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100 Physicians and Lawyers warn Parliamentarians: Do Not Legalize Physician Assisted Suicide or Euthanasia

DOCTORS: 'We do not want to become the executioners of our patients.'

(OCTOBER 26, 2005) - A group of 100 physicians and lawyers has issued a strong warning not to legalize physician assisted suicide or euthanasia. This statement has been issued in advance of the second reading of Bill C-407 on October 31st. This Bill would legalize physician assisted suicide. The document was signed by 61 physicians (comprising essentially all medical specialties

including several professors, practicing in such diverse fields as family and internal medicine, oncology, surgery, anaesthesiology, psychiatry, neurology, radiology, medical ethics and palliative care) and is being sent to all MPs to alert them to the dangers of altering existing legislation. The document has been endorsed by 39 lawyers.

The statement warns that *'while euthanasia and* (Continued on page 5...assisted suicide)

Fetal Pain

"It has generally been assumed ... that neonates [newborns] may not perceive pain or may perceive it only minimally. Assumed by whom? Certainly not by those of us at the bedside of critically ill infants, who see them flinch from procedures, startle in response to loud noises Why then has surgery in neonates been conducted without anaesthesia? Is this barbarism, as some have suggested?"

—Dr. Anne Fletcher (1987), Children's Hospital Medical Center, Washington.

Pro-Abortion Fetal Pain Study: An Overplayed hand

by Paul Ranalli, MD

"Fetal Pain: a systematic multidisciplinary review of the evidence" is a highly controversial, scientifically flawed study published in the August 24/31 issue of the Journal of the American Medical Association (JAMA). Authored by medical student (and former NARAL activist) Susan Lee and four doctors, the seven-page-long study purports to conclude that the human "fetus" cannot feel pain until 29 to 30 weeks gestation.

Setting aside the glaring moral and political underpinnings of this topic, from a purely scientific and clinical perspective, this article

is an appallingly substandard mix of self-contradictory analysis, suspicious omissions, and scientifically erroneous conclusions.

The following is a brief catalogue of these deficiencies.

Undisclosed bias

Lead author Susan Lee previously worked as a lawyer for NARAL, while another author, Dr. Elizabeth Drey, is the medical director for the largest San Francisco abortion clinic, which annually aborts 600 babies between 20 and 23 weeks of age. Dr. Drey is also on the

(Continued on page 4...JAMA fetal pain study)

Legalised euthanasia will violate the rights of vulnerable patients

R J D George, senior lecturer¹, I G Finlay, baroness², David Jeffrey, chair of ethics committee³

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Introduction

The chameleon of euthanasia continues to change, and the current shade is physician assisted suicide. The politically correct position for clinicians is “studied neutrality” since doctors will not really be involved in assisted suicide. Thus the issue has slipped past the BMA,¹ and the recent House of Lords’ report on assisted dying suggests that euthanasia and assisted suicide are different.² This cannot be. What doctor prescribing for assisted suicide would refuse to complete it with euthanasia? In the Netherlands just under one in five physician assisted suicides ends in lethal injection.³ Were physician assisted suicide legalised, doctors would have the new duty of therapeutic killing,⁴ even if they planned only to prescribe lethal medication. Both are killings justified as treatment, hence we use the term therapeutic killing simply because it describes precisely what is done. Medicine cannot escape; quite aside from patient safety, legalising physician assisted suicide will have a profound and ubiquitous effect on clinical codes, duties, and practice.

Change is unjustified

Autonomy and suffering are the usual justifications for change. The autonomy argument is thin. In all legislatures, the final decision for physician assisted suicide or therapeutic killing rests with the doctor. Patients’ perception of total control over this type of death is illusory. Evidence from Oregon shows that patients have to shop around for compliant doctors, and in the Netherlands about a fifth of requests are denied because patients are not suffering enough.⁵⁻⁷

Protecting the vulnerable

The cardinal argument against legalised euthanasia, however, is the insoluble ethical conflict between meeting individuals’ demands for therapeutic death and ensuring that incapable, vulnerable, or voiceless patients will not have lethal treatment prescribed as their best interest. Coercion is a real, immeasurable risk. As with cardiopulmonary resuscitation, clinicians will have to discuss the potential for assisted suicide with all dying patients. Arguably this promotes freedom, trust, and openness, yet, as disabled people find with discussions about resuscitation, it could also infer a duty to die.^{8,9} Requests for physician assisted suicide because of “being a burden” have risen in Oregon from 1:5 to 1:3 since its Death with Dignity Act was implemented.¹⁰

Treatments are medical goods. Since justice dictates that rights to appropriate treatment are universal, if assisted suicide is legal it becomes an optional treatment, not just for patients who want it but also for those who need it. A moral obligation exists for death to be a legitimate interest for all our patients. Therefore, assisted suicide or therapeutic killing becomes our proper duty towards anyone claiming or appearing to suffer unbearably, regardless of prognosis or capacity to consent. The inevitable accommodation of this shift in the status of assisted suicide and therapeutic killing is seen clearly in the Netherlands. Therapeutic killing is now extended to children,^{11,12} people with psychiatric illness,^{13,14} and those who are mentally incapable.¹⁵ Therapeutic killing without con-

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Canadian Physicians for Life holds that reverence for every human life lies at the root of all medical tradition. Through the ages, this tradition has been expressed in the Oath of Hippocrates. It was rephrased in modern times in the Declaration of Geneva, which says in part, “I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.” We affirm this declaration.

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sent has become laudable and morally necessary.^{16, 17} The Netherlands now plans a committee to decide on such cases nationally.¹⁸ Even UK protagonists recognise that safeguards are limited and expect legislation to be incremental.² Yet therapeutic killing without explicit request, or of those lacking capacity, is the ultimate violation of autonomy. Although the principle of autonomy is extended for requesting individuals, this is at the expense of others' freedoms.

Such collateral damage from the entitlement to therapeutic killing is inescapable. Dutch legislation has failed to improve reporting beyond 54% of all cases or to limit therapeutic killing without consent,^{16, 19} which consistently accounts for about 1 in 7 of reported cases.¹⁶ Experience is similar in Belgium.²⁰ Oregon does not police its deaths. The size of this problem is unknowable, and the argument that this promotes autonomy in the sick population as a whole is misleading and unsustainable. Extrapolating the current Dutch figures to the United Kingdom suggests that at steady state, 13 000 deaths may result each year, with around 2000 occurring without request or consent.²

Moral consequences

In short, any safeguards have no ethical basis once any form of assisted suicide or therapeutic killing is sanctioned. The real question, therefore, is whether we are happy with the moral cost to society and loss of life among vulnerable patients as a result of reclassifying the freedom to die to the right to be killed.

Naturally, once promoted to a medical good, therapeutic killing becomes a legitimate consideration in resource management. In the first Dutch report in 1990, only one case was cited of a dying patient who was killed to free the bed,²¹ whereas in the latest survey, 15% of doctors were concerned about economic pressures.¹⁶ The nursing literature records similar experience.²²

Achieving a good death

Finally, suffering is extremely complex, part of our humanity, and not exclusive to people who are dying. Paradoxically, as disease overwhelms the dying person, the challenge is not how to be killed, but how either to hang on, or to let go, of life. Suffering can be mitigated but it requires the highly specialised skills and perseverance of a multidisciplinary team and goes well beyond controlling symptoms with drugs.²³

Although the presence of specialist palliative care is no argument against therapeutic killing, its absence certainly is, and lack of even basic, consistent provision across the UK is clear.²⁴ An average general practitioner cares for fewer than five dying patients a year; educational programmes consistently find general practitioners and hospital consultants are poor at controlling symptoms and relieving suffering, and many still believe that opioids and sedatives hasten death.^{25, 26} It is unsurprising, then, that many clinicians have seen suffering patients who they have been unable to help. Many doctors assume that they already kill frequently with analgesia or sedation when they do nothing of the sort.

On a balance of harms, legalising physician assisted suicide or therapeutic killing is a far greater risk than compassion for the small minority pleading to be killed might imply. In detailed evidence to the Select Committee the implications for individual doctors in the UK was glossed.² Every doctor caring for patients will be asked at some stage to assist suicide or kill therapeutically. Before another bill is laid before parliament every doctor must think through all the moral and practical implications for their own practice, for all the others in their clinical team, and, of course, for other patients in their care. Promoting autonomy for all is to help people understand that they can let go and to learn the skills to assist them to do that.²³ ♦

Competing interests: RJDG and DJ gave oral evidence to the Select Committee on the Assisted Dying for the Terminally Ill Bill on behalf of the Association for Palliative Medicine. IGF was a member of that committee.

Contributors and sources: The authors are among the national leaders in specialist palliative care, practising clinicians, and have researched, taught, and published widely in the discipline. IGF is also professor of palliative medicine, School of Medicine, Cardiff University. This article arose from discussions to distil the issues that emerged from a systematic literature review by RJDG of euthanasia and assisted suicide. RJDG is the guarantor.

This article appeared in the September 24 issue of the British Medical Journal. Reproduced with permission of Dr. R J D George.

References

1. British Medical Association. Assisted dying. www.bma.org.uk/ap.nsf/Content/Endoflifeissues?OpenDocument&Highlight=2,Annual,Representatives,Meeting,2005 (accessed 31 Aug 2005).
2. House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill. Report [HL Paper 86-I]. London: Stationery Office, 2005.
3. Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas PJ, van der Wal G. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med* 2000;342: 551-6.
4. British Medical Association, General Medical Council. Oral evidence to the select committee on the assisted dying for the terminally ill bill [HL] Vol II Evidence. London: HMSO, 2005.

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Summary Points

Any legislation will leave vulnerable groups open to therapeutic killing without consent

Since this is the ultimate violation of autonomy assisted suicide cannot be separated from euthanasia

Arguments that legalised euthanasia promotes autonomy do not stand

Doctors need to consider carefully the full implications of legalisation

staff of the Center for Reproductive Health Research and Policy (CRHRP), a pro-abortion advocacy center with a mandate to develop late abortion methods, and train doctors to perform late abortions.

This background in abortion advocacy is not disclosed by the authors. Drey's staff position at CRHRP, and the income source of the abortion clinic where she works, would appear to demand a disclosure here. Moreover, the spirit of disclosure appears to me to be violated by Drey and Lee. The article is not original research, but a review of existing research, and thus is much more subject to interpretive bias. Moreover, the late abortions that are of such interest to CRHRP are exactly the period of fetal life under discussion.

To make a comparison, were this an article on a new drug, the new ethical standards would demand that the authors disclose any important relationships to pharmaceutical companies. In the case of fetal pain, the equivalent would be any relationship to an "abortion provider." When called on her conflict, author Dr. Drey was quoted as saying, "I think my presence ... should not serve to politicize a scholarly report."

Incomplete review

The authors made much of the exhaustive nature of their review. One wire service reporter was led to believe that "nearly 2,000" studies were reviewed (actually, there are 96 references), but the authors admit these were confined to English-language articles.

While we cannot all read foreign languages, there are interpreters who can. Many of these articles are also accompanied by an English abstract (summary), including an authoritative fetal pain review in 2000 authored by four French authors. This study, which the authors missed, is more recent than many of the references cited in the JAMA article, and acknowledges the possibility of fetal

pain perception after 20 weeks gestational age.

A more subtle form of omission occurs when the authors reference Dr. K.J. Anand's landmark study published in the New England Journal of Medicine in 1987, "Pain and its effects on the neonate and fetus." The text that refers to the article discusses the definition of pain, but avoids Dr. Anand's major observations: that the final anatomical pain connections start to reach their destination on the cortical surface of the brain at 20 weeks; that the 20-week fetus has the full complement of 1 billion neurons; and synchronous brain wave (EEG) activity exists by 22 weeks.

For nearly two decades, Dr. Anand has been recognized as one of the world's foremost authorities on the subject of pain in the fetus and newborn. Following his breakthrough research in the anaesthesia department of Boston Children's Hospital and Harvard Medical School, Dr. Anand was given the prestigious honour of writing a state-of-the-art special review article on the topic for the New England Journal of Medicine. In an accompanying editorial, Washington neonatologist Dr. Anne Fletcher stated, "The excellent review ... should dispel the now outmoded notion that newborns are insensitive to or immune from pain."

Could it be that the authors wanted the appearance of a complete reference list (they could hardly ignore Anand's major study), but were unwilling to expand on its content, since it undermines their thesis that no fetal pain is possible before 29–30 weeks? Dr. Anand, one of the world's foremost authorities on fetal pain, told Knight Ridder reporter Marie McCullough, "They have literally stuck their hands into a hornet's nest. ... [T]his is going to inflame a lot of scientists who are very, very concerned and are far more knowledgeable in this area than the authors appear to be. This is not the last word—definitely not."

Self-contradiction

After devoting much of their analysis attempting to debunk the possibility of fetal pain perception before 29 weeks, the authors spend much of the second half of their review questioning whether specific forms of analgesia could be effective at relieving fetal pain during an abortion—pain they simultaneously deny exists.

The authors also contradict themselves on specific scientific points. First, they detail studies that document anatomical pain neuron connections reaching the surface cortex of the brain as early as 21 weeks (it's actually 20 weeks). Yet their Conclusions section misstates this as 29–30 weeks. Also, they correctly review data that show normal brain-wave (EEG) signals recorded in newborn preemies as young as 24 weeks (it's actually 22 weeks). Yet their Conclusions section distracts readers by referring to the age at which conscious (non-sleeping) EEGs are more commonly seen—"around 30 weeks."

In dismissing the use of analgesia for the fetus in abortion, the authors talk about the lack of any evidence of potential effectiveness or safety. Yet they ignore a paper quoted in their own review that describes an animal experiment in which an anaesthetic given by direct intra-amniotic injection (by needle into the baby's amniotic sac in the womb) resulted in fetal blood concentrations that would control postoperative pain in human adults. Moreover, by missing the 2000 French fetal pain paper, they did not review the proposed fetal anaesthesia protocol proposed by those pediatric experts.

Ignoring the obvious

Premature babies are now viable at a birth age of 23–24 weeks. The nation's Neonatal Intensive Care Units are full of tiny struggling preemies, many in the 23–30 week gestational age range under discussion in this paper.

(Continued on page 5...JAMA fetal pain study)

(JAMA fetal pain study...cont'd from page 4)

The only difference between a child in the womb at this stage, and one born and cared for in an incubator, is how they receive oxygen—either through the umbilical cord or through the lungs. There is no difference in their nervous systems. The implication of this paper's conclusion is that these newborn babies—no longer fetuses—cannot feel pain either. But the evidence demonstrating that they do is immense.

Physiologic responses to painful stimuli have been well documented, with over 20 years of research, in newborns of various gestational ages. Pain-induced changes in hormones, metabolism, and heart and breathing function are similar to those of adults, only greater.

For example, endorphins—the body's internal narcotic chemical—are released

in large amounts into the blood of newborns subjected to distress. Painful diagnostic procedures inflicted on preemies and newborns, such as the lancing of the baby's heel with a sharp piece of metal to draw a blood sample, reliably jolt the heart rate and blood pressure upward; sweating and breathing changes are also observed.

Simply giving a topical anaesthetic cream to newborn babies before circumcision will prevent these changes in heart rate and blood pressure, whereas giving a "pacifier" to the baby (a baby placebo, as it were) does not alter the babies' response to pain. Dr. Anand has concluded that "current knowledge suggests that humane considerations should apply as forcefully to the care of neonates (newborns) and young, nonverbal infants as they do to children and adults in similar painful and stressful situations."

Were the JAMA conclusions to be accepted, the effect would be to set back humane pediatric medicine 20 years, back to a time—barbaric, to paraphrase Dr. Fletcher's remarks—when doctors still believed babies could not feel pain. This article's conclusion is so ghastly (not to mention counter-intuitive), it may take some time for its import to sink in with the medical community, and the public at large.

This substandard, out-of-step review article—so manifestly created in response to proposed fetal pain awareness legislation—may well come to be seen as an overplayed hand, setting the abortion industry on a collision course with the humane modern practice of child-centered pediatric medicine. ♦

Paul Ranalli is a neurologist at the University of Toronto. This article first appeared in the September 2005 issue of National Right to Life News. Reprinted with permission.

(assisted suicide...cont'd from page 1)

physician-assisted suicide may superficially appear attractive, they have profound adverse effects on the social fabric of our society, on our attitude towards death and illness and on our attitude towards those who are ill or have disabilities.'

The brief warns that in the Netherlands, where euthanasia and physician assisted suicide have been legalized, at least 1,000 patients including children and newborn babies are being killed every year without their consent by doctors. Nearly one in ten deaths of newborn babies in Holland occurs after doctors administer medication to babies with the explicit purpose of hastening death.

The statement quotes UK palliative care specialists who warn that *'Euthanasia, once accepted, is uncontrollable for philosophical, logical and practical reasons. Patients will certainly die without and against their wishes if any such legislation is introduced.'*

The doctors state: *'It is easier and cheaper to kill a patient than to treat.'* The brief warns that once euthanasia or physician

assisted suicide has been legalized, this would put immense pressure on those who, due to illness or disability, consider themselves to be a burden to relatives or society. Patients or individuals with disabilities will be pressured into euthanasia or physician assisted suicide. This has been the case in Oregon, where physician assisted suicide has been legalized. Almost two-thirds of all those who died through physician assisted suicide in Oregon were at least to some extent motivated by the belief that they had become a burden to others. Yet the desire to die and the will to live frequently changes over time, especially if pain and depression have been treated. The 'wish to die' is rarely a truly autonomous decision.

The brief is very concerned that physician assisted suicide may be legalized because some think that this would allow for a 'good death'. However, medical evidence from Holland shows that nearly one in five patients who attempt physician assisted suicide was terminated by their doctors, because the procedure failed. Some patients took many

hours to several days to die, when they eventually succumbed to the poison they took – certainly not a 'death with dignity.'

The document warns that legalizing euthanasia and physician assisted suicide will have a very negative effect on the doctor-patient relationship. Patients will wonder whether the physician is wearing *'the white coat of the healer or the black hood of the executioner'*. The doctors state categorically: *'As physicians, we never want to become the executioners of our patients.'*

The document warns that it is impossible to legislate without this legislation being abused. A change in the legislation will only lead to further devaluing of human life, especially for the vulnerable members of society. The 'right to life' has been included in the Canadian Charter of Rights and Freedoms and must be protected. ♦

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2005 Medical Students Forum

Canadian Physicians for Life sponsored 50 medical students and two residents to attend our 2005 Medical Students Forum in Montreal, November 17-20. This event was an enormous success, thanks to the excellent speakers, enthusiastic audience, and the generosity of our donors.

Dr. Margaret Somerville spoke about the ethical implications of the new reproductive technologies. **Dr. Stephen Genuis**, in his first talk, traced some of the major developments leading to the sexual revolution, and discussed concrete solutions for dealing with issues such as the high rates of unintended pregnancy and sexually transmitted disease epidemic. In his second talk on end of life decisions, Dr. Genuis discussed the challenging decisions physicians encounter as they manage issues related to the latter stages of life. For example, when does a physician discontinue therapy or interventions? When should one NOT initiate treatment? And how do physicians deal with the issue of assisted death? Recipient of the Family 2004 Council Award of The College of Physicians and

Surgeons of Ontario **Dr. Deborah Zeni** discussed what is not taught in medical school—the aftermath of abortion, analyzing the literature on such issues as abortion's link to breast cancer, ectopic pregnancy, and risk of future pre-term birth. Students enjoyed the wisdom of **Dr. John Patrick** as he discussed what happens in society when we accept abortion practice. UBC Med Student **Sherry Yang** described how she and some classmates were successful in introducing a pro-life perspective into their reproductive choices lecture by bringing in **Dr. Sheila Harding** to address the class on "Finding the Balance: Observations on the Ethical Practice of Pro-Life Medicine." Dr. Harding then repeated that presentation to this audience. Students learned from these pro-life doctors important information not taught in medical schools. They also learned how to deal with colleagues and patients over contentious moral issues.

Students, residents and physicians also took part in the national pro-life conference on Friday where they heard such speakers

Photos of **Dr. Catherine Ferrier** (above) and **Dr. John Patrick** (right) courtesy of Tony Gosgnach, *The Interim*.



as: editor of Reader's Digest, **Peter Stockland**, who discussed the problem of media bias and what can be done about it in this high-tech information age; Professor **Ian Dowbiggin** discussed the history of euthanasia; **Dr. Catherine Ferrier** talked about the potential for palliative care; and more.

The student forum ended on an inspirational and humorous note when the keynote speaker at Saturday night's banquet, **Dr. Dave Hepburn**, addressed his audience on the theme, "What good have I done in the world today?"

And how did the students react to all of this? Here is what some of them said:

Lauren Beres, Class of 2007, University of Saskatchewan

Dear Canadian Physicians for Life,

On behalf of other medical students and myself who attended the CPL Medical Student Forum in Montreal this November, I wish to express our sincere gratitude for your support that made our attendance at this conference possible. We were able to learn valuable information at the conference that is not presented to us elsewhere in our medical education, and as a result we are better equipped to approach the pro-life issues we will face throughout our training. We also were able to interact with physicians who have more wisdom and experience in the practice of pro-life medicine, and they are an invaluable source of mentorship to us aspiring physicians. Thank-you for your investment in us, as the next generation of physicians who endeavor to practice medicine with honour and respect for life as a foundational principle.

Brian Dembinski, Class of 2008, University of Alberta

Coming into the pro-life conference I was a pro-life medical student who was feebly standing upon a few simple arguments that I had not thoroughly thought through. I knew that someday I would have to actively pursue important is-

sues if I was to have any chance at implementing my beliefs into my practice. Unfortunately, I have found that medical school is not an institution that develops ethical and moral thinking; if anything it has turned out to be one which removes them.

However, at the end of the conference I was an inspired medical student strengthened with the testimonies of practicing pro-life doctors who hold the tools to be able to talk about these issues with students, patients, and future colleagues. More than ever before I now feel that the pro-life stance is very defensible.

In particular, discussions about not referring for abortion were very useful. I have previously been taught that not referring for abortion is ethically considered to be abandoning your patient. The stories and evidence presented by speakers at this conference were very compelling and clearly revealed a high standard of care towards patients who were not referred by these doctors.



CPL president **Dr. Will Johnston** welcomes the students and residents Thursday evening.

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One of the strengths of the conference was that it addressed issues from several vantage points – medical, philosophical, ethical and faith-based. All of the speakers, no matter what their background, were interesting and gave talks that I felt were important for me as a medical student to hear.

Again, I would like to thank the Canadian Physicians for Life and the donors who made it possible for me to go to this conference. I would not have been able to attend without sponsorship. Thank you.

Dan Crompton, Class of 2008, UBC (Prince George)

The conference was an amazing experience for me. It was great to meet students and physicians who are working to further the pro-life cause. In the current climate of medical school it is becoming increasingly difficult to express, let alone hold, pro-life views. It was so encouraging to see how others are successfully acting on their beliefs in practice.

This conference impressed upon me the fact that unlike the vast majority of the population, doctors are in a very powerful position from which to help women and their babies. We will be directly involved in helping women make the decisions around a pregnancy she is not ready for. We are in the position to help her realize the value of the life inside her. We are in the position to save the life of her child! It impressed upon me a great sense of responsibility to act on my beliefs.

Discussing these issues with other pro-life students made me realize again how valuable the conference was. They, like I, were galvanized by the conference to act on their belief of the intrinsic value of life.

Thank you so much for sponsoring me. It changed the way that I will practice.

Marie-Claude Bourque, Resident, University of Montreal

I sincerely want to thank everybody who made this congress possible. I really enjoyed my experience at the congress and found it most inspiring and encouraging. I do feel sometimes quite alone in my belief in my work field, and hearing from the concrete experiences of other physicians who stand for the same values I do and who share a truly human and caring approach to their patients was very special for me. I especially enjoyed the talks from Dr Genuis. I do hope that such an event will take place again in the future.

2Lt Dave Lounsbury, Class of 2008, U of Western Ontario

As leaders in health care, physicians are charged with the enormous responsibility of deciding, at least on a microscale, who shall live, and who shall die. Traditionally, this task has been handled reverentially according to Hippocratic and Judeo-Christian ethics. Unfortunately, in North America, as in much of the developed world, the sanctity of the doctor-patient relationship has been violated by such forces as: healthcare economics, radical feminism, ageism, political correctness, and an attitude of selfish entitlement. When healthcare is influenced by these insidious factors, the inevitable result is death of the weak...the unborn, the debilitated, and the elderly...and survival of the strong...young, healthy citizens who spend, vote, and lobby their way toward ever greater power. There are at least two ways to combat such social Darwinism. The first, and most direct is to tear down the roots of systemic corruption, as exemplified by the overthrow of the Nazi regime. The second, less direct approach is to create a "silent revolution" of independent thinkers. Doctors can be made aware of the systemic devaluation of human life. After acknowledging the threat, they can be armed with the critical knowledge and persuasive tools to rise against it, one patient encounter at a time. Most importantly, they can become impassioned, fuelled by the greatest natural force of all: Love. I would humbly assert that all of these functions are being admirably fulfilled by Canadian Physicians for Life. ♦

Students enjoy some relaxation time at the banquet Saturday evening after a full weekend of intensive training.



In Support of Life: Comfort and Hope for the Dying (ISOL),

an educational initiative, originally developed under the auspices of the Massachusetts Catholic Conference, has been launched in the Roman Catholic Archdiocese of Ottawa this fall. This program is meant to be an introductory workshop, designed as a single-session overview of the Church teaching on End of Life issues.

Workshop objectives are to introduce basic information on the subject, to provide a forum for discussion that would engage participants in positive conversations about these issues, and to equip the participants who have need of compassionate care, information, or other services, with local referrals. Each workshop includes a fifteen-minute video presentation, followed by a group discussion, and finishes with a question and answer period during which local health care professionals respond to participants' questions. So far forty local parishes are taking part in this endeavor.

Any health professional interested in helping with this program or in bringing the workshop to his/her diocese is invited to contact:
Dr. Rene Leiva at
rene.leiva@mail.mcgill.ca

Health Canada requests public input on pre-implantation genetic diagnosis (PGD) regulations

"Pre-implantation Genetic Diagnosis (PGD), a technique that involves the genetic testing of in vitro embryos, is considered a controlled activity under the Assisted Human Reproduction Act. The regulation of PGD presents unique regulatory policy issues because of the social and ethical concerns it raises, and the speed of advancement in this field." (*Health Canada*.)

Health Canada is seeking input from the public regarding PGD regulations. It has prepared a document which gives background information on PGD and identifies issues surrounding the regulation of PGD under the AHR Act (www.hc-sc.gc.ca/ahc-asc/public-consult/col/pgd-dgp/index_e.html). The deadline for submissions was to be January 30, 2006, but due to the election, the consultation has been suspended for now. Health Canada's website will be updated as further information becomes available and a new submission deadline will be announced. ♦

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- don: Stationery Office, 2005: 125-6.
5. Ganzini L, Nelson HD, Lee MA, Kraemer DF, Schmidt TA, Delorit MA. Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon death with dignity act. *JAMA* 2001;285: 2363-9.
 6. Ganzini L, Nelson HD, Schmidt TA, Kraemer DF, Delorit MA, Lee MA. Physicians' experiences with the Oregon death with dignity act. *N Engl J Med* 2000;342: 557-63.
 7. Haverkate I, Onwuteaka-Philipsen BD, van der Heide A, Kostense PJ, van der Wal G, van der Maas PJ. Refused and granted requests for euthanasia and assisted suicide in the Netherlands: interview study with structured questionnaire. *BMJ* 2000;321: 865-6.
 8. Campbell J. A right to die? I'm more concerned that everyone has the right to live. *Times* 2004 Dec 2.
 9. Templeton S-K. Better for old to kill themselves than be a burden, says Warnock. *Times* 2004 Dec 12.
 10. Oregon Department of Human Services. Fifth annual report on Oregon's death with dignity act. <http://egov.oregon.gov/DHS/ph/pas/docs/year5.pdf>.
 11. Leenen JI, Gieselski-Carlucci C. Force majeure (legal necessity). Justification for active termination of life in the case of severely handicapped newborns after forgoing treatment. *Camb Q Healthc Ethics* 1993;2: 271-4.
 12. Van Thiel GJ, van Delden JJ, de Haan K, Huibers AK. Retrospective study of doctors' "end of life decisions" in caring for mentally handicapped people in institutions in the Netherlands. *BMJ* 1997;315: 88-91.
 13. Jochemsen H. Dutch court decisions on non-voluntary euthanasia critically reviewed. *Issues Law Med* 1998;13: 447-58. [ISI] [Medline]
 14. Sheldon T. Dutch GP cleared after helping to end man's "hopeless existence". *BMJ* 2000;321: 1174.
 15. Sheldon T. Euthanasia endorsed in Dutch patient with dementia. *BMJ* 1999;319: 75.
 16. Onwuteaka-Philipsen BD, van der Heide A, Koper D, Keij-Deerenberg I, Rietjens JA, Ru-rup ML, et al. Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. *Lancet* 2003;362: 395-9.
 17. Sheldon T. Dutch GP found guilty of murder faces no penalty. *BMJ* 2001;322: 509.
 18. Sterling T. Netherlands hospital euthanizes babies. http://aplancasteronline.com/4/netherlands_child_euthanasia (accessed 15 Sep 2005).
 19. Jochemsen H, Keown J. Voluntary euthanasia under control? Further empirical evidence from the Netherlands. *J Med Ethics* 1999;25: 16-21.
 20. Deliens L, Mortier F, Bilsen J, Cosyns M, Vander SR, Vanoverloop J, et al. End-of-life decisions in medical practice in Flanders, Belgium: a nation-wide survey. *Lancet* 2000;356: 1806-11.
 21. Dutch Department of Health. The Remelink report. The Hague: DoH, 1990.
 22. Hendin H. The Dutch experience. *Issues Law Med* 2002;17: 223-46.
 23. George RJD, Martin J. Non-physical pain: suffering in action. In: Hoy A, Finlay I, Miles A, eds. *The effective prevention and control of symptoms in cancer*. London: Aesculapius Medical Press, 2004: 107-26.
 24. House of Commons Health Select Committee. Palliative care fourth report session 2003-4. HC 454-I. London: Stationery Office, 2004.
 25. Sykes N, Thorns A. Sedative use in the last week of life and the implications for end-of-life decision making. *Arch Intern Med* 2003;163: 341-4.
 26. Thorns A, Sykes N. Opioid use in last week of life and implications for end-of-life decision making. *Lancet* 2000;356: 398-9.