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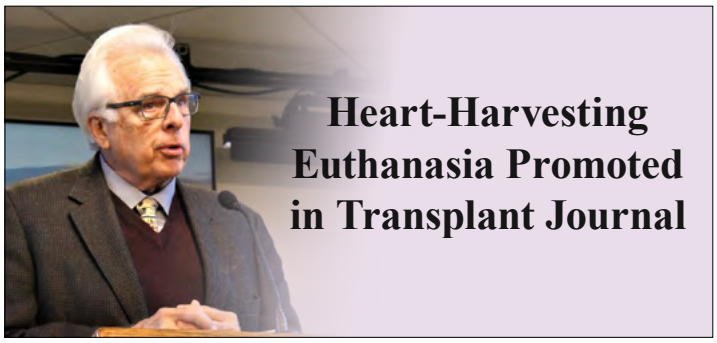

Heart-Harvesting Euthanasia Promoted in Transplant Journal

By Wesley J. Smith, published in the *National Review* January 29, 2019 (edited)

My first anti-euthanasia column (*Newsweek*, 1993) worried that once euthanasia became normalized, it would lead to conjoined organ harvesting "as a plum to society."

I was screamed at and labeled an alarmist. Oh, Wesley, people assured me, *that* will never happen!

Yeah, right. The world's most respected bioethicists have published serious articles in influential medical journals urging that doctors be allowed to harvest cognitively disabled patients while they are alive—known as ODE, e.g., "organ donation euthanasia"—as a means of cutting transplant waiting times.

That is not yet being done. But as I predicted all those years ago, organ harvesting after euthanasia is allowed in the Netherlands and Belgium, and has been performed at least once in Canada.

Now, the *Journal of Heart and Lung Transplantation*—a respected medical journal, published an article proposing *beating-heart harvesting* as a form of euthanasia where medicalized homicide is legal. Good grief.

First, the authors propose that doctors bring up organ transplantation to euthanasia seekers. From "Euthanasia through living organ donation":

> Current guidelines [in the Netherlands] state that only the patient should pose the question of organ donation, and only after a positive response to the euthanasia question, thus keeping both procedures strictly separated. However, it is our belief that a physician should always inform a patient who is

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Canada's New Justice Minister is Radically Pro-Euthanasia

On January 16, Prime Minister Trudeau indicated his intention to expand Canada's euthanasia law by appointing David Lametti as the new Justice Minister.

After the release of the Council of Canadian Academies (CCA) reports on the expansion of euthanasia in Canada to include children, psychiatric conditions alone and incompetent people who previously requested euthanasia, Justice Minister Jody Wilson-Raybould stated that no changes to the law were coming.

Lametti voted against the euthanasia bill because he thought that it was restrictive and thus unconstitutional.

We are concerned about the expansion of euthanasia to children. The CCA report on child euthanasia stated:

> Denying MAID to mature minors would pose a potential future legal challenge if a case were to be brought forward in which a mature minor argued that their constitutional rights were being denied.

The CCA reports were negative to the idea of expanding euthanasia to people with psychiatric conditions alone while the report on expanding euthanasia to incompetent people, who made a prior request, had a mixed response.

We are also concerned about the conscience rights for medical professionals and institutions that refuse to participate in killing.

Long-time euthanasia activist and "academic" Jocelyn Downie is campaigning to force St. Martha's hospital in NS to participate in euthanasia. This is a provincial issue; the federal government could impact this debate.

Since the Liberals have a majority government, we hope that Lametti will wait until after the October 21 federal election, but the Liberals may view euthanasia as a wedge issue and try to expand the law before summer.

Lametti

The Euthanasia Prevention Coalition exists to protect people by building a well-informed, broadly-based network of groups and individuals for an effective social resistance to euthanasia and assisted suicide.

US Assisted Suicide Lobby Wants to Eliminate "Safeguards"

By Alex Schadenberg

New Mexico's assisted suicide House Bill (HB) 90, is the most extreme assisted suicide bill that I have ever seen.

After reading HB 90 I asked the question: Is the assisted suicide lobby behind HB 90 or is the author of the bill, Deborah Armstrong (Dem), more radical than the rest of the suicide lobby?

The leading suicide lobby group published a guideline on January 1, 2019 calling on fewer restrictions and wider definitions for assisted suicide laws in the US.

In her article, "End-of-Life option laws should avoid needless red tape," Kim Callinan, CEO of the suicide lobby group, Compassion & Choices (formerly known as the Hemlock Society), argues that assisted suicide laws require fewer regulations. Callinan writes:

> If lawmakers want to improve medical aid in dying laws, then let's address the real problem: There are too many regulatory roadblocks already! I am not suggesting changing the eligibility requirements, as our opposition will suggest. I am merely suggesting that we drop some of the regulations that put unnecessary roadblocks in place.

Callinan continues her article by arguing that waiting periods for assisted suicide should be eliminated and claims that there have been no problems with assisted suicide laws.

The New Mexico assisted suicide bill was recently amended to remove assisted suicide by telemedicine but it continues to be very radical. **House Bill 90:**

1. Allows nurses and physician assistants to participate in assisted suicide by defining "health care provider" to include: a licensed physician, a licensed osteopathic physician, a licensed nurse, and a licensed physician assistant.

2. Does not require the person to "self-administer." The bill states "may self-administer" meaning that euthanasia is possible.

3. Reduces waiting period to 48 hours to receive the lethal drugs.

4. Allows people with mental health disorders to die by assisted suicide by enabling licensed psychiatrist, psychologist, master social worker, psychiatric nurse practitioner or professional clinical mental health counselor to approve assisted suicide for people with mental health disorders.

5. Requires health care providers to falsify the death certificate.

6. Removes conscience rights for health care providers who object to assisted suicide by requiring them to refer patients to a health care provider who is willing to prescribe assisted suicide.

7. Bases decisions on a "good faith compliance." It is impossible to prove that someone who participated in the act did not do so in "good faith."

Years ago I stated that the suicide lobby would expand the parameters for prescribing lethal drugs in the future. Callinan is saying in her article that she believes the future is now.

The decision to expand assisted suicide is evident in the new assisted suicide bills. Delaware defines assisted suicide as palliative care, which is part of a long-term goal of normalizing it. Oregon has a few bills to expand assisted suicide laws and New Mexico has the most extreme bill that I have ever seen in the US.

Most of the bills attack conscience rights for medical professionals by forcing doctors who object to assisted suicide to refer their patients to a pro-assisted-suicide doctor.

Two thousand nineteen is a watershed year for assisted suicide legislation in the US.

Oregon Debates Expanding Assisted Suicide Law

Recently, the Oregon assisted suicide lobby stated that they intend to expand the definitions in the assisted suicide law. The 2017 Oregon assisted suicide report stated that the number of assisted suicide deaths had, once again, increased.

Oregon House Bill (HB) 2232 appears to clarify the definition of self-administer in the Oregon assisted suicide act, but in fact the bill changes the definition of terminal from a six-month terminal prognosis to:

> a disease that will, within reasonable medical judgment, produce or substantially contribute to a patient's death.

Considering the fact that the Oregon Health Authority (OHA) bases the definition of terminal to include refusing medical treatment, such as a diabetic who refuses insulin, therefore the new definition of terminal has an undefined and nearly unlimited application.

Many people who are not close to being "terminally ill" have a disease that will, *within reasonable medical judgement, produce or substantially contribute to death*. When considering the OHA inclusion of refusing medical treatment, I conclude that this new definition enables wide-open assisted suicide.

There may be more concerns with HB 2232. This article only focuses on the new definition of terminal.

Oregon Senate Bill (SB) 0579 creates an exception to the 15-day waiting period in the Oregon assisted suicide law enabling a physician to wave the 15-day waiting period before prescribing lethal drugs for suicide.

The current Oregon assisted suicide law requires a 15-day waiting period. SB 0579 states:

> Notwithstanding subsection (1) of this section, if the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die before the expiration of at least one of the waiting periods described in subsection (1) of this section, the prescription for medication under ORS 127.800 to 127.897 may be written at any time following the later of the qualified patient's written request or second oral request under ORS 127.840.

There may be more concerns with SB 0579. This article only focuses on the waiting period.

Delaware Bill Defines Assisted Suicide as Palliative Care

The assisted suicide lobby has instituted a new direction by redefining assisted suicide as palliative care. This has long been a talking point for assisted suicide advocates but now they are attempting to change the legal definition of palliative care.

The Delaware assisted suicide bill follows the new suicide by physician game plan by redefining palliative care to include assisted suicide. The bill states:

> WHEREAS, the integration of medical aid in dying into the standard for end-of-life care has improved quality of services by providing an additional palliative care option to terminally ill individuals.

The World Health Organization definition of palliative care states that, "Palliative care intends neither to hasten or postpone death;"

The assisted suicide lobby and the Delaware assisted suicide bill intend to change the meaning of palliative care.

Montana Bill Would PROHIBIT Assisted Suicide

For the past few years Montanans have faced a confusing situation concerning assisted suicide. In 2009, the *Baxter et al.* court decision declared that Montana citizens had a right to assisted suicide. The *Baxter et al.* decision was appealed to the Montana Supreme Court where it was decided that Montana citizens do not have a right to assisted suicide but the Court granted a tightly worded defense of consent, if a physician was prosecuted for assisted suicide.

Physician-assisted suicide is not legal in Montana.

Since the Montana Supreme Court decision, the assisted suicide lobby has claimed that assisted suicide is legal in Montana, while in fact assisted suicide is technically prohibited.

This year, House Bill 284 was introduced to reverse the effect of the Montana Supreme Court decision by clarifying that consent is ineffective for homicide or assisted suicide.

Canadian Woman Seeks Euthanasia for Pelvic Mesh Pain

Published by the *Australian Care Alliance* on January 11, 2019

A Canadian study that tracked more than 57,000 women has found patients with complications after pelvic mesh implants are at increased risk of depression, self-harm–even suicide.

The study published in the journal JAMA tracked more than 57,000 women in Ontario who had complications like pain and infections after receiving the polypropylene implants used to treat incontinence. The study found that:

- Of those referred for mesh removal surgery, 11 per cent were treated for depression
- Meanwhile, 2.7 per cent suffered from self-harm/ suicidal behavior, almost double the rate in the control group

One woman from British Columbia, who asked not to be identified, has told *CTV News* that after being in agony for many months and unable to find a doctor willing to remove her implant she has "filled out paperwork for assisted dying due to the agonizing pain of mesh and the fact that I have no medical care regarding mesh."

This story illustrates two important points.

First, "assisted dying"—in the Canadian context this means euthanasia—is simply another form of suicide. This woman is seeking euthanasia for the same reason that other depressed women dealing with pain from pelvic mesh are committing suicide.

Secondly, euthanasia or assisted suicide can easily become the go-to solution when the health system fails a class of patients—in this case a failure to respond quickly by providing removal of pelvic mesh from women suffering from its adverse effects.

*...**Heart** from page 1*

> medically suitable about the possibility of organ donation, even if this could disrupt the trust relationship, as many patients may choose not to ask about donation because they assume it is not possible in this context. Consent of the patient's relatives for organ donation after euthanasia is not required.

Realize that the people who are harvested after euthanasia are sometimes mentally ill, with no other underlying medical condition. Why? Because they have good organs. Others are disabled by neuromuscular conditions, who may also be harvested for this reason.

But why wait until the patients are dead? Let's permit ODE, including live heart harvesting! First, they admit the obvious:

> Because the proposed procedure does not involve patients who are brain dead, "living donation" is the correct term to use, even though this is normally used for people who donate their kidney, and do not die as a result of donation.

Yes, taking out a beating heart will be 100 percent fatal.

The authors engage in the usual bioethical hand-wringing discussing objections, only to—voila!—conclude that heart harvesting would be peachy keen where euthanasia is legal. They even invoke the Hippocratic Oath!

> Making ODE possible, compared with neglecting the patient's wish and not facilitating this procedure, respects the Hippocratic Oath, which mandates taking care of the organ donor and the recipient in the best possible way.

The Hippocratic Oath explicitly forbids euthanasia, but never mind. The authors conclude:

> The right of self-determination of the patient who meets the due diligence requirements for euthanasia should ideally give such a patient the possibility of also donating his heart, so that others can be helped and/or saved by as many donated organs as possible. Implementing ODE into practice should be approached with caution, however, as public perception may not yet be ready for this combination of procedures.

May the public never be ready to accept doctors' taking a living patient—who may not even be physically ill—into a surgical suite, anesthetizing him, and then harvesting his beating heart.

Oh, Wesley, *that* will never happen! Yeah, right.

Those with eyes to see, let them see.