Euthanasia Prevention Coalition

The Newsletter

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Report recommends euthanasia for: dementia, minors, and psychiatric conditions

The *Report of the Special Joint Committee on Physician-Assisted Dying* was released under the veneer of a "Patient-Centred Approach."

The report contains 21 recommendations (rec.) that ensure access to euthanasia and assisted suicide, under the term "Assisted Dying" for people who seek to be killed by a medical professional, based on physical or psychological suffering.

The report recommendations go beyond the Carter Supreme Court decision that stated that a person must be:

"a competent adult person who clearly consents to the termination of life."

The report recommends assisted death, by lethal injection (also known as euthanasia), be done, without effective oversight (rec. 12 & 15) for people who are not terminally ill (rec. 2), who are unable to clearly consent due to dementia (rec. 7), or mature minors (rec. 6), and for people with psychiatric conditions (rec. 3), including treatable depression (rec. 4).

The report also demands that medical professionals, who refuse to kill their patients, must refer those patients to a physician who will kill (rec. 10) and that medical institutions must permit killing on their premises (rec. 11)

Analysis of the recommendations:

Recommendation 1 states that the terminology does not require definitions. One of the many problems with the Supreme Court decision was that the language of the decision was not defined. Definitions are important to ensure clarity of the law.

If parliament does not clearly define the law, it will lead to future court cases designed to define or expand the excepted definitions of the law.

Recommendation 2 states that assisted dying must be permitted for people who are not terminally ill.

Recommendation 3 states that assisted dying can apply to persons with psychiatric conditions. Based on Recommendation 4, recommendation 3 opens the door to people who have treatable psychiatric conditions being approved for lethal injection.

Recommendation 4 states that the reason for assisted death should be based on what is intolerable to the individual. Objective criteria are not required to determine who will live and who should die.

Recommendation 5 requires an assessment for capacity to provide informed consent. This recommendation appears

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Vulnerable: The Euthanasia Deception Documentary

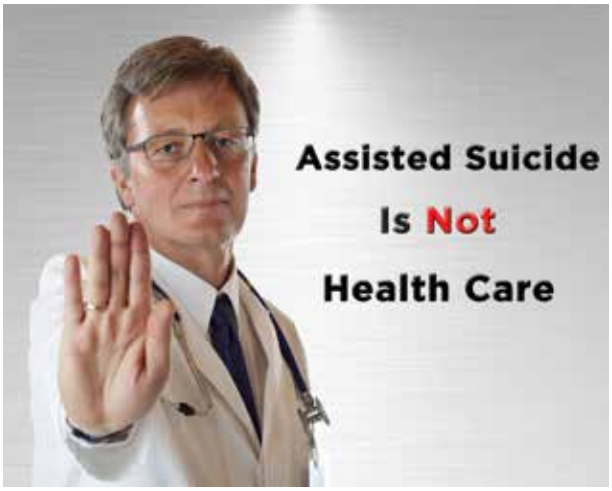
Vulnerable: The Euthanasia Deception is a documentary which exposes what euthanasia laws can do to a country's culture in a mere 15 years.

The case study is Belgium: euthanasia's 'ground zero'. Heart-wrenching testimonies along with medical, legal and expert analysis reveal the sad truth about euthanasia and assisted suicide: all of us become vulnerable when life and death matters are handed over to lawmakers and doctors.

The initiative is being produced by the Euthanasia Prevention Coalition in association with Dunn-Media & Entertainment and is made possible through the support of generous donors like you.

Assisted Dying Report Goes Beyond the Scope and Ignores Evidence

On February 25, the Special Committee on Physician-Assisted Dying released its report advising the government on euthanasia legislation in Canada.



The Supreme Court struck down Canada's assisted suicide law (February 6, 2015) and has given parliament until June 6, 2016 to implement a new law.

Similar to the Provincial-Territorial panel report that was loaded with pro-euthanasia activists, the federal committee recommended euthanasia for people with dementia, for minors, for people with psychiatric conditions and without effective oversight.

EPC legal counsel, Hugh Scher, called the committee proposal "a dangerous social policy experiment."

On Saturday, February 27, the *Globe and Mail* published a commentary by constitutional lawyer, David Baker, who represented the national disability groups at the Supreme Court and Trudo Lemmens, University of Toronto Professor in health law and policy at the Faculty of Law.

Baker and Lemmens argue that the Assisted Dying report goes beyond the scope of the Supreme Court decision, and that they also ignored evidence. According to Baker and Lemmens:

The court foresaw it (the government) enacting a "complex regulatory regime" of "carefully designed and monitored safeguards." Unfortunately, the federal report recommends exactly the opposite, and proposes the world's most open-ended regime with arguably the lowest safeguards.

The article continues by defining what the Committee on Assisted Dying recommended:

The parliamentary committee seeks to expand the criteria for physician-assisted death way beyond what was required by Carter or Bill 52. It includes mental-health conditions and all other disabilities, including developmental disabilities, autism, acquired brain injuries, fetal alcohol syndrome, not to mention blindness and deafness.

Essentially all disabilities can be included in the open-ended criteria for access, extending the law beyond the persons with irreversibly declining capacities at the end-of-life that the Supreme Court ruled upon, and disregarding the court's determination that "psychiatric disorders" were expressly excluded, as well as children, even if children would only have access three years after the new legislation is introduced. The committee further recommends access by advanced directive for people suffering from dementia, which most agree would create a practical and ethical minefield.

The article documents some of the evidence that the Committee had received but ignored:

The committee disregarded strong evidence (detailed analyses as well as various case reports) from Belgium and the Netherlands, that confirms vulnerable people are put at risk when vague and expanding access criteria are employed. The risk worsens when the regulatory system relies on individual physicians for determining access and for assessing competency of patients.

Physician-assisted death in those countries is increasingly being performed on people who are lonely and are concerned about becoming dependent on others, people who are tired of life, and people suffering from mental-health conditions, including depression, anxiety, schizophrenia, eating disorders, autism, post-traumatic stress, and even complicated grief.

In many analyzed euthanasia cases, treatment options were available but not used. Reports from those countries raise questions about how some physicians assess competency, and about how vulnerable patients have been able to shop around until they find physicians who, having had no prior therapeutic relationship with them, are willing to end their lives.

The article states that experts and political commentators in the Netherlands and Belgium are now calling for an end to the open-ended, after-the-death-review system that exists in their countries, and yet the Committee suggested we go in that direction. Baker and Lemmens state:

Imagine that Canada would become a country where people, including children, receive a physician-assisted death for lack of access to appropriate palliative or other health care.

It is time for Canadians to rise up and say NO.

Study uncovers problems with euthanasia for psychiatric reasons in the Netherlands

The journal *JAMA Psychiatry* published a study on February 10, 2016 examining euthanasia for psychiatric reasons in the Netherlands by researchers Scott Y. H. Kim, MD, PhD; Raymond G. De Vries, PhD; John R. Peteet, MD.

The study examined 66 cases of euthanasia for psychiatric reasons between 2011 and 2014. The data for this study was provided by the Netherlands Regional Review Committee.

The Netherlands 2014 euthanasia report stated that there were 41 euthanasia deaths for psychiatric reasons and 81 people with dementia died by euthanasia.

Since data is from the euthanasia reports that are submitted after the person dies, by the doctor who causes the death, the data rarely uncovers problems since doctors are self-reporting the euthanasia.

A *CTV* report by Marlene Leung and Michael Shulman, indicated that the study uncovered some controversial data. According to the study, of the 66 people who died by euthanasia for psychiatric reasons:

- 70% were women;
- 52% had attempted suicide;
- 80% had been hospitalized for psychiatric reasons.

Further to that the study indicates that there were controversial cases:

However, in one EAS case, a woman in her 70s without health problems had decided, with her husband, that they would not live without each other. After her husband died, she lived a life described as a "living hell" that was "meaningless."

A consultant reported that this woman "did not feel depressed at all. She ate, drank and slept well. She followed the news and undertook activities."

The study found that 21 patients had been refused EAS at some point, but in three cases the physicians later changed their minds.

In 41% of the cases, the physician performing EAS was a psychiatrist, but in the rest of the cases it was usually a general practitioner.

Consultation with other doctors was "extensive, but in 11% of the cases, there was no independent psychiatric input. In 24% of the cases, there were disagreements among the physicians.

Dr Kim expressed several concerns. Kim stated:

> *While the assessment of most terminal illnesses does not involve a lot of "physician discretion," and doctors can be "fairly sure" what the eventual outcome for the patient will be, psychiatric conditions are less clear.*
>
> *"Physicians must make tricky clinical determinations ... without the help of a robust evidence base,"*
>
> *"There is no evidence base to operationalize 'unbearable suffering,' there are no prospective studies of decision-making capacity in persons seeking EAS for psychiatric reasons, and the prognosis of patients labeled as 'treatment-resistant depression' varies considerably, depending on the population and the kind of treatments they receive."*

Tara Brousseau-Snider, executive director of the Mood Disorders Association of Manitoba, told *CTV News* that she is concerned about the potential of Canada offering assisted death to those with mental illness. She said a woman with severe depression came into the Winnipeg centre just months ago and told a counsellor that she wanted to end her life.

> *"I find this is very alarming, very worrisome because people, through different avenues, find a different way of life and nobody needs to sit with depression and be miserable all through their lives. There are options; there are supports available,"* said Brousseau-Snider.

The Canadian government should heed the results of this study and ensure that if euthanasia becomes legal, that it is not permitted for psychiatric reasons.

Newly Published—Entangled 1: Caught Between Choices

Entangled 1: Caught Between Choices Jen Romnes shares her chilling family's story so that her mother's legacy won't be an abuse statistic, but a mechanism for change.

Jen's mother had a genetic form of early-onset Alzheimer's that made her vulnerable to coercion. Also, her condoned lack of personal autonomy and consent put her at risk of euthanasia—via the slow method of withholding medical treatment. It is also a saga about lost rights. *Entangled 1* is the story of a daughter's love for her mother, and how Romnes is willing to put everything on the line to protect her ailing mother.

Purchase a copy of *Entangled 1* for $25 from the EPC.

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to ensure capacity to consent. The report states several times that safeguards and oversight will strike the balance between vulnerability and a clear request to die, and yet, the report rejects the necessary safeguards and oversight to accomplish that task.

Recommendation 6 states that the federal government should implement euthanasia in a two-stage process, whereby the first stage would limit euthanasia to competent adults, with euthanasia being extended to "mature minors" within three years of implementing stage 1.

Recommendation 7 states that an incompetent person could be approved for euthanasia, so long as the person made the request after receiving the diagnosis, and while they were competent.

Assisted death based on advanced directives can lead to misuse of the law. If a person states in their advanced directive, that they want to die by euthanasia, often the euthanasia will occur when the person cannot change their mind since, at that moment, the person may be incompetent.

Recommendation 8 states that the person who died must be eligible for publicly funded healthcare services in Canada. This recommendation will not prevent death tourism.

Recommendation 9 suggests that the request for assisted death should be made in writing and witnessed by two people who have no conflict of interest. Rec. 9 does not permit a request for assisted death by a substitute decision maker, and yet recommendation 7 will require the substitute decision maker to make the request.

Recommendation 10 requires health care practitioners, who object to killing their patients, to effectively refer their patients to someone who will kill their patient or arrange it. This report provides no conscience protection for medical professionals.

Recommendation 11 requires all publicly funded health care facilities to permit euthanasia and assisted suicide. This would require all religiously affiliated health care facilities to kill patients.

Recommendation 12 requires two independent physicians to assess a person who requests assisted death.

In all jurisdictions, where assisted death is legal, the law allows two doctors to determine who lives and who dies. Recommendation 12 does not provide effective oversight since recommendation 15 rejects a prior review and approval process and recommendation 16 requires the doctor who causes the death to submit a report. Doctors do not self-report misuse of the law.

Recommendation 13 permits nurse practitioners and registered nurses to lethally inject patients under the direction of a physician and it also protects pharmacists and other health care practitioners from possible prosecution for participating in killing people.

Rec. 13 appears to provide protection for nurses, but in fact it ensures that there are sufficient medical professionals who are willing to kill by expanding killing to nurses.

Recommendation 14 discourages a "cooling off" period. The Oregon and Washington State assisted suicide laws require a 15 day "cooling off" period.

Recommendation 15 rejects a before-the-death approval or review system to ensure that the requirements of the law are followed. A before-the-death approval system enables effective oversight of the law. The report rejects effective oversight of the law for a system where doctors self-police and self-report compliance with the law.

Recommendation 16 mandates a system of data collection and reporting to be published on a yearly basis. The data will come from the reports that physicians are required to submit, after-the-death of the person. This system provides no effective oversight, because the person is dead when the doctor submits the report. Doctors do not self-report misuse of the law.

Recommendation 17 requires a mandatory review of the law, by the House of Commons and Senate, every four years.

Recommendation 18 recognizes that indigenous patients require culturally and spiritually appropriate care, including palliative care.

Recommendation 19 urges the federal, provincial and territorial governments to re-establish a Secretariat on Palliative Care and End-of-Life Care.

Recommendation 20 urges the federal, provincial and territorial governments to support the Changing Directions, Changing Lives Mental Health commission.

Recommendation 21 urges the federal, provincial and territorial governments to develop a pan-Canadian strategy for individuals living with dementia.

The report of the Special Joint Committee on Physician-Assisted Dying is very similar to the one-sided Provincial/Territorial report.

The recommendations permit a wider regime for euthanasia that exists in Belgium, where the law has grown out of control.

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