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To Someone You Love?

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Jocelyn Downie demands legalization of euthanasia and assisted suicide in Canada

By: Kevin McDonald

On Oct. 26, 2006 Dr. Jocelyn Downie, Professor of Law and former Director of the Health Law Institute at Dalhousie University spoke on "*The Ends of Life and Death: Public Policy, Spirituality, and the Law*".

Hosted by the Dalhousie University School of Public Administration, it was the second lecture of the Segelberg Trust's annual lecture series and is intended to facilitate public discourse.

Panelists included Dr. Paul McIntyre, division head of Palliative Medicine, QE II Health Sciences Centre, Halifax; Dr. Marilyn Walker, Associate Professor of Anthropology at Mt. Allison University; and Senator Sharon Carstairs, former Minister with Special Responsibility for Palliative Care in the Federal Government and former Leader of the Opposition in the Manitoba Legislature.

Dr. Downie argued that the legal status of assisted death in Canada should be clarified, changed and "reformed". Refusals of treatment and requests for assisted suicide and euthanasia should be respected if they are made by informed and mentally competent individuals.

She proposed that Canada permit assisted suicide and euthanasia if agreed upon mental competency requirements can be met but that defining competency is "complicated" – something we have to do a better job defining. She argued that we need better tests for this but did not elaborate who would decide what an agreed upon standard of competency might be or how such tests should be administered.

Regarding the subject of organ donation and the complex, disputed issue of "brain death" Dr. Downie admitted that she had spent the "whole summer" trying to find one comprehensive, satisfactory definition of what constitutes a legal definition of death but had still not succeeded in finding one she likes or could yet propose.

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In her opinion, current definitions of what constitute "death" are a "mess". This confusion greatly impacts both organ donation possibilities and has negative future implications in hindering acceptance of assisted suicide and euthanasia.

She decried the differences in provincial laws regarding these issues and called on Canada to "harmonize" its laws and make them less restrictive. She also does not consider that, where used elsewhere, euthanasia has ever caused a "slippery slope" of rapidly declining value for human life.

To her, neither the Nazi regime's widespread use of euthanasia, Holland's adoption of it, the failed experiment with it in one Australian state and its ongoing legality in Oregon are evidence of any causal connection between introducing euthanasia or assisted suicide and a subsequent decrease in a society's valuation of human life. She acknowledged the Nazi genocide but did not consider any linkage between Nazi euthanasia practices and its subsequent racial and politically motivated mass murder or war crimes.

She noted that the rate of persons seeking assisted suicide in Oregon has remained "steady" and that the Dutch experience has convinced her that no "temporal slope" or "slipping" is likely to occur if Canada introduces similar laws.

While she did not think that the introduction of euthanasia and assisted suicide would necessarily hasten changing attitudes towards end of life issues, she told her audience that "we are already on the slope" – citing increasing numbers of people who believe that euthanasia and assisted suicide are morally permissible and should be made legal.

She cited a survey of Manitoba physicians in which seventy-two percent expressed support for assisted suicide. She disagreed with those who believe that just making more and better palliative care available would negate the desire for assisted suicide because, as she noted, not all people seeking assisted suicide seek it only or solely to relieve their pain. Likewise, she thinks not all physical pain is controllable and some people prefer death to palliative care and sedation.

She stated that some people in Oregon were seeking physician-assisted suicide mostly to "avoid a loss of dignity and autonomy" and admitted that even grief and fear can cause assisted suicide requests. Dr. Downie believes that Oregon has become a leader in the international right-to-die movement and that Canada should examine the Oregon model partly because only fifteen percent of Canadians have access to hospice care.

Panelist Senator Sharon Carstairs declared that she was proud to have promoted the need for better palliative care for many years but also complained of glaring regional discrepancies in access to quality palliative care, citing the fact that many rural and aboriginal Canadians do not have adequate access to palliative care.

With evident bitterness, Senator Carstairs complained that convicted murderer Karla Homolka had been freed in less time than farmer Robert Latimer who was convicted of killing his disabled daughter Tracy and is still imprisoned.

Senator Carstairs also decried the leadership ability of elected Canadian officials. She claimed that there is no problem of alleged "judicial activism" – the argument that judges often "legislate from the bench" by use of court orders and other decisions or rulings. In her opinion, "so called judicial activism" was actually preferable -- it is overdue action that only occurred when Canadian judges filled political vacuums left by politicians who "were afraid to lead."

In his remarks, panelist Dr. Paul McIntyre did not specifically advocate or condemn assisted suicide or euthanasia but commented that "…assisted suicide would only be a low impact reform on health care." He told the audience that palliative care is not a "panacea" for everything. However, better palliative care would be a "high impact reform" since the number of ill people in Canada is increasing.

Called on to discuss the spiritual components of this issue, anthropologist Dr. Marilyn Walker opined that spirituality is actually more inchoate than most people and religions define it: "Spirituality is the person, the individual – free from theology." She further noted that Western attitudes towards death and dying are markedly different than other cultures since our high standard of living has divorced us from death and the dying process while our advanced technology has made us see death as a "failure" of science, medicine and technology.

In her opinion, humans and nature have too often become "antagonists" and that we have become increasingly separated from nature. Agreeing with Dr. Downie, she shared the sentiment that "we must get on with dying" , accept it as normal, and make euthanasia and assisted suicide legal.

Kevin McDonald is a member of the Euthanasia Prevention Coalition who lives in Halifax.

Infanticide and Euthanasia:

Who should live and who should die?

By: Alex Schadenberg - November 13, 2006
Executive Director, Euthanasia Prevention Coalition

It seems that negative attitudes toward people with disabilities have recently grown from the theoretical ideas of Peter Singer, of Princeton University, that it is acceptable to kill disabled infants, into the actual practice of allowing infants with disabilities to be euthanized.

In any other time in history this was known as the crime of infanticide. It is now becoming viewed as "dying with dignity."

Last year the Netherlands, which has allowed euthanasia and assisted suicide for many years, approved the Groningen Protocol. The Groningen Protocol is a criteria that dutch physicians follow to allow them to euthanize infants with disabilities and not be prosecuted.

Many people were shocked that the Netherlands had not only accepted euthanasia for competent adults, but also infants with disabilities, who could not ask to be killed.

The judgement call on whether a child should live or die is solely based on the attitudes of the physician or parents toward the possible quality of life of the individual. These acts of infanticide have been justified by people who believe that it is acceptable to kill infants who are born with significant disabilities because their lives will either be filled with constant suffering or without human meaning.

The fact is that most of the infants that have been euthanized under the Groningen Protocol are children born with spina bifida, a condition that can be successfully treated, often resulting in a "normal" life for the person.

Just ask Darrell Thomas in London Ontario who was born 50 years ago in Winnipeg Manitoba with spina bifida. His mother was told that he would be severely disabled and yet Darrell has lived an active normal life. Darrell recently said to me: "Thank God I was born in Canada 50 years ago and not the Netherlands today."

Not all children who are born with spina bifida will live as active a life as Darrell, but who are we to judge who should live and who should die?

Last week the Royal College of Obstetricians and Gynaecologists in Britain requested that they not only be permitted to allow natural death to occur by not providing life-sustaining medical treatment, but that they also be allowed to euthanasize infants born with disabilities.

There is a huge ethical difference between allowing natural death to occur by not providing extra-ordinary medical treatment, as compared to intentionally causing the death of an infant with disabilities. To withdraw or withhold medical treatment that <u>may or may not</u> provide benefit for a person is not euthanasia but rather accepting the limits of life.

We must reject the slide into the quality of life ethic that is promoted by the philosopher Peter Singer because this ethic dehumanizes people, granting them the status of personhood only when they have a certain level of utility or cognition. This philosophy represents the worst form of eugenics, an ethic that like Peter Singer, believes that we should eliminate the weak and the vulnerable for the sake of the "happiness" of society as a whole.

The Royal College of Obstetricians and Gynaecologists need to return to an ethic of caring for the most vulnerable. They must commit to not only protecting the lives of children with disabilities but also to provide basic medical care to all of their patients.

Once we determine who should live and who should die the only question remaining is who should live.

Alex Schadenberg is the executive Director of the Euthanasia Prevention Coalition.

British council rejects 'active euthanasia' for newborns

By: Tom Strode – BP News
December 6, 2006

A British bioethics council rejected a suggestion for "active euthanasia" of severely disabled infants but recommended babies born before 22 weeks into pregnancy not be treated.

The Nuffield Council on Bioethics issued its report Nov. 15 after a request by the Royal College of Obstetricians and Gynecologists produced worldwide anticipation. The ob-gyn group urged the Nuffield council "to think more radically about non-resuscitation, withdrawal of treatment decisions, the best-interests test and active euthanasia." As a result, the bioethics council agreed to include euthanasia of "extremely premature and seriously ill babies" in its consultation.

The Nuffield council rejected "active euthanasia," saying it "concluded the active ending of life of newborn babies should not be allowed, no matter how serious their condition. The professional obligation of doctors is to preserve life where they can. If doctors were to be permitted actively to end the lives of seriously ill newborn babies, there is a risk that the relationship between parents and doctors would be negatively affected."

The council, however, established week-by-week recommendations for care of early born babies:

• Babies born before 22 weeks should not receive "intensive care."

• Children born between 22 and 23 weeks, who leave the hospital alive only 1 percent of the time, should not normally receive such care "unless parents request it after a thorough discussion of the risks and if the doctors agree."

• Parents, after a complete discussion with health providers, should make the final decision on "intensive care" for babies born between 23 and 24 weeks.

• Babies born between 24 and 25 weeks normally should receive such care "unless the parents and the doctors agree that there is no hope of survival or if the level of suffering outweighs the baby's interest in continuing to live."

• After 25 weeks, babies should normally receive "intensive care."

"Natural instincts are to try to save all babies, even if the baby's chances of survival are low," said Margaret Brazier, chair of the committee that drafted the guidelines for the council. "However, we don't think it is always right to put a baby through the stress and pain of invasive treatment if the baby is unlikely to get any better and death is inevitable."

Wesley Smith, a lawyer and pro-life specialist in biomedical issues, said the "very good news is that [the Nuffield council] rejected infanticide out of hand."

Of the week-by-week guidelines, Smith wrote on the weblog at bioethics.com that he is "not comfortable with such guidelines in that each patient should be evaluated and treated as an individual, not as part of a group. Of course, knowing the odds of survival at any given stage would be part of that agonizing decision making process. I also worry that futile care theory could seep into this process and that infants would be denied treatment because they would be disabled.

"Still, it could have been worse," Smith noted.

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Box 25033 London ON N6C 6A8 or phone: 1-877-439-3348, or email: info@epcc.ca.

UK Doctors may Face Jail

if They Refuse to Euthanize Patients

By: Hilary White - LifeSiteNews.com

November 20, 2006

In a statement yesterday Lord Falconer, the Lord Chancellor of England has warned doctors that they may face prison sentences if they refuse to starve and dehydrate patients to death. Criminal charges of assault could be laid against doctors or nurses who refuse to allow patients to die, by removal of food and hydration.

The Labour government unveiled its new guidelines for doctors to follow the Mental Capacity Act that is to come into effect next spring.

The guidelines instruct doctors that a patient's "advanced decision," what is often called a "living will," that includes a request for cessation of medical treatment must be followed even if it means the patient will die. To fail to do so, in other words, to take action to keep a patient alive, could result in criminal charges or heavy fines.

The government's guidelines instruct doctors, "If you are satisfied that an advance decision exists which is valid and applicable, then not to abide by it could lead to a legal claim for damages or a criminal prosecution for assault."

British courts, in conjunction with jurisdictions around the world, have determined that it is sometimes in the patient's best interest to be dehydrated to death by removal of feeding and hydration tubes. In many parts of the world, including Canada, food and hydration is considered "medical treatment" and as such can be, and frequently is, withheld on the grounds that it constitutes "extraordinary treatment".

This was the thinking that allowed the court-ordered killing of Terri Schindler Schiavo in 2005.

Alex Schadenberg, Executive Director of Canada's Euthanasia Prevention Coalition, warned that the Act is a means of installing "euthanasia by omission." Schadenberg says the Act allows for the intentional killing of patients who would not otherwise be dying by withholding food and fluids or other ordinary medical treatments.

Schadenberg told LifeSiteNews.com that the distinction is often misunderstood but is simple to grasp. "We're talking about basic medical care for patients who are not in imminent danger of dying and need regular medical care. Withholding this care means death is caused by that omission, and not by a disease."

Dr. Peter Saunders, head of the Christian Medical Fellowship, concurs saying that the worry is not for those dying patients who are already so close to death that they could not benefit from food and hydration.

"But we are concerned that patients will make unwise and hasty advance refusals of food and fluids without being properly informed about the diagnosis. It is too easy for patients to be driven by fears of meddlesome treatment and 'being kept alive', into making advance refusals that later might be used against them."

Dr Jacqueline Laing of London Metropolitan University, who called the measures an obvious "cost-saving" effort on behalf of the National Health, said the Act "inverts good medical practice by criminalizing medical staff who intervene to save the lives of their patients with simple cures and, in certain cases, even food and fluids."

Schadenberg concurred with objections in the UK that this is a means of installing legal euthanasia by the 'back door.'He told LifeSiteNews.com that he attended an international right-to-die conference in Toronto this year where the discussions included methods of bringing forward legal euthanasia by omission.

Schadenberg said "If we are now going to legally force passive euthanasia to happen, the practice of active euthanasia will quickly follow. It won't be long before people watching the death of their loved ones by dehydration will demand it."

"Death by dehydration is horrible. It won't take very long before people will say, 'why don't we just give an injection, it's more humane.'"

While the new Act insists doctors kill patients who might otherwise live, the reverse determination was not upheld either by British or European courts. Leslie Burke, a British man who suffers from a degenerative disease that will one day render him unable to communicate, went to court to obtain a guarantee that he would not be dehydrated to death on the orders of doctors.

Mr. Burke argued that British guidelines left too much latitude to individual doctors to decide when a patient's life was no longer worth living. He lost his case in Britain and the European Court of Human Rights who said that adequate protections for patients already exist in British law.

German nurse convicted of euthanizing 28 patients

Reuters - Nov 20, 2006

A German nurse was convicted on Monday of killing 28 elderly patients with a lethal cocktail of injections and sentenced to life in prison in the country's worst post-war murder spree.

A state court in the southern town of Kempten convicted the 28-year-old man, who said he gave the elderly patients the deadly injections because he felt sorry for them, of 12 counts of murder, 15 counts of manslaughter and one of mercy killing.

The man, also convicted of a separate count of attempted manslaughter, admitted at the start of the trial that he had given patients in the Sonthof hospital's internal diseases ward a lethal mixture of drugs that he stole from hospital supplies.

But the tall and heavyset man, who was identified only as Stephan L., denied charges that he had acted with malice.

He said the killings started in January 2003. He was arrested in the summer of 2004 after police investigated stolen drug supplies. Two victims survived. He was asked to explain 81 deaths that happened during his shifts in the hospital.

He admitted he killed patients because he was unable to bear seeing them "wasting away." He stole quantities of a tranquiliser drug and a muscle relaxant which, when used in combination, cause death.

“He killed as if it were an assembly line,” state prosecutor Peter Koch said in his closing arguments of the trial that began in February.

Judge Harry Rechner ruled that because of the severity of the crime Stephan L., who reacted calmly to the verdict, would not be eligible for parole after 15 years. He also issued a lifetime ban against him ever working as a nurse again.

“The nurse knew that the drugs were lethal,” Rechner said. “They were not ordered by any doctor. He acted on his own.”

“The defendant said he was performing active mercy killing. But he killed people, in many cases people who were sleeping or without any inkling.”