

COST ANALYSIS OF MEDICAL ASSISTANCE IN DYING IN CANADA

By Alex Schadenberg

The *Canadian Medical Association Journal* (CMAJ) published a study by Aaron J. Trachtenberg, MD DPhil and Braden Manns, MD MSc, entitled, “[Cost analysis of medical assistance in dying in Canada.](#)”

The researchers found that the Canadian healthcare system will save between \$34.7 million and \$138.8 million per year, depending on the number of euthanasia deaths. Canada has a universal healthcare system, whereby the financial cost for healthcare is primarily paid by the government.

The cost savings were based on a Netherlands study estimating the number of weeks that life is shortened by euthanasia, multiplied by the average cost of care for a person nearing death, and by the likely number of euthanasia deaths in Canada. The study also considered the cost of the euthanasia procedure and potential costs related to patients using palliative care.

The researchers emphasized that they are not encouraging people to die by euthanasia.

Firstly, associating euthanasia with medical cost savings creates a belief that euthanasia is a social good. People who feel that their life has lost value may now consider it altruistic to “choose” to die by euthanasia.

“I will give back to society by having my life ended and save money.”

I fear that the social pressure to save money and provide a greater access to [organs for donation](#) will become the ultimate form of social responsibility.

Secondly, associating euthanasia with medical savings creates negative pressure for people who believe that killing is wrong.

“How dare you choose to live. You are costing society money.”

Promoting the concept that euthanasia saves money coupled with the media stories and TV shows, such as *Mary Kills People*, will create a new powerful social pressure to die.

Recently, I spoke to a group in a small Ontario community. After my presentation, a man told me that he supported euthanasia based on the last few months of his mother-in-law’s life, after she had a stroke.

He asked me what the purpose of her life was. He then said, “How much did her care cost the government?”

I responded by saying, “I guess euthanasia is not about ‘choice’ or ‘autonomy’ but rather killing people at the most vulnerable time of life.”

During the euthanasia debate, very few people were speaking about the fact that Canada’s health care systems are in a financial crunch. The reality is that killing people is cheaper than caring.

The authors of this study suggest that the financial savings gained from premature deaths by euthanasia could be re-invested into palliative care. This is naive. The more people die prematurely by lethal injection, the less demand will exist for palliative care.

Dead people don’t need palliative care.



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ASSISTED SUICIDE BILL PUTS PATIENTS AT RISK AND PRIORITIZES COST OVER COMPASSION

This article was written by Representatives Brad Wenstrup and Phil Roe and published by the *National Review* on February 03, 2017.

Two members of Congress, both physicians, urge caution.

“Do no harm.” Three short words, but to physicians they represent a sacred charge. Three short words that now hang in the balance here in the District of Columbia, after the D.C. council passed the Death with Dignity Act (Act 21-577), legalizing physician-assisted suicide in the nation’s capital. In authorizing doctors to violate the Hippocratic oath of “do no harm,” physician-assisted suicide undermines a key safeguard that protects our nation’s most vulnerable citizens and helps to ensure our loved ones receive the best medical care when they need it most.

Personally, as doctors, we are concerned about providing care and comfort to those facing the heart-wrenching difficulty of dealing with a terminal disease. It is an issue close to our hearts. However, for patients with terminal diseases who are not seeking treatment and instead coping with the complexities of end-of-life preparations, there are already a myriad of end-of-life care options currently at a patient’s disposal.

Instead of simply providing end-of-life comfort, D.C.’s new law is poised to do more harm than good. Even those disagreeing on the merits of the larger issue should [take a close look at the text of Act 21-577](#), which leaves patients unprotected, doctors unaccountable, and our most vulnerable citizens at risk of having fewer medical options at their disposal rather than more.

Act 21-577 allows adults diagnosed with a terminal disease, having less than six months to live, to receive a prescription for medication to end their life. There are concerns that the definition of “terminal disease” is too broad, since most doctors will admit that accurately predicting life expectancy is almost impossible. Additionally, many conditions, such as diabetes and HIV, are considered “incurable and irreversible” or “terminal” if left untreated.



Representative Brad Wenstrup



Representative Phil Roe

One of the greatest concerns that medical professionals have about Act 21-577 is its failure to adequately protect patients from potential coercion and abuse. When someone is considering ending his or her own life, regardless of the reason, he or she is in a vulnerable mental and emotional state. A [report by the National Institute of Health](#) found that, contrary to popular belief, pain is not the primary factor motivating patients to seek assisted suicide. More frequently cited motivations include depression, hopelessness, dependency, and loss of control or autonomy. Despite the fact that depression is commonly associated with a patient’s seeking assisted suicide, D.C.’s legislation does not make screening for mental illness mandatory. It also has no safeguard against pressure that family members, heirs, or health-care providers might exert on a patient to choose assisted suicide. This leaves some of our nation’s most vulnerable citizens—the disabled, the elderly, and those fighting mental illnesses—at the most risk under this law.

Additionally, a stunning lack of accountability is built into the bill, as doctors self-report their participation in assisted suicide and their compliance with regulation. Compliance with the bill’s limited safeguards is difficult to track because the bill directs doctors not to place the actual cause and manner of death (assisted suicide) on the death certificate, and the reporting requirements in the bill are not subject to the Freedom of Information Act. Once the prescription for lethal medication is filled, oversight is non-existent. This means that after the lethal medication, which can cause death in hours, leaves the pharmacy, it can be left unsecured in the medicine cabinet or on a bedside table. The lack of oversight opens up a number of potential nightmare scenarios: The medication could be accidentally taken by a child. It could be administered to a patient against his or her will. It could be used on an individual for whom the medication was not intended.

Perhaps most troubling of all, under the new law, patients may end up with fewer options, not more. D.C. residents who are not able to pay for health care out of pocket may find their options severely limited when facing a new diagnosis, suffering from a

...see Assisted on page 4

DUTCH EUTHANASIA REVIEW COMMITTEE: FORCED EUTHANASIA OF WOMAN WITH DEMENTIA WAS DONE IN “GOOD FAITH”

A Dutch Regional Euthanasia Review Committee has decided that a forced euthanasia done on a woman with dementia, where the doctor sedated the woman by secretly putting the drugs in her coffee, was done in “good faith.” The committee chair is also urging that the case be reviewed by the court, not to punish the doctor, but to set a precedent concerning these acts.

Janene Pieters reporting for the *Netherlands Times* stated:

The review committee determined that the woman’s declaration in her will did not clearly state that she wanted to be euthanized after being admitted to a nursing home. The words “when I myself find it the right time” does not take into account a situation in which the woman was no longer mentally competent. The committee can understand how the doctor read it as a well-considered wish, but still feels that it was too broad an interpretation.

The committee also concluded that the doctor “crossed a line” by giving the woman the first dose of sedative secretly—hidden in a cup of coffee. And that the doctor should have stopped at the woman’s movements at the end. Even though it is possible that the movements were purely physical reactions, it cannot be certain.

Giulia Crouch for the *Daily Mail*:

The doctor secretly placed a soporific in her coffee to calm her, and then had started to give her a lethal injection.

Yet while injecting the woman she woke up, and fought the doctor. The paperwork showed that the only way the doctor could complete the injection was by getting family members to help restrain her.

It (the paperwork) also revealed that the patient said several times ‘I don’t want to die’ in the days before she was put to death, and that the doctor had not spoken to her about what was planned because she did not want to cause unnecessary extra distress. She also did not tell her about what was in her coffee as it was also likely to cause further disruptions to the planned euthanasia process.

Jacob Kohnstamm, Chairman of the Regional Euthanasia Review Committees, wants the case brought to court to create a precedent to enable other doctors to lethally inject people with dementia, without fear of prosecution.



According to the article in the *Daily Mail*:

Kohnstamm said he was in favour of a trial: ‘Not to punish the doctor, who acted in good faith and did what she had to do, but to get judicial clarity over what powers a doctor has when it comes to the euthanasia of patients suffering from severe dementia.’

So let’s examine the facts surrounding this death by lethal injection:

- The woman had dementia and was incapable of asking for euthanasia,
- The declaration in her will was not clear,
- She stated several times that she did not want to die,
- She was not informed that a sedative was put in her coffee,
- Her family was required to hold her down so the doctor could lethally inject her.
- The Regional Review Committee found that it was done in “good faith.”
- The Regional Review Committee wants the court to hear the case to set a precedent approving the lethal injection of people with dementia, who cannot consent.

Euthanasia is out-of-control in the Netherlands.



I am also concerned about [the contagion effect connected to programs that promote killing](#).

This is not the first time *Global* has aired a program promoting euthanasia. In 2012 they aired *Taking Mercy*, a show that promoted eugenic euthanasia featuring Robert Latimer, who killed his daughter with cerebral palsy, Annette Corriveau, who wanted her two disabled adult children euthanized and pro-euthanasia “ethicist” Arthur Schaefer. At that time, [the Euthanasia Prevention Coalition](#) and [the Council of Canadians with Disabilities](#) responded with strong opposition to portraying the lives of people with significant disabilities as life unworthy of life.

We need a mini-series featuring people with disabilities who are living fulfilling lives, or people with a terminal illness who through effective symptom management and community support live a fulfilling life until their natural death, or people who are survivors of a terminal illness. The world needs real stories that provide hope; stories that promote caring, not killing.

Liz Carr, a famous British actress who is also a leader of the disability rights

group Not Dead Yet UK, recently produced a successful musical opposing assisted suicide called *Assisted Suicide: The Musical*. Carr, who is an incredible comedian, proves that opposing assisted suicide can also be entertaining.

Kevin Dunn and I have been speaking at events connected to the screening of *The Euthanasia Deception* documentary. Recently in Spruce Grove, Alberta, more than 250 people attended a screening and question-and-answer period.

You can respond to the *Mary Kills People* propaganda by screening *The Euthanasia Deception* in your community.

We also need you to [donate to the Euthanasia Prevention Coalition](#) towards the production cost of our next film now being produced under the working title *Fatal Flaws*.

The Euthanasia Deception cost EPC almost \$100,000 to produce and has been aired across North America, Australia and world-wide via Vimeo. Your investment in our next film for social change may be the most effective response to media propaganda.

Global TV is airing a six part mini-series called *Mary Kills People*.

Programs that portray euthanasia as heroic, caring and maybe even daring, are promoting euthanasia. They don't show the real life circumstances of a person who is lonely, afraid of suffering and feeling like they have no viable alternative; these programs portray euthanasia as an act done by strong, independent people. People we should emulate.

Social change is accomplished through storytelling that alters our ideas of what constitutes reality, what a good death is, what murder is and what mercy is.

[...Assisted from page 2](#)

chronic illness, facing a disability, or struggling with mental illness. For certain medical conditions, assisted suicide could become the cheapest option. By some estimates, lethal medication costs no more than \$300. The consequences could be harmful on two levels: given less incentive, innovative treatments could become less likely to develop, and then insurance programs could deny payment for costly treatment options even if they prove to be successful for many cases.

At age 53, Randy Stroup was living in Oregon after assisted suicide was legalized there. Uninsured and fighting prostate cancer, he was relying on Oregon's state-run health plan for care when he applied for an expensive form of chemotherapy that his doctor recommended and was denied. Instead, he received a letter informing him

that the state of Oregon would pay for physician-assisted suicide. As much as we wish it weren't the case, cost factors into practical implementation of health-care policy. Because assisted suicide could end up being the cheapest “treatment,” it's not difficult to see how patients could be incentivized to end their lives when the alternative is a costlier treatment option.

Ultimately, whatever its intentions, D.C.'s new law puts patients at risk and could limit their access to high-quality health care. It prioritizes cost over compassion. Since the Constitution charges Congress with legislative jurisdiction over D.C., Congress has a duty to carefully scrutinize this bill, its impact on medical patients, and its effects on our health-care system. We have weighed the legislation and found it wanting. D.C. residents deserve better.