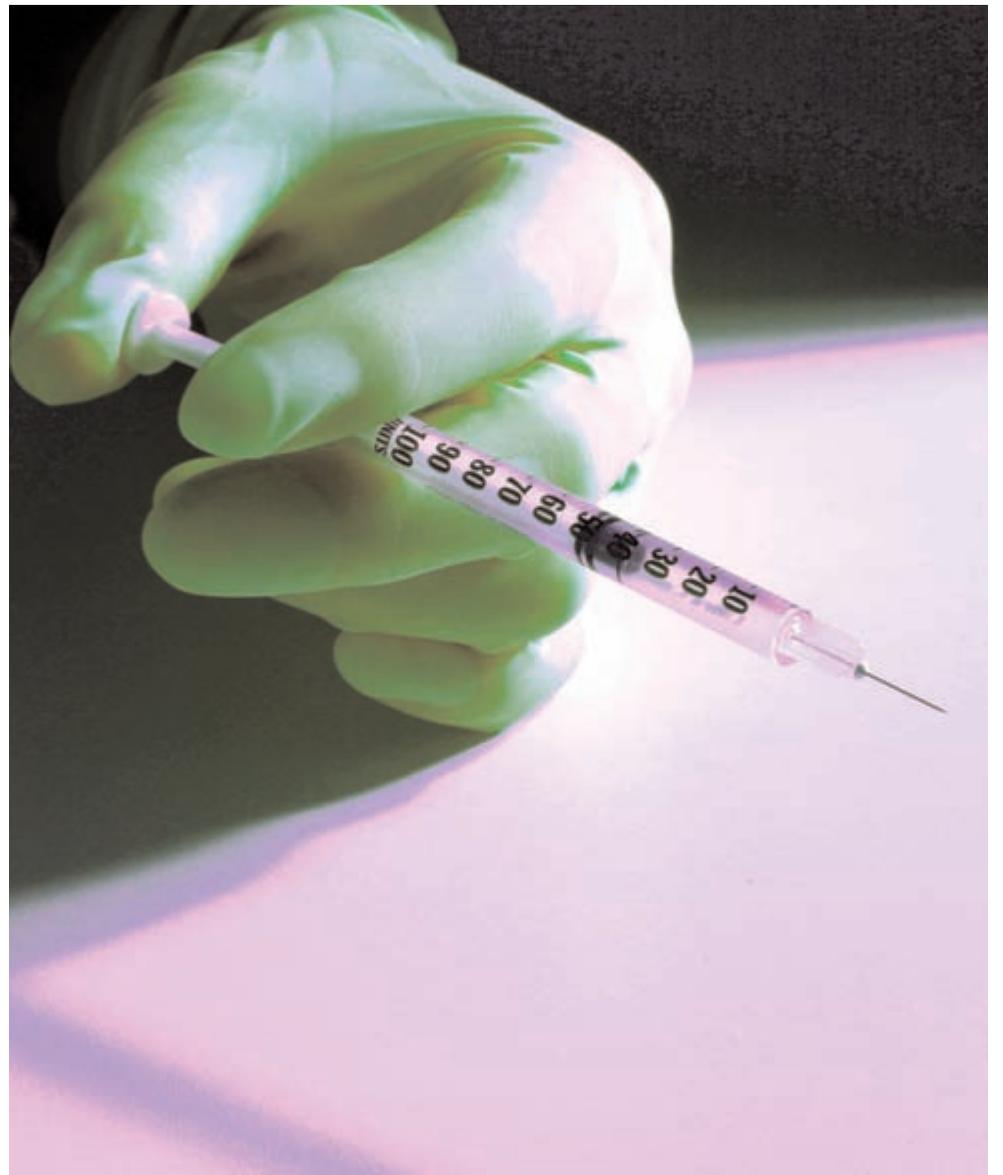


# How Will You Say Goodbye...



## To Someone You Love?

**Canada is moving closer to legalizing assisted suicide and euthanasia.**

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# Is Parliament Considering The Legalization Of Euthanasia Or Assisted Suicide?

By Alex Schadenberg, Executive Director, Euthanasia Prevention Coalition



Recently the Parliament of Canada debated the legalization of euthanasia and assisted suicide under Bill C-407. Bill C-407, a private member's bill sponsored by Bloc Québécois MP Francine Lalonde, which had advanced to second reading. Thanks to the election, Bill C-407 did not go to a final vote, and has died on the Parliamentary order paper. Yet the Bill's publicity and debate caused thousands of Canadians to express their opposition to euthanasia and assisted suicide to Members of Parliament.

Now that Bill C-407 is history, do we still need to be concerned about the potential legalization of euthanasia and assisted suicide? Judging by the debate surrounding this last attempt, we can state with certainty that Canada will face another similar bill in parliament that will attempt to legalize "mercy" killing.

This article takes a look back at Bill C-407 and explains why we must remain concerned about the prospect of a new bill that will almost certainly arise in parliament to legalize euthanasia or assisted suicide. As we will be facing similar legislation after the January election, we will do well to examine the intent of the last bill, and its underlying philosophy.

Bill C-407 was originally designed to amend sections 222 and 241 of the Criminal Code. Section 222 of the Code concerns homicide (euthanasia), while Section 241 prohibits assisted suicide.

In its preamble Bill C-407 stated that it would legalize "dying with dignity." The true face of the bill was, however, something completely different. What was the reality?

- Bill C-407 was not about dying with dignity, it sought to euthanize and assisted suicide for people suffering chronic physical and mental pain. Chronic physical and mental pain can be treated effectively. Chronic depression would have qualified under the mental pain provision.

- Bill C-407 did not require that a person at least try effective treatments for their chronic physical or mental pain. It stated that a person could qualify for euthanasia even if he had refused to try effective treatments.

- Bill C-407 was not limited to competent people "choosing" death. Bill C-407 would have legalized euthanasia and assisted suicide for people who "appeared to be lucid". Appearing to be lucid does not assure that one is lucid.

- Bill C-407 was not about "physician aid-in-dying". The Bill allowed anyone to euthanize or assist in the suicide of a person, so long as they were "assisted by a medical practitioner", and acted in the manner indicated by the person who wishes to die. The term medical practitioner is not limited to physicians alone.

- Bill C-407 allowed any person to kill another person for reasons that included chronic depression.

## Concerns about the future

Now that Bill C-407 has died an actual death we must continue to be very concerned, especially considering the public statements made by Justice Minister Irwin Cotler. Far beyond anything else, these statements have precipitated our concern that another bill will be introduced in parliament soon after the election. Such a bill might appear moderate com-

pared to Bill C-407 and thus receive more political support. And it will constitute a renewed threat to vulnerable Canadians.

We should be concerned. Minister Cotler is on record in November 2004 stating to the Justice Committee that the issue of assisted suicide needs a renewed debate in Canada and Parliament. There will be many MPs enthusiastically supporting this idea in the new Parliament come February. Another private members bill is certain, and the likelihood of a new minority government, whether Conservative or Liberal, will aid its passage through the House.

Cotler gave us another clue to his intentions this past fall when he explained that Bill C-407 was too wide and lacked the necessary safeguards in order to protect people with disabilities. He stated his belief that the Bill might be too much for Canadians, who were not ready for euthanasia for reasons that include mental pain.

He then went on to explain that he would consider a Bill that would legalize assisted suicide for the terminally ill and those experiencing chronic physical pain. In other words, he wasn't opposed to Bill C-407 because of his concerns for vulnerable persons, including people with disabilities, but rather he found that the bill needed moderation in order to be politically acceptable.

The Euthanasia Prevention Coalition expects that either a government or a private members bill to legalize euthanasia or assisted suicide will be introduced in the next parliamentary session. We recognize that Bill C-407 has softened the opposition to moderate forms of "mercy" killing and we ask Canadians who share our concerns for vulnerable people to strongly oppose any legislation that changes our laws concerning euthanasia and assisted suicide.

Euthanasia and assisted suicide directly threaten the lives of people with disabilities, those suffering from chronic physical or mental conditions, the frail elderly and other vulnerable people.

Legalizing euthanasia or assisted suicide places the power over life and death into the hands of another person, a power that can be abused by the individual or the state. When someone has the right or "duty" to directly cause the death of another person, the question becomes who decides, and why?

In relation to the vulnerable person, legalizing euthanasia or assisted suicide becomes an issue of having power over the weak. The person who has the right or duty to cause death may be encouraged to act based on pressure by family members, friends or medical care-givers who decide to kill based on their perceptions of quality of life, or a perceived burden.

Our opposition to legalizing euthanasia or assisted suicide in any form is not simply based on the inability to devise effective safeguards but rather that the issue is fundamental to our concerns for vulnerable people based on the nature of the human person. Every human person needs to be treated in a dignified manner, as an equal member of society.

A society that has accepted death as a treatment for difficult medical conditions, and abandons its vulnerable members from the care that they need, is a society that has become hard and callous.

We support a society that cares for all of its citizens.



## The Euthanasia Prevention Coalition

was established to prepare a well-informed broadly based, network of groups and individuals who support measures that will create an effective social barrier to euthanasia and assisted suicide.

L.L. (Barrie) deVeber M.D. FRCP(C)

- to preserve and enforce legal prohibitions and ethical guidelines prohibiting "mercy killing."
- to increase public awareness of hospice, palliative care.
- to promote improvement in the quality and availability of hospice/palliative care, and effective methods of controlling pain and suffering.
- to develop and build compassionate care community services as alternatives to "mercy killing."

## Our Purpose

- to educate the public on the harm and risks associated with the promotion of euthanasia and assisted suicide through the use of pamphlets, information seminars, media campaigns and research articles.
- to co-ordinate and disseminate research and information on issues related to euthanasia, assisted suicide.
- to represent the vulnerable and, where appropriate, advocate before the courts on issues related to euthanasia and assisted suicide.

Yes, I would like to support your efforts. Enclosed is my donation of \$ \_\_\_\_\_

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### Support Agencies

- Euthanasia Prevention Coalition .....519-439-3348 (Toll Free) 1-877-439-3348
- Euthanasia Prevention Coalition of B.C. ....604-617-0038 103-1075 Marine Drive, North Vancouver, BC V7P 3T6
- Canadian Palliative Care Association .....1-800-668-2785
- Council of Canadians with Disabilities .....204-947-0303
- DisAbled Women's Network (DAWN) .....1-866-235-3296
- Human Life Matters .....1-877-205-4602
- International Anti-Euthanasia Task Force ..... 740-282-3810
- Ontario Suicide Prevention Network ..... 905-897-9183
- Roehrer Institute .....1-800-856-2207
- J.P. Das Developmental Disabilities Centre .....780-492-4505



**Jean Echlin, RN, MScN**  
Nurse Consultant--Palliative Care  
Awarded the prestigious 2004 Dorothy  
Ley Award of Excellence in Palliative  
Care by the Ontario Palliative Care  
Association (OPCA).



Dying with Dignity can only be achieved with expert hospice/palliative care, strong community and institutional health care and compassionate support of vulnerable people. This care must be available for all Canadians.

With 26 years experience as a palliative care nurse specialist and consultant; I have been at the bedside of more than one thousand dying individuals. Thus, I can assure you that persons, who receive timely, appropriate and expert pain and symptom management, including attention to significant socio-spiritual, psychological and emotional issues, do not ask for assisted suicide or euthanasia. With the inclusion of family members as the "unit of care," people want to live as long as possible! In fact, good hospice/ palliative care can actually extend the life span. As well, it gives patients an improved quality of life at the end of life.

Over the years of caring for people at the bedside as they face life-threatening or terminal illness, I have found that depression is a common symptom. Depression is treatable even in late stage disease, thus euthanasia and assisted suicide are a threat to people who need both medical and psychological support for clinical depression.

If euthanasia and assisted suicide were legalized, this would adversely affect the priority and need placed on the development of palliative care standards and norms of practice already developed by the Canadian Hospice Palliative Care Association (CHPCA). Expert palliative care requires a commitment of health care dollars. Euthanasia and assisted suicide is a financial, moral and ethical "cop out!" With financial efficiency and expedience a health care priority, these killing methods may catch on quickly in a system strapped for money and resources. Doctors and nurses should not be killers.

Euthanasia treats people as disposable objects. All Canadians should be concerned...even frightened by the possibilities.

# Palliative Care Is Compassion

**To truly care  
for a dying person  
is to ensure  
that someone is  
with them in  
their time of need, that  
their pain and symptoms  
are compassionately  
managed,  
that their life  
is treated as sacred  
until its end.**

*L.L. (Barrie) deVeber M.D. FRCP(C)*

*Dr. John Scott, former head of Palliative Medicine, University of Ottawa*

**S**upporters of "choice" in dying exploit and foster fear of pain in order to further their drive to legalize physician-assisted suicide. But the reality is that no one should have to make the awful choice between intolerable pain and suicide. We are not awaiting some scientific breakthrough with which to conquer pain. There is already available a vast array of means to help patients live free of pain. Advances in pain management in recent years include new drugs, self-administered morphine pumps, epidural catheters, biofeedback, adaptive devices, and even clinics established specifically to treat pain.

Health and Welfare Canada defines palliative care as "a program of active compassionate care primarily directed towards improving the quality of life for the dying."

Dame Cicely Saunders, who in the late 1960s pioneered palliative care units, or hospices for the terminally ill in the United Kingdom, speaks of it as, "ELC - efficient loving care." Her philosophy and methods of care for dying patients have spread to all parts of the world.

Formal palliative care began in Canada in 1975, when units were opened at the St. Boniface Hospital in Winnipeg and the Royal Victoria Hospital in Montreal. One of the first leaders of the hospice/palliative care movement was Dr. Balfour Mount, of the Royal Victoria Hospital. He described the philosophy of the movement as follows:

"Several features characterize hospice/palliative care as being distinct from traditional health care programs. There is concern for the family and other loved ones as well as the patient. The fears and doubts of all involved, the strain on relationships and financial resources, the need for spiritual care, are all considered in addition to the more traditional issues relating to the disease itself. There is also a relaxation of institutional regulations concerning visitors, food, pets, and other details of daily life. When the length of remaining life is recognized as lying outside the influence of further treatment, the focus is not on curing or prolonging life but on its quality each day; not on death, but on life and on living in the moment!"

## Palliative Care Goals

Palliative care units have been established in many hospitals across Canada, and as well, many day-care and outpatient support services have become available for those who are able to spend their last days away from a hospital. The goal of those involved in offering palliative care is to relieve pain and thus to reduce the great fear of pain that is sometimes associated with dying. It is this fear which drives people to accept euthanasia as the only available option and feeds the propaganda of the euthanasia movement.

Dr. John Scott the former Director of the Regional Palliative Care Service in Ottawa, and Head of the Palliative Medicine Program at the University of Ottawa describes present day palliative care service as: “a philosophy and a system of care that affirms life when a person with irreversible disease is approaching death...Palliative Care involves a shift of treatment goals — from cure and prolongation to the control of suffering. This shift will often be reflected in the cessation of some therapies and the initiation of new symptom-directed therapies. However, Palliative Care is not passive euthanasia. At the heart of Palliative Care is the affirmation of life, not the choosing of death.”

Palliative care is relatively inexpensive. However, because of the current lack of palliative care beds in Canada, patients are often forced into acute care units which are more costly. For example, an acute-care bed for a

cancer patient costs \$600 per day, while a palliative care bed costs only \$273.70.

## Pain Management

Physicians, nurses, and patients must be aware that psychological and physical dependence on pain medication are distinct phenomena. Contrary to a widely shared misunderstanding, psychological dependence on pain medication rarely occurs in terminally ill patients. While physical dependence is more common, proper adjustment of medication can minimize negative effects.

The provision of appropriate pain relief rarely poses a serious risk of respiratory depression. Moreover, the provision of pain medication is ethically and professionally acceptable even when such treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death, and is provided in accord with accepted medical practice.

The education of health care professionals about pain relief and palliative care must be improved. Training in pain relief and palliative care should be included in the curriculum of nursing schools, medical schools, residencies and continuing education for health care professionals.

Hospitals and other health care institutions should explore ways to promote effective pain relief and palliative care, and to remove existing barriers to such care.

## Public Education Needed

Public education is crucial to enhance pain relief practices. Like many health care professionals, patients and families often have an exaggerated sense of the risks of pain medication, and are reluctant to seek treatment for pain. Nurses and physicians should create an atmosphere that will encourage patients to seek relief from pain. Strategies for pain relief should also maximize patients' sense of control.

When a patient requests assisted suicide or euthanasia, a health care professional should explore the significance of the request, recognize the patient's suffering, and seek to discover the factors leading to the request. These factors may include insufficient symptom control, clinical depression, inadequate social support, concern about burdening family or others, hopelessness, loss of self esteem, or fear of abandonment.

The provision of palliative care services is one means of stopping the call for legalized euthanasia. At the same time, efforts must be made by governments, and by health care workers, to inform and to educate the public about the necessity of promoting the hospice philosophy of dying.

Good hospice/palliative care, in all its facets, is the alternative to euthanasia.♥

# DEPRESSION ISN'T A REASON

**M**ental illness raises the suicide risk even more than physical illness. Nearly 95% of those who kill themselves have a psychiatric illness diagnosable in the months before suicide. The most common mental illness in these suicides is depression, which can be treated. This is particularly true of those over fifty, who are more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to treatment.

Like other suicidal individuals, patients who desire an early death during a serious or terminal medical illness usually suffer from a treatable depressive condition. Although pain and other factors such as lack of family support contribute to their wish for death, depression is the most significant factor, and researchers have found it is the only factor that predicts the desire for death.

Both patients who attempt suicide and those who request assisted suicide often test the affection and care of others, confiding feelings like “I don't want to be a burden to my family” or “My family would be better off without me”.

Such expressions usually reflect depressed feelings of worthlessness or guilt, and may be a plea for reassurance. They are also classic indicators of suicidal depression in patients who are in good physical health. Whether physically healthy or terminally ill, these patients need assurance that they are still wanted; they also need treatment for depression.

Depression, often precipitated by discovering one has a serious illness, exaggerates the suicidal patient's tendency to see problems in absolute black and white terms, overlooking solutions and alternative possibilities. Suicidal patients are especially prone to setting such absolute conditions on life: “I won't live ...without my husband”, ...if I lose my looks, power, prestige or health, ‘or ...if I am going to die soon.’” These patients are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and circumstances of their death is the most dramatic expression of their need for control.

Studies of suicide clarify the nonrational elements of the wish to die in reaction to serious illness. Suicidal patients may have the unconscious wish to be put to death by their doctor. Psychiatrists treating suicidal patients may assume the patient sees them as a savior, when actually they are cast in the role of executioner, with the patient sometimes fantasizing closeness or union with the doctor through death. Patients can feel that getting rid of a perceived bad part of themselves is necessary for such a union, and they may see death as a deserved punishment. Similar dynamics can be seen in patients requesting assisted suicide and euthanasia. Often the illness is seen as part of the bad self that must be eliminated before the desired union can take place. Fantasies of achieving closeness through death are often shared by patient and doctor.

The fact that a patient finds relief in the prospect of death is not a sign that the decision is appropriate. Patients who are depressed and suicidal may appear calm and less

depressed after deciding to end their lives, whether by themselves or with the help of a doctor. It is coping with the uncertainties of life and death that agitate and depress them.

Unfortunately, depression is commonly under-diagnosed and inadequately treated. Although most people who kill themselves are under medical care at the time of death, their physicians often fail to recognize the symptoms of their depressive illness, or fail to provide adequate treatment. Patients who, fearing illness or death seek death via assisted suicide or euthanasia, may be different from patients who want relief from suffering in their last days. When there is legal sanction for assisted suicide for patients who are not immanently dying, the two groups of patients become hopelessly intertwined and cannot reliably be separated.

*(Excerpt from the American Foundation for Suicide Prevention, Policy on Assisted Suicide.)*

## Must we always prolong life?

**NO!** There may come a time when a Do Not Resuscitate (DNR) order is appropriate. There may be a time when disconnecting a respirator, declining surgery, or discontinuing treatment is the medically appropriate thing to do.

There is no moral or ethical requirement to provide treatment which is not medically indicated or which is useless, futile or unduly burdensome to the patient.

If a time comes when we can no longer heal or cure, our roles change. We become caregivers, doing what we can to meet the physical, emotional, social and spiritual needs of the dying person.

Many conscientious caregivers make reference to the importance of balancing the burden of treatment to the patient with the benefit to the patient. We must be careful, however, that what we judge to be a “burden” is truly a burden to the patient, not the family, insurance company, or institution.

To best meet the needs of the person who is dying, we must first be willing to overcome our personal fear of involvement. Then, we can begin to listen, to share and to help.

We must maintain a clear distinction between allowing a dying person to die naturally and doing or omitting something which is directly intended to cause death. It is the intent which we must keep uppermost in our minds.



# It's A Frightening Time

by Mark Pickup, founder of Human Life Matters Canada  
Excerpts from a Speech on the Threats in Bill C-407  
Toronto, September 24, 2005

Another case came forward for kidney transplant consideration involving a 17 year old boy born with a mental disability. He'd also suffered from kidney failure since early childhood. The background assessment to the case spoke glowingly of his loving and supportive family. One member of the committee raised the prospect of child abuse. I responded: "Where do you see that in this report?" He said, "We don't know what goes on behind closed doors." I said, "Precisely! So don't read abuse where none is mentioned." Another doctor said, "We know there's abuse in this family." I respond, "Really? How is that?" She responded, "They agreed to dialysis in the first place!"

Think about what was being said: Life sustaining medical treatment for a child with a serious disability is a form of child abuse? Or, to put it bluntly, the eminent doctor believed it's better to be dead than disabled, that there's such a thing as a life unworthy to be lived. This is all happening in a climate where the previous sanctity of life ethic has been usurped and replaced by a quality of life ethic.

## Quality of life?

Can you see why someone who is incurable and a burden to the state might sleep with one eye open? It is frightening to live with serious degenerative disability in the Brave New World of the 21st Century, [1] where the sanctity of human life ethos has been replaced by the quality of life.

Quality of life is a moving target. What gave my life value at 25 years of age was physical capacity: I was an active, athletic husband and father. My biggest fear was to be disabled. If some clairvoyant could have looked into my future to reveal progressive disability, I would have said there's no quality of life in that kind of existence. Yet today at 52 years I am wheelchair-dependent but my life has quality. Today at 52, what gives my life quality is love not physical capacity. I am loved and I love.

## The final arbiter of life's value

I am convinced that the final arbiter of human life's value is not physical or mental capacity. It should not be the goal for enlightened societies to rid themselves of their weakest members. No. It should be the goal of enlightened society to foster life with dignity for all, not so-called death with dignity for some, at the expense of our collective conscience of inter-dependent community.

Let me tell you something about dying with dignity. After more than two decades of degenerative multiple sclerosis that is slowly stripping me of physical function . . . I have come to a conclusion. Death with dignity is not an event—it is a process. People do not generally die with any more dignity than they have lived with. Dignity is not injected into somebody's bloodstream when they are at their lowest point.

The value of a person's life can not be subordinated to its quality. Cost of care cannot outweigh the fundamental good of protecting human life. Never confuse 'quality of life' and the inviolable 'dignity of the human person': The first is a human condition while the second is an unalienable possession of every human life.

I know little or nothing about most things, but after 21 years of degenerative MS, I've learned a thing or two about suffering and loss. Suffering, sorrow and loss are common to the human experience. We will all suffer at some point in our lives. It can not be eradicated. We will all face death.

Suffering taught me that at the heart of existence rests a heartrending and beautiful mystery. Once that mystery is glimpsed, everything else becomes an irrelevance, a diversion.

[1] Taken from the 1932 novel *Brave New World* by Aldous Huxley (1894-1963). His story described a fictional nightmarish 25th century where social stability is based on a scientific caste system

I was invited to address Bill C-407, a very dangerous private member's bill that is presently before Canada's Parliament for consideration.

Canada's Justice Minister, Irwin Cotler is on record as saying perhaps it's time to reconsider euthanasia and assisted suicide. He seems to think that public attitudes toward euthanasia have changed in the past 10 years since a Senate Committee last considered the topic. What does he think has changed, other than a general coarsening of attitudes?

## People with disabilities

It's a frightening time to be disabled or chronically ill in Canada. There is every fiscal reason to get rid of people like me. I am, quite frankly, a medical expense with no prospect of cure. It costs increasing amounts of money to keep people like me around. In my own case, degenerative multiple sclerosis is gradually stripping me of physical function. It's been a slow 22 year journey from being healthy, athletic and contributing worker, to this: Only my left arm remains unaffected by disease. I haven't worked in years. In many peoples' view I'm excess baggage, and I have been told that.

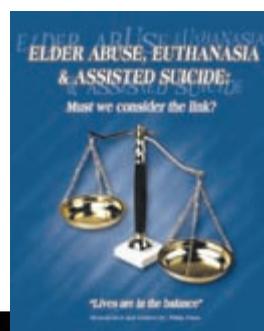
## Futile care theory

Futile Care theory is the rising attitude whereby hospitals reserve the right to withhold treatment, even over a family's wishes. They believe that treating people with a certain level of disability is wrong. Let me give you two examples of how futile care theory plays out.

From 1993-2004, I was the community representative to the Ethics Committee of a major Canadian teaching hospital. Just prior to leaving the Ethics Committee, a case was presented involved a young man with multiple sclerosis. The only movement he had left was blinking his eyes to communicate (once for Yes, twice for No.) He had the foresight to write an advanced directive that said he wanted all treatments to preserve his life. He even said that if pain medications threaten to shorten his life then he would forego the pain medications. That's how intent he was to live! His treating physician brought the case to the Ethics Committee because she didn't like feeling bound to honour such a life affirming directive.

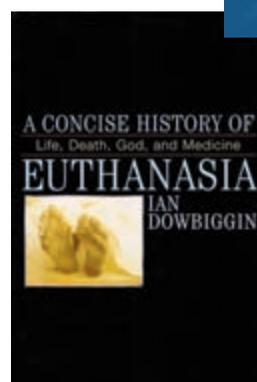
I reminded her that 10 years earlier the rage was to have a living will to articulate one's wishes when they could not. Now I was hearing the message that the physician will only follow a living will if they happen to agree with it. His physician glared and said, "I do not have to provide treatment if I think it's futile." So much for the protection of living wills!

## RECOMMENDED READING



Philip Prins, who has 15 years' experience in labour relations, has written a paper on the connections between abuse of the vulnerable and assisted suicide legislation. He looks at government and private reports on elder abuse as well as the current legal and social climate. The situations in Oregon and the Netherlands are also discussed, along with some of the literature advocating legalization in Canada. *Elder Abuse, Euthanasia and Assisted Suicide: Must We Consider the Link?* points out the "disarming connections" between elder abuse and assisted suicide.

To purchase a copy of this report, send a donation of \$15.00.



Ian Dowbiggin, the chair of the history department at the University of PEI, has published his second book on euthanasia entitled: "A Concise History of Euthanasia: Life, Death, God and Medicine", published by Rowman and Littlefield. Dowbiggin is a history scholar who has effectively researched and written on the history of euthanasia from the time of antiquity to the present. It is a must read for anyone who is concerned about euthanasia, the sanctity of human life, and attitudes toward people with disabilities. This book is readable, concise, and written from an unbiased perspective.

Order copies of "A Concise History of Euthanasia: Life, Death, God and Medicine" for \$25.00 per copy + (Shipping and Handling)

**To Order Books Call Toll Free 1 877 439-3348**



# WHO DECIDES WHO'S A PERSON?

Wesley J. Smith is a senior fellow at the Discovery Institute, an attorney for the International Task Force on Euthanasia and Assisted Suicide, and a special consultant to the Center for Bioethics and Culture. He is the author most recently of *Consumer's Guide to a Brave New World*. He debated Terri Schiavo's case with Florida bioethicist Bill Allen on Court TV Online. What follows are some key points made in that interview along with some of Wesley's own insights.

**Wesley Smith:** Bill, do you think Terri is a person?

**Bill Allen:** No, I do not. I think having awareness is an essential criterion for personhood. Even minimal awareness would support some criterion of personhood, but I don't think complete absence of awareness does.

If you want to know how it became acceptable to remove tube-supplied food and water from people with profound cognitive disabilities, this exchange brings you to the nub of the Schiavo case — the “first principle,” if you will. Bluntly stated, most bioethicists do not believe that membership in the human species accords any of us intrinsic moral worth. Rather, what matters is whether “a being” or “an organism,” or

even a machine, is a “person,” a status achieved by having sufficient cognitive capacities. Those who don't measure up are denigrated as “non-persons.”

Allen's perspective is in fact relatively conservative within the mainstream bioethics movement. He is apparently willing to accept that “minimal awareness would support some criterion of personhood” — although he doesn't say that awareness is determinative. Most of his colleagues are not so reticent. To them, it isn't sentience per se that matters but rather demonstrable rationality. Thus Peter Singer of Princeton argues that unless an organism is self-aware over time, the entity in question is a non-person. The British academic John Harris, the Sir David Alliance professor of bioethics at the University of Manchester, England, has defined a person as “a creature capable of valuing its own existence.” Other bioethicists argue that the basic threshold of personhood should include the capacity to experience desire. James Hughes, who is more explicitly radical than many bioethicists (or perhaps, just more candid), has gone so far as to assert that people like Terri are “sentient property.”

So who are the so-called human non-persons? All embryos and fetuses, to be sure. But many bioethicists also categorize

newborn infants as human non-persons (although some bioethicists refer to healthy newborns as “potential persons”). So too are those with profound cognitive impairments such as Terri Schiavo and President Ronald Reagan during the latter stages of his Alzheimer's disease.

Personhood theory would reduce some of us into killable and harvestable people. Harris wrote explicitly that killing human non-persons would be fine because “Non-persons or potential persons cannot be wronged” by being killed “because death does not deprive them of something they can value. If they cannot wish to live, they cannot have that wish frustrated by being killed.”

And killing isn't the half of it. Some of the same bioethicists who have been telling us how right and moral it is to dehydrate Terri Schiavo have also urged that people like Terri — that is, human non-persons — be harvested or otherwise used as mere instrumentalities. Bioethicist big-wig Tom Beauchamp of Georgetown University has suggested that “because many humans lack properties of personhood or are less than full persons, they...might be aggressively used as human research subjects or sources of organs.”

Such thinking is not fringe in bioethics, a field in which the idea of killing for organs is fast becoming mainstream. In 1997, several doctors writing for the International Forum for Transplant Ethics opined in *The Lancet* that people (like Terri) diagnosed as being in a persistent vegetative state should be redefined as dead for purposes of organ procurement:

If the legal definition of death were to be changed to include comprehensive irreversible loss of higher brain function, it would be possible to take the life of a patient (or more accurately to stop the heart, since the patient would be defined as dead) by a lethal injection, and then to remove the organs needed for transplantation subject to the usual criteria for consent.

Knowing that this kind of thinking predominates in contemporary bioethics, I decided to bring up the matter in my Court TV debate with Bill Allen.

**Wesley Smith:** If Terri is not a person, should her organs be procured with consent?

**Bill Allen:** ...Yes, I think there should be consent to harvest her organs, just as we allow people to say what they want done with their assets.

Put that in your hat and ponder it for a moment: If organ harvesting from the cognitively devastated were legal today — thank goodness, it isn't — Michael Schiavo would be the one, no doubt sanctioned by Judge Greer, who could consent to doctors' “stopping” Terri's heart and harvesting her organs.

Think that's a horrid thought? Well, ponder this: More than ten years ago, transplant-medicine ethicists Robert M. Arnold and Stuart J. Youngner painted a disturbing picture of the kind of society that the bioethics movement is leading us toward: literally a culture in which organ procurement is a routine part of end-of-life care and “planned deaths.” The ethicists predicted that in the not-too-distant future:

Machine dependent patients could give consent for organ removal before they are dead. For example, a ventilator-dependent ALS patient could request that life support be removed at 5:00 P.M., but that at 9:00 A.M. the same day he be taken to the operating room, put under general anesthesia, and his kidneys, liver and pancreas removed...The patient's heart would not be removed and would continue to beat throughout surgery, perfusing the other organs with warm, oxygen-and-nutrient-rich blood until they were removed. The heart would stop, and the patient would be pronounced dead only after the ventilator was removed at 5:00 P.M., according to plan, and long before the patient could die from renal, hepatic, or pancreatic failure.

**Know this:** There is a direct line from the Terri Schiavo dehydration to the potential for this stunning human strip-mining scenario's becoming a reality. Indeed, as Arnold and Youngner put it so well, “If a look into such a future hurts our eyes (or turns our stomachs), is our discomfort any different from what we would have experienced 30 years ago by looking into the future that is today?”

# Safeguards? What Safeguards?

Marilyn Golden, Executive Committee, California Disability Alliance (CDA)

We must focus on the significant dangers of legalizing assisted suicide as public policy in this society as it is today. Assisted suicide would have many unintended consequences.

## MANAGED CARE AND ASSISTED SUICIDE ARE A DEADLY MIX

Perhaps the most significant problem is the deadly mix between assisted suicide and profit-driven managed health care. Health maintenance organizations (HMOs) and managed care bureaucrats are already overruling doctors' treatment decisions, sometimes hastening patients' deaths. The cost of the lethal medication generally used for assisted suicide is about \$35 - \$50, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment is already a significant danger; it would be far greater if assisted suicide is legal.

Supporters of assisted suicide frequently say that HMOs will not use assisted suicide as a way to deal with costly patients. They cite a 1998 study in the *New England Journal of Medicine* that found the savings of allowing people to die before their last month of life would be \$627 million, which is only .07% of the nation's total health care costs per year. But this study has several significant problems that make it an unsuitable basis for claims about assisted suicide's potential impact. The researchers based their findings on the average cost to Medicare of patients with only four weeks or less to live. But assisted suicide proposals (as well as the law in Oregon, the only state where assisted suicide is legal) define terminal illness as having six months to live. The researchers also assumed that about 2.7% of the total number of people who die in the U.S. would opt for physician assisted suicide, based on reported physician-assisted suicide and euthanasia deaths in the Netherlands. But Dutch doctors are not required to report such deaths, which casts considerable doubt on this figure. And how can you compare the U.S. to a country that has universal health care? All these considerations would skew the costs much higher.

## FEAR, BIAS, AND PREJUDICE AGAINST DISABILITY

Another major problem with assisted suicide is who ends up using it, both in Oregon and in the only places on earth where it is legally tolerated, the Netherlands and Belgium (B. legalized after the article was published). The point of assisted suicide is purported to be relief from untreatable pain at the end of life. However, all but one of the people in Oregon who were reported to have used that state's assisted suicide law during its first year wanted suicide not because of pain, but for fear of losing functional ability, autonomy, or control of bodily functions. [\*2] Oregon's second year report has similar results. Further, in the Netherlands, more than half the doctors surveyed say the main reason given by patients for seeking death is "loss of dignity." [\*3]

This fear of disability typically underlies assisted suicide. Said one assisted suicide advocate, "Pain is not the main reason we want to die. It's the indignity. It's the inability to get out of bed or get onto the toilet...[People]...say, 'I can't stand my mother - my husband - wiping my behind.' It's

about dignity." [\*4] But needing help is not undignified, and death is not better than dependency. Have we gotten to the point that we will abet suicides because people need help using the toilet?

## SUPPOSED SAFEGUARDS

Assisted suicide proposals are based on the faulty assumption that you can make a clear distinction between who is terminally ill with 6 months to live, and everyone else. Everyone else is supposedly protected and not eligible for assisted suicide. But it is extremely common for medical predictions of a short life expectancy to be wrong. Studies show that only cancer patients show a predictable decline, and even then, it's only in the last few weeks of life. And with every disease other than cancer, there is no predictability. [\*5] Prognoses are based on statistical averages, which are nearly useless in predicting what will happen to an individual patient. Moreover, doctors and the courts frequently classify people with long-term disabilities as "terminally ill." Thus, the potential effect of assisted suicide is extremely broad, far beyond the supposedly narrow group the proponents claim.

This poses considerable danger to people with new or increasing disabilities or diseases. Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in their lives. [\*6] However, the adaptation usually takes considerably longer than the mere two week waiting period required by assisted suicide proposals and Oregon's law. People with new diagnoses of terminal illness appear to go through similar stages. [\*7] In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy to make the final choice one that is irrevocable, if assisted suicide is legal.

## OTHER SUPPOSED SAFEGUARDS

In Oregon's law and similar proposals, doctors are not supposed to write a lethal prescription under inappropriate conditions that are defined in the law. This is seen as a supposed safeguard. But what's happened in several cases in Oregon is "doctor shopping" - if one physician refuses assisted suicide because the patient doesn't meet the conditions in the law, another physician is sought who will approve it, often one who's an assisted suicide advocate.

There is one safeguard in most assisted suicide proposals - for HMOs and doctors: the "good faith" standard. This "safeguard" provides that no person will be subject to any form of legal liability if they claim that they acted in "good faith." A claimed "good faith" belief that the requirements of the law are satisfied is virtually impossible to disprove, rendering all other proposed "safeguards" effectively unenforceable.

## "NARROW" PROPOSALS WILL EXPAND

As the New York State Task Force on Life and the Law wrote, "Once society authorizes assisted suicide for... terminally ill patients experiencing unrelievable suffering,

it will be difficult if not impossible to contain the option to such a limited group. Individuals who are not (able to make the choice for themselves), who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of assisted suicide, and no principled basis will exist to deny (it)." [\*8]

The Netherlands is a very frightening laboratory experiment where, because of assisted suicide and euthanasia, "pressure for improved palliative care appears to have evaporated," [\*9] according to Dr. Herbert Hendin in Congressional testimony in 1996. Assisted suicide and euthanasia have become not just the exception, but the rule for people with terminal illness.

"Over the past two decades," Hendin continued, "the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical (assistance to die), i.e. euthanasia, to those who could not effect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination. Involuntary euthanasia has been justified as necessitated by the need to make decisions for patients not competent to choose for themselves." [\*10] In other words, for a substantial number of people in the



# THE LATIMER IMPACT

## EUTHANASIA OF PEOPLE WITH DISABILITIES

by Professor Dick Sobsey, Director, JP Das Developmental Disabilities Centre, University of Alberta

Netherlands, doctors have decided patients should die without consultation with the patients.

Furthermore, assisted suicide proponents and medical personnel alike have documented how taking lethal drugs by mouth is often ineffective. Such ineffective suicide attempts happen in a substantial percentage of cases -- estimates range from 15% to 25%. [\*11] The way to prevent these "problems," in the view of euthanasia advocates, is by legalizing lethal injections by doctors, which is active euthanasia. This is an inevitable next step if society first accepts assisted suicide as a legitimate legal option.

We are told by assisted suicide proponents that these things will not happen. But why not? How can the proponents, or anyone, stop it? The courts have already completely blurred these categories. If the next step is wrong, then taking this step is tantamount to taking the next step.

### NOT TRULY FREE CHOICE

Assisted suicide purports to be about free choice. But there are significant dangers that many people would take this "out" due to pressure, such as elderly individuals who don't want to be a financial or caretaking burden on their families. There's a significant amount of well-documented elder abuse in this country, and it's very often by family members, [\*12] which could easily lead to such pressures. Also, leaders and researchers in the black and Latino communities have stated their fears that pressures to choose death would be applied disproportionately to their communities. [\*13] Other people would undergo assisted suicide because they lack good health care, or in-home support, and are terrified about going to a nursing home. Assisted suicide would actually result in deaths due to a lack of choices for many people. Given the absence of any real choice, death by assisted suicide becomes not an act of personal autonomy, but an act of desperation. It is fictional freedom; it is phony autonomy.

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There are several things that tie the Latimer effect directly to the killing of children with disabilities. I am happy to share some information with you. It took a little time to do this analysis from our database but I think it makes the point.

About the database: We used electronic news databases to find 1258 cases of homicide and attempted homicide that involved victims with developmental disabilities. These include only identified developmental disabilities such as severe or profound mental disabilities, cerebral palsy, autism, etc. They do not include other disabilities (e.g. chronic health impairment). The cases came from all around the world but for the purpose of this analysis, I have restricted it to Canadian and U.S. cases that have reasonably complete information.

The numbers may seem small, but you have to remember that people with developmental disabilities make up only 1 to 2 per cent of the population. So the 73 Canadian cases would be equivalent to about 4000 homicides if scaled to the total Canadian population.

The reason for using American data for comparison is simple. Our search of the electronic media is not perfect and since more recent news is better recorded, it could falsely create the impression that more cases are occurring. However, the recording of Canadian and American cases in the electronic media has proceeded at about the same rate. Therefore, it is reasonable to expect that the ratio of Canadian cases to American cases should be the same before and after the Latimer case.

Since the U.S. has a population that is about 9.3 times as large as Canada's, it would be reasonable to expect the number of cases there to be about 9.3 times as many as here. Since they also have a higher murder rate, however, it would be reasonable to expect their numbers to be more than 9.3 times as high as ours. The important thing is to compute the ratio based on cases up to 1993, and then to compute the ratio from 1994 (when the first Latimer trial and surrounding publicity began to have potential effects).

## HOMICIDE-SUICIDE "MERCY" MYTH

When an elderly spouse - usually the husband - kills his ailing mate and then himself, the public perception is often that the homicide-suicide was committed out of love, with mutual knowledge and consent.

In fact, this "mercy-killing" perception is a myth, say scientists who have studied homicide-suicides among the elderly. The husbands in such cases are often abusers, and the wives are rarely complicit. In many such cases, defense wounds indicate that the wife fought for her life.

Murder-suicides involving elderly couples have been relatively uncommon, but may be on the rise due to the aging of the population and the fact that more older people are living with serious disabilities, driving caregivers to despair and desperation, said Donna Cohen, a University of South Florida professor who heads a violence-prevention program there.

Cohen, who has been studying homicide-suicide among the elderly since 1993, said that in the majority of cases, the homicide-suicide is committed without the wife's consent or knowledge by a husband who has a need to control and who is depressed and feeling overwhelmed by his care-taking responsibilities.

Cohen said the husbands in such cases are usually domineering and controlling. Often they are or were employed in

Here is the actual finding. Up to and including 1993, we found 20 cases of homicide or attempted homicide in Canada involving victims with developmental disabilities and 385 in the U.S.. This suggests that even after considering the relative size of the country, an individual with a developmental disability had slightly more than double the risk in the U.S..

From 1994 to present, we found 54 cases in Canada and 413 cases in the U.S.. This means that a Canadian with a developmental disability was actually at 19.3% greater risk than his or her counterpart in the U.S.. This is a huge change. It would be equivalent to suddenly waking up and finding that the murder rate in Canada was 20% higher than the U.S. rate.

However, this drastically underestimates the actual effect. If we only look at cases in which parents killed their own children, those most likely to be affected by the Latimer publicity, we see a more dramatic effect. We found 4 cases in the years up to and including 1993, and 94 cases in the U.S.. After correcting for population, Americans with developmental disabilities were 2.5 times as likely to be killed by their parents as Canadians. From 1994 to present, we found 20 cases in Canada and 101 cases in the U.S.. This means that suddenly Canadians with developmental disabilities were 84% more likely than Americans to be killed by their parents.

Another way to look at this is that in the United States the percent of homicide victims with developmental disabilities did not change significantly since 1994. Up to 1993, 24.4% of developmentally disabled homicide victims were killed by their parents. Since 1994, the number increased in the U.S. to 24.5%, a 0.1% increase. In Canada, by contrast, the rate changed drastically. Up to 1993, 20% of developmentally disabled homicide victims were killed by their parents. In 1994, the percentage increased dramatically to 37.7%. The rate of change in the U.S. was much less than 1% while in Canada it increased 88.5% since 1994.

professions in which control or structure is important, such as law enforcement, the military and engineering, she said. Also, the greater the age difference between perpetrator and spouse, the greater the risk. Usually the need to control is not apparent to outsiders, who tend to take a relatively benign view of such cases.

"The neighbors say, They loved each other, they were sick, they're better off," Cohen said. "It makes my blood boil."

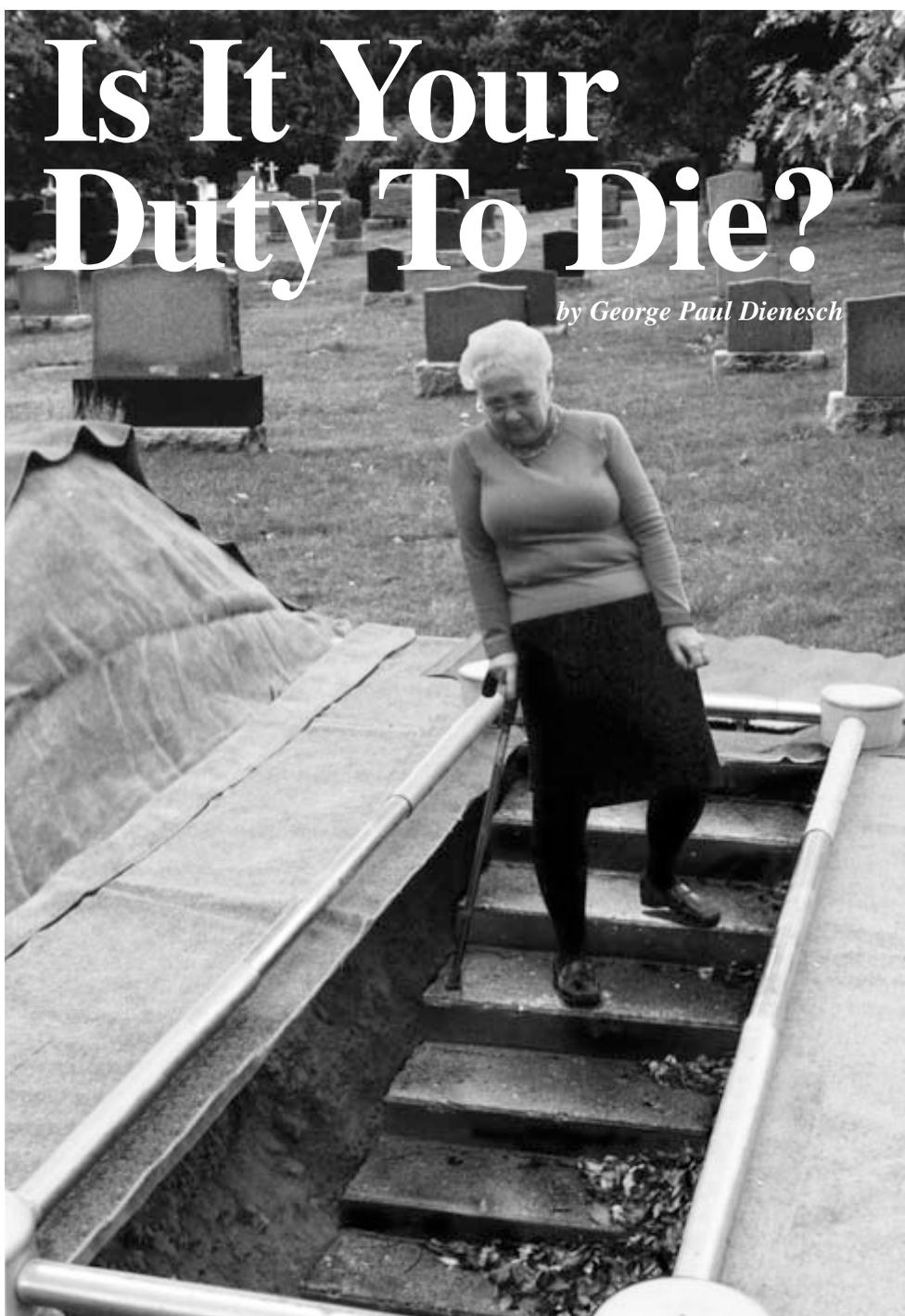
Indeed, Cohen said that the victims of such "mercy killings" often have defense wounds showing that they have tried to fight back. And the reason for the mercy killing may be trumped up, she said, citing the case of a man who killed his wife because he predicted that she would some day get emphysema and he wouldn't be able to care for her.

Cohen's research is based on information from the case files of the Florida medical examiner, autopsy reports, police reports, forensic investigations and newspaper accounts, she said.

The trouble is that physicians aren't doing a good job at recognizing and treating depression in the elderly, Cohen said. A shortage of physicians and other clinicians trained in geriatric care has contributed to the problem, as has a lack of community resources for home care for elderly patients, she said.

# Is It Your Duty To Die?

by George Paul Dienesch



In 1984, Governor Richard Lamm of Colorado appeared to be a lonely voice when he told a conference of doctors that, given the aging population and the rise in health care costs, “we have a duty to die and get out of the way of younger generations”. At the time, Lamm earned national notoriety and was buried in a mountain of angry letters. Unfortunately, while the general public was rightly horrified, the business, political and bioethical elite began discussing the idea with great seriousness. An avalanche of articles, conferences and books began to discuss this and more hidden “cost saving measures”, in light of the rapid aging trend in the West.

Medical care givers of course, are generally committed to the well being of their patients. Hence a campaign was begun to insinuate the idea of the burdensome cost of the elderly and disabled sick into the journal literature. An example of this was the cover article in the popular physician’s journal, *Medical Economics*, June 8 1987, vol. 64, No.12 which had the revealing title “It is time we helped patients die”. The writer did not mean help them by holding their hands, he had in mind accelerating the

process for the sake of cost containment. A similar article by the same title appeared in the American nursing journal, *RN*, in November of the same year. Articles of this type began appearing as well in journals for

hospital administrators. One example, “Right to die – duty to die: The growing debate over scarce resources”, broached the idea to hospital administrators in the Winter 1994 issue of *Hospital Topics* Vol. 72, No. 1.

While trial balloon articles were being floated throughout the medical/healthcare literature, bioethicists worked diligently, to make the idea of a “duty to die”, acceptable to delicate moral sensibilities. In 1997 for example, an important article appeared in the prestigious *Hastings Center Report* (the most widely read bioethical journal in the English speaking world) entitled “Is there a duty to die?” John Hardwig, a widely published bioethicist, seriously postulated that:

“There can be a duty to die before one’s illnesses would cause death, even if treated only with palliative measures. In fact, there may be a fairly common responsibility to end one’s life in the absence of any terminal illness at all. Finally, there can be a duty to die when one would prefer to live.”

With an ironic twist of language, he makes his case by emphasizing that the burdens “imposed” on families (highlighted by the inevitable hard cases), can constitute a lack of love on the part of the bothersome patient, if they do not show the moral sensitivity to lessen the strain on care givers by exercising their “duty to die”. Love of the elderly patient for family members becomes the rationale for death. This inversion of the principle of moral solidarity, would be laughable if the author were not serious. His arguments are deadly in their negative effects on the real moral solidarity that both society and individuals owe to the vulnerable. An unfair pressure is placed upon the vulnerable elderly who are psychologically pressured to view themselves as burdensome. As the author himself notes, “Many older people report that their one remaining goal in life is not to be a burden to their loved ones”. How are the vulnerable to react as they become systematically stigmatized as burdensome while

being told, in both tacit and overt ways, that they have a “duty to die”?

The author goes still further, suggesting that 75-80 years of age might be the morally appropriate outer limit for life. “To have reached the age of, say, seventy-five or eighty years without being ready to die is itself a moral failing, the sign, of a life out of touch with life’s basic realities.” Is Dr. Hardwig an oddball, an ivory tower academic, being vilified by his colleagues? Strangely the answer is “no”. While many bioethicists would not state the case so bluntly, few indeed would disagree with Hardwig’s basic beliefs.

The bioethics literature abounds with commentary and argument whose real effect is to justify the theoretical “duty to die”. In the words of the philosopher Richard John Neuhaus:

“Thousands of ethicists and bioethicists, as they are called, professionally guide the unthinkable on its passage through the debatable on its way to becoming the justifiable, until it is finally established as the unexceptional.”

A utilitarian thinking provides impetus for decisions which only a few decades ago would have been unthinkable. Economic factors drive the public debate. Occasionally, economic incentives are even suggested to speed along the process. An especially crass example of this is found in an article which appeared in the *American Journal of Economics and Sociology*. The author in citing the commonly quoted statistic that 35% of medicare spending goes to the 6% who are about to die, asserts that tremendous savings could be made to health budgets if financial incentives were paid out to the estates of dying patients, if they agreed to physician assisted suicide. The author euphemistically called his proposal “physician-assisted suicide with benefit conversion”. The estate would be paid a percentage of the savings in costs of anticipated end-of-life care.

## The Power To Terminate

While bioethicists debate the “duty to die”, and economists discuss “physician assisted suicide with benefit conversion”; social policy experts, bureaucrats, and the health management elite work behind the scenes on quieter cost containment measures which, hidden in harmless sounding terms, actually prove a grave threat to the medically vulnerable.

The basis of these new measures is called “futile care theory”. Futile care theory is a means of terminating treatment to those whom the hospital/health care bureaucrats assess to have a poor quality of life. Futility criteria override the desires of patient and family. Futility does not refer to

medical procedures which are of no medical use, such as radiation therapy to treat acne. Futile care (as the new theory has developed) refers to treatment which could be beneficial to the patient, but which the bioethics committee or physician deem inappropriate because of a subjective determination that the patient’s quality of life does not warrant the financial cost. “In futile care theory, the treatment itself isn’t designated as futile - the Patient is.”

Related to the futile care ethos are the growing phenomena of health care providers pressuring family members to permit their seriously brain injured relatives, and even patients in the later stages of

terminal illness, to be starved and dehydrated to death through the removal of food and fluids. Food and fluids are being re-categorized as “medical treatment” to make it “ethical” to remove this most fundamental basic care from the medically vulnerable. Around the country, cost cutting-efforts are rendering it more dangerous for the medically vulnerable to go to the hospital. The sanctity of life ethic, the basic foundation that the health care professional must Do No Harm to patients, has been eroded, and we are rapidly entering the brave new world in which hospital accountants, clipboard in hand, talk of the “duty to die”, and are all too willing to impose this “duty” on our loved ones whether they choose it or not.

From time to time we read news accounts of elder abuse incidents. Some of these are said to occur in nursing homes, while others are allegedly at the hands of family members. Researchers have classified the types of abuse that take place. These abuses may be physical, verbal, mental (psychological), or financial in nature, and include neglect or deprivation of necessary care.

According to various studies (The Shame of Canada's Nursing Homes FAIRE, 2001; Family Violence in Canada: A Statistical Profile 2004 Statistics Canada & The Canadian Centre for Justice Statistics; Abuse of Older Adults in Institutions Health Canada 1999; Getting Together Against Elder Abuse: Seniors Speak Out One Voice, The Canadian Seniors Network 1994), elder abuse is not an imaginary problem, but something pervasive even in Canada, a country so often portrayed as concerned with the social welfare of its citizens.

But the recent debate of Bill C-407 means we may expect another threat to the well-being of many Canadians. Legalizing assisted suicide, or physician-assisted suicide (PAS) as it is sometimes called, will open the door to the further abuse of the elderly and otherwise vulnerable people.

Of course, access to assisted suicide, or euthanasia, is portrayed by its advocates as a benefit to the elderly, and others. They often bring up the argument that it is a matter of personal decision, and even a legitimate "treatment" in the spectrum of health care. The right of the individual to choose is based on an understanding of personal autonomy that claims only the individual can decide what is morally right in a given situation. Yet to say that a person is better off ending his own life than going on living is a deeply troubling notion.

In addition, proponents of PAS point to various recent polls. These opinion surveys show that most Canadians are in favour of the idea of assisted suicide. Nevertheless, it has also been shown that this support holds only when the question is notional and wavers as the question becomes more specific. A more realistic, true-to life question was found to gain only 29% support for legalizing assisted suicide, with 50% opposed (Henry, Frank & Ian Gentles, "Euthanasia and the Elderly: A Pilot Study" in Gentles, Ian, ed. Euthanasia and Assisted Suicide: The Current Debate. Toronto: Stoddart 1995).

What is the real connection between elder abuse and assisted suicide? Take a real life story as an example: the case of Kate Cheney. According to a report by the Vermont Alliance for Ethical Healthcare, 85 year old Mrs. Cheney lived in Oregon, where the Death With Dignity Act provides for physician-assisted suicide, or PAS. She had been diagnosed with terminal cancer and said she wanted PAS, but there was a suspicion she might suffer from dementia, so she was referred by her doctor to a psychiatrist, in accordance with the law. The suicide request was declined because:

"The psychiatrist found that Kate had a loss of short-term memory. It also appeared that her daughter had more interest in Cheney's assisted suicide than Cheney did herself. The psychiatrist wrote in his report that while the assisted suicide seemed consistent with Kate's values, 'she does not seem to be explicitly pushing for this.'"

The account (available on the Vermont Alliance for Ethical Healthcare website [www.vaeh.org](http://www.vaeh.org) "The Oregon Experience with Physician-Assisted Suicide") goes on to say that according to a report in a local newspaper, The Oregonian, Cheney appeared "to accept the psychiatrist's verdict, but her daughter did not." The daughter seemed to consider the Act's protective measures as obstacles to her mother's right to die. As a result, the daughter insisted that the regional HMO permit another psychiatric opinion, which was agreed.

This time a clinical psychologist approved the assisted suicide request, despite reservations that Cheney's decision to die "may be influenced by her family's wishes." After a respite stay in a nursing home, Cheney took the lethal pill

prescription the very day she returned home. As one commentator observed, perhaps it is not surprising that Cheney finally succumbed when she returned to her home environment (Smith, Wesley J. "Doctors of Death: Kaiser Solicits Its Doctors to Kill" in National Review Online). Such an example of undue influence in the Oregon setting should be a serious caution for us in Canada. Yet, the Oregon statute is the sort of law that is sought in Canada by Bloc MP Francine Lalonde and other advocates of assisted suicide such as Dying With Dignity.

Sure, the example is from another jurisdiction – Oregon in this case. But how much better can we do than to look at a current law in practice? Certainly, concerned people in other American states have taken the Kate Cheney abuse very seriously. Vermont recently entertained this debate and rejected PAS legislation. Why? In part, at least, because doctors and other health professionals stood in opposition.

Doctors, especially, are opposed because assisting a person to commit suicide runs counter to the medical calling. The Canadian Medical Association has gone on record against legalizing assisted suicide. And the Vermont Alliance says: "Almost all organizations of healthcare professionals, disability rights advocates and religious leaders who have taken official positions on the issue are opposed to legalization of physician-assisted suicide" ([www.vaeh.org](http://www.vaeh.org)). Wesley Smith also noted this ethical reticence on the part of doctors, in the National Review Online article noted above. Most doctors would rather heal, than kill or enable someone else to kill himself. Doctors understand that pain can be eliminated over 90% of the time, and controlled within comfortable levels the rest of the time.

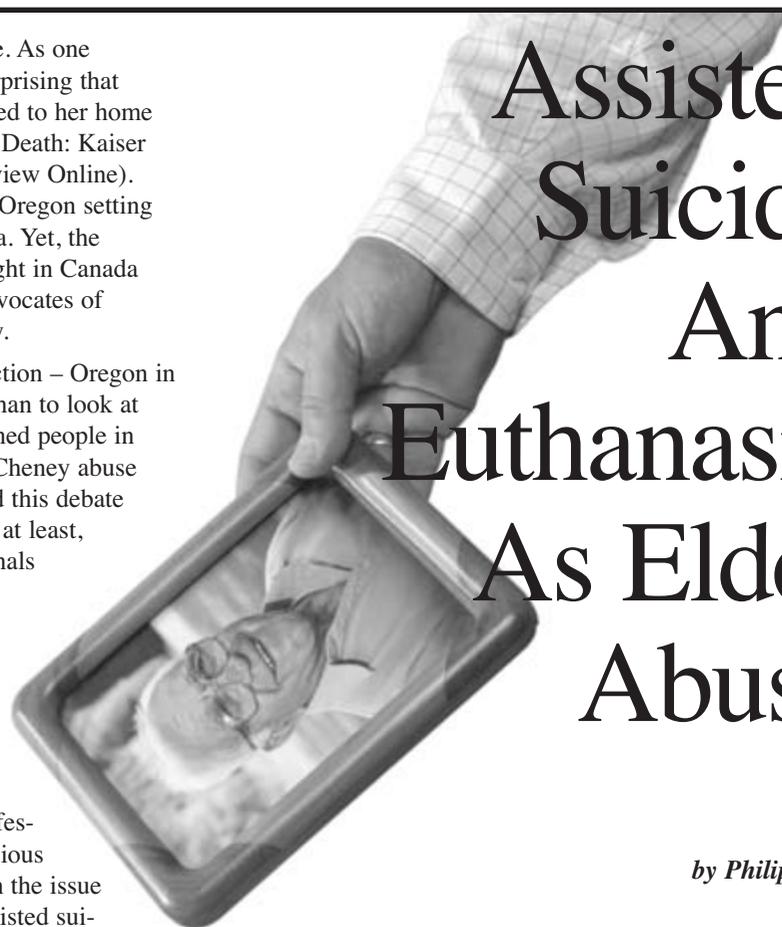
Some will say that we ought to control elder abuse, not take away the right to opt for a hastened death. The fact is, a bad idea like PAS only gets worse when it is put into practice. It is not reasonable to accept assisted suicide as a personal option. Doing so only opens the door to the manipulation of the elderly and vulnerable. It may even establish a duty to die for such people.

The most important thing to note is that these are not just speculations. They are already documented in places like Oregon, where PAS is legal, and under certain controls. We are not fear-mongers if we point out that PAS legislation is dangerous despite all the so-called safety measures that are built in to it.

Assisted suicide or euthanasia, by whatever name or euphemism, will allow the ultimate elder abuse to become common.

# Assisted Suicide And Euthanasia As Elder Abuse

by Philip Prins



## WHAT YOU CAN DO TO MAKE A DIFFERENCE

- Know your rights as a patient, especially your right to: considerate and respectful care and information.
- Appoint a Power of Attorney for Personal Care who will protect you when you are unable to make decisions for yourself.
- Oppose any political action aimed at legalizing euthanasia or assisted suicide.
- Support hospice and palliative care programs.
- Respect those who are mentally or physically challenged, elderly or chronically ill.
- Remember that our choice of words can dehumanize, devalue and discourage others.
- Show concern for those in your community who are isolated and lonely. It doesn't financially cost anything to offer compassionate care to someone in need of your presence.

# Protecting Your Life In Today's Hospital

by Rita Marker & Alex Schadenberg

A lot of people think advance planning about health care is only for those who are very sick or very old. But that's not the case at all. It's absolutely essential that anyone who is 18 years or older have an advanced directive - but not just any type of advanced directive.

Suppose, after you finish reading this column, you walk across the street and a car hits you. If you are badly injured and you can't make health care decisions for a few days, who will make them for you?

Unless you have specifically named someone to make decisions for you, you run the risk that a health care provider or some committee could end up making critical decisions affecting your life and health. That's why it's important to have an advanced directive.

There's another reason, too. Hospitals will usually inform all adults — the woman in labor, the young man receiving treatment for an injury, the person who has a life-threatening condition — about advanced directives upon admission. In fact most nursing homes or retirement residences will not accept an application for admission without the person first having an advanced directive.

Many health facilities go beyond providing simple information. They actually give patients or residents a Living Will (Power of Attorney for Personal Care) to sign at the time of admission — at the very time they're under stress and are filling out pages of other required forms. Signing an advanced directive under those conditions is very risky.

It is so important that you have the type of advanced directive that will protect you.

And it's vital that you only sign such a document after you have been able to review it at your leisure.

There are many types of advanced directives, and some, like the "Living Will" are downright dangerous.

The Living Will (sometimes called a directive or a declaration) is a document that gives power and authority to an "attending physician" to withhold or withdraw medical treatment and care under certain circumstances. Because your attending physician may be a total stranger who is completely unfamiliar with your values and wishes, that physician may interpret terms in the document in a way you didn't intend. Your family and others who know your wishes have no legal standing to interpret the meaning of the document. Other "directives" or "declarations" have wording that is so vague that they are open to broad interpretation (or misinterpretation).

The most protective and the most flexible type of advanced directive is the Power of Attorney for Personal Care (health care) which is recognized in all provinces in Canada. With this type of document, you designate someone else to make health care decisions on your behalf if you're temporarily or permanently unable to make these decisions for yourself. The person you name is called your "attorney" or "agent".

But, remember, a Power of Attorney for Personal Care is a legal document. As with any legal document, its wording is extremely important.

That's why the Euthanasia Prevention Coalition developed the *Life-Protecting Power of Attorney for Personal Care*, a power of attorney for personal care that includes specific wording to protect a person's rights in the current medical climate.

The Life-Protecting Power of Attorney for Personal Care specifically prohibits assisted suicide and euthanasia. It was originally designed for use in Ontario, but it is legal for use throughout Canada.

For example, nowadays some health care providers have taken it upon themselves to put Do Not Resuscitate (DNR) orders in place without the patient's or attorney's/agent's authorization. Similarly, some health care providers

are deciding what is "appropriate" or "beneficial" for, or wanted by, the patient. So the Life-Protecting Power of Attorney for Personal Care makes it clear that DNR orders and decisions about "appropriate" or "beneficial" are to be made only by your attorney/agent (and only if you're not able to do so yourself).

The document limits your attorney's/agent's authority in one specific way. Unlike other advanced directives, the Life-Protecting Power of Attorney for Personal Care clearly states that your attorney/agent does not have the authority to approve the direct and intentional ending of your life. For example, your attorney/agent may not authorize that you be given an intentional drug overdose. Furthermore, your attorney/agent may not direct that you be denied food or fluids for the purpose of causing your

death by starvation and dehydration. This limitation not only protects you, but it also protects your attorney/agent from being subjected to pressure to authorize such actions or omissions.

Taking the time now to name someone to make health care decisions for you takes only a few minutes, far less time than preparing for a snowstorm. And it can be just as important.

To obtain the Life-Protecting Power of Attorney for Personal Care, call the Euthanasia Prevention Coalition at: 1-877-439-3348, or see the order information below this article.

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## What Happened To Terri Schiavo Could Happen To You

Recently, people in North America were shocked by the fact that Terri Schiavo, a cognitively disabled woman in Florida, could be dehydrated and starved to death over thirteen days.

People were stunned by the fact that this death was court ordered and sanctioned and that neither the President of the United States nor the Governor of Florida were legally capable of stopping it.

What you need to know is that the same thing could happen in Canada.

When it comes to personal care most Power of Attorney documents contain ambiguous language which may result in your premature death or costly legal challenges to medical care decisions. The Euthanasia Prevention Coalition has designed the Life-Protecting Power of Attorney for Personal Care to protect you if you become incapable of making medical care decisions for yourself. It will also protect you from those who might question your right to live if laws forbidding euthanasia or assisted suicide in Canada are weakened.

To find out more call 1 877 439-3348. We receive calls regularly from people who are concerned about the end of life decisions that are being made for their spouse or loved one.

You can receive a Life-Protecting Power of Attorney for Personal Care with a donation of \$25.00. It will assure you and your loved ones that ethical decisions will be made in your time of need.

**Yes, I would like to receive a Life Protecting Power of Attorney for Personal Care. Enclosed is my donation of \$ \_\_\_\_\_**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Prov \_\_\_\_\_ PC \_\_\_\_\_

Email Address \_\_\_\_\_

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