: Wesley Smith

San Francisco Chronicle - Sunday, Jan 22, 2006

Tuesday's 6-3 decision by the U.S. Supreme Court preventing the federal government from punishing doctors who prescribe federally controlled substances — narcotics — for suicide is being spun by euthanasia advocates as a big boost for their cause.

Never mind that the ruling was very narrow and did not, as proponents claim, "uphold" Oregon's law. And never mind that Justice Anthony Kennedy's majority opinion indicated that the federal government probably could prevent narcotics from being prescribed by doctors to intentionally cause death — just not in the way chosen by former Attorney General John Ashcroft. What mattered most to proponents was the political spin they were able to place on the decision.

But spin can only take you so far. It is the real world in which assisted suicide would be carried out — not threats from the federal government — that has kept the practice from being legalized beyond Oregon.

Consider the following: We are told by backers that assisted suicide would be restricted to cases of unbearable suffering. Yet legislation in California to legalize assisted suicide — AB651 by Assemblywoman Patty Berg, D-Eureka — contains no such requirement. Nor does the law in Oregon, where doctors who assist suicides report that most patients do not seek death because of pain, but because they fear being a burden, can no longer engage in enjoyable activities or fear losing dignity.

Don't get me wrong. These are important issues that cry out for proper care. Thankfully, we have hospice — the true death with dignity — to treat these needs. Indeed, studies show that when these problems are dealt with, suicidal desires almost always disappear even in people who are imminently dying.

That is true, assisted suicide proponents admit, but there will always be a few people who want assisted suicide anyway. But placing California's seal of approval on some suicides, while opposing others, would send insidious messages to dying patients that they are a burden; that their illness does make them less worthy of being loved; that they will die in agony. And it would signal the broader society, including young people, that in some cases, suicide is right.

Legalizing assisted suicide would also be very risky. The Netherlands proves that once mercy killing is allowed for the few, it steadily spreads. In the past 30 years, Dutch doctors have gone from killing the terminally ill, to the disabled, and even to the depressed that aren't physically sick. Recent headlines report that infanticide of dying and disabled babies will soon be legalized by the Dutch Parliament.

Assisted suicide boosters claim it would be different here, and point to Oregon, to show that there is no "slippery slope." But nobody knows what is actually going on in Oregon. The state conducts no independent reviews of assisted suicide deaths. Moreover, almost all of the published data about Oregon cited by advocates are based primarily on information provided by death-prescribing doctors -- who are as likely to report violating the law as they are to tell the IRS that they cheated on their taxes.

Still, abuses have been revealed. In the only case in which the medical records of a potential assisted suicide were independently examined, a peer-reviewed report in the Journal of the American Psychiatric Association disclosed that a patient received a lethal prescription almost two years before he died naturally.

Yet, Oregon law requires that a patient be likely to die within six months. Not only that, but the patient whose death was reviewed was permitted to keep his pills even after being hospitalized as delusional.

In another case reported in the Oregonian newspaper, a woman with Alzheimer's disease and cancer received assisted suicide even after a psychiatrist reported that she didn't know what she was asking for and that her daughter was the driving force behind the request.

We must also take heed of the real world in which assisted suicide would be conducted. California health services for the poor are being cut to the bone. The number of medically uninsured Californians exceeds the entire population of Oregon, and those with coverage usually are in health maintenance organizations that make profits by limiting costs. The drugs used in an assisted suicide would cost less than $100. Yet, it could cost $100,000 to provide quality care to the patient who doesn't want suicide. Then, there are issues of inheritance and life insurance. Elder abuse and neglect are terrible concerns. These and other problems of cultural dysfunction would make assisted suicide especially dangerous for the most vulnerable among us.

People who are dying need love, inclusion and medical care that value their lives, not hasten their deaths. Legalizing assisted suicide in California would be bad medicine and even worse public policy. Last week's decision by the Supreme Court cannot change that reality.

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

Official position of Gilles Duceppe, leader of the Bloc Québécois on euthanasia and assisted suicide

Ottawa, January 19th, 2006

Dear Mr. Schadenberg:

On behalf of Gilles Duceppe, MP for Laurier–Sainte-Marie and leader of the Bloc Québécois, I want to thank you for your email of January 17th, 2006.

We appreciate the fact that you took the time to share with us your opposition to Bill C-407, on the right to die with dignity.

In our view, however, everyone has the right to make decisions about the health care they want to receive, and to expect that their decisions about their own body will be carried out. People should be able to choose freely to die if it is clear to them that they no longer have any quality of life and that their suffering has become intolerable.

For some people, prolonging life involves a loss of independence and control, which in turns means a loss of dignity that they cannot accept. We have a moral obligation to respect the preferences of such people, in such circumstances, as to when and how they wish to die.

The right to kill oneself is recognized in Canadian law, which permits an individual who is physically capable of it to commit suicide. But a person who is not physically capable of it has no right to receive help when such help involves the administration of a medical procedure. While the Charter of Rights and Freedoms guarantees equality for all, we have here a form of discrimination against people with certain disabilities.

What is more, assisted suicide in secret is not uncommon. Some patients have the good fortune to

obtain the help of a doctor, and everything goes smoothly. But there have been cases where no doctor has been available or willing, and the attempted suicide has failed, involving horrible suffering both for the patient and for those around him. Legalizing assisted suicide would put a stop to this kind of situation.

As it happens, a majority of Canadians are in favour of legalizing assisted suicide. In 1995, 75% of respondents answered Yes to the following question: "If someone is suffering from an incurable illness, and suffering severe pain, do you think that the law should allow competent doctors to euthanize that patient if the patient formally requests this in writing?"

Lastly, other countries such as the Netherlands and Belgium have already legalized assisted suicide, with a strict legislative framework around the practice. Foreign experience shows that the legalization of assisted suicide works well and has not led to a proliferation of requests for assistance in dying.

Please rest assured that the Bloc Québécois will continue to take a responsible approach and act at all times with respect for the Canadian people.

Yours sincerely,

Nadine Charbonneau

For Marie Bourgeois

Correspondence Coordinator

Study: Euthanasia extremely rare in UK

By: Alex Schadenberg

A recent study in Britain states that fewer than 1% of all deaths in the UK involve euthanasia.

Professor Clive Seale, author of the study National survey of end-of-life decisions made by UK medical practitioners(Palliative Medicine 20,2006) stated to BBC news that: "Euthanasia and physician-assisted suicide are understandably very emotive subjects, but this work shows that UK doctors are less willing to take such actions than in several other countries."

Only 2.6% of British doctors strongly support changing the law. Of 857 doctors who took part in the survey, none claimed to have assisted in a suicide.

Deborah Annetts, of Britain's Voluntary Euthanasia Society stated: "This [euthanasia] is all done in secret and denied in public. This cannot be safe."This study shows that these claims are simply not true. The study was conducted as a blind study protecting participants from prosecution.

We hope that the results of this study will terminate Lord Joffe's bill to legalize assisted suicide that was introduced in the UK's House of Lords in November 2005 .

Study confirms: depression primary indicator for requests for euthanasia and assisted suicide

By: Alex Schadenberg

A Dutch study that was recently published in the *Journal of Clinical Oncology* confirms that depression is the primary indicator for requests for euthanasia and assisted suicide.

This is not the first study to state that people who are depressed are more likely to request euthanasia or assisted suicide.

This study is viewed as more convincing than previous studies because the authors, *van der Lee et al,* stated that the reason they conducted this study on 138 terminally ill cancer patients was to prove that the depression thesis was wrong. Their hypothesis was that requests for euthanasia and assisted suicide reflected deep values rather than psychological distress.

***Van der Lee et al,* set out to prove that previous studies that indicated that psychological distress was the primary indicator for requests for euthanasia and assisted suicide were wrong because those studies were conducted in countries where euthanasia and assisted suicide were illegal or socially unacceptable.**

What did *van der Lee et al* find?

Contrary to their hypothesis, *van der Lee et al* found that depressed patients were 4 times more likely to request euthanasia with 44% of patients with signs of depression requested euthanasia. 50% of all requests for euthanasia were made by people who were depressed.

This is very significant considering the fact that *van der Lee et al* found that between 15 - 25% of all terminally ill cancer patients probably experience depression and 80% of all requests for euthanasia and assisted suicide are terminally ill cancer patients.

In an editorial written by Dr. Ezekiel J. Emanuel for the *Journal of Clinical Oncology*, Emmanuel states that the data from this study: "should also help to erase the perceived link between pain and interest in euthanasia and assisted suicide, while substantially solidifying the depression link."

Emanuel further examines the data from *van der Lee et al* in relation to other studies that have been conducted over the past 15 years.

Emanuel states that: "However, the empirical data strongly suggest that requests for euthanasia or assisted suicide are less like traditional requests for the withdrawal or withholding of life-sustaining interventions than like plain old suicide."

Emanuel affirms that: "requests for these interventions tend to be guided by psychological distress rather than rational choices about a good death. ... euthanasia and assisted suicide look more like a method of acting on suicide ideation than a type of termination of medical treatment."

Other studies confirm the depression thesis...

Dr. Harvey *Chochinov* from Winnipeg in 1999 completed a study on the *Will to Live* in which he interviewed 168 terminally ill cancer patients. He concluded that when a patient was experiencing psychological distress, such as due to a poor prognosis or a family crisis, that they were more likely to consider euthanasia or assisted suicide. But when they were properly treated for depression and received the necessary support, the same patients were not interested in euthanasia or assisted suicide.

Another study completed in 1996 and published in the *American Journal of Psychiatry* on 378 HIV/Aids patients reported that interest in assisted suicide was not related to severity of pain, pain-related functional impairment or physical symptoms.

Since 1998, there have been 208 people who have died by physician-assisted suicide in the State of Oregon. Only 22% of those people stated that pain was a motivating factor, but not necessarily the primary factor in their decision to commit suicide with assistance.

A study published in 2000 in the *Journal of American Medical Association* surveyed 988 terminally ill patients. This study concluded that patients with depressive symptoms were more likely to have demonstrated a personal interest in euthanasia.

We can conclude that psychological distress or depression is the leading indicator for people who request euthanasia or assisted suicide. If they are provided good care and support their desire for death will most likely wane. To support an individual death wish is to abandon them in their time of need.