



# VITAL SIGNALS

Spring 2012

Building a culture of  
Care, Compassion  
& Life...  
Canadian Physicians  
for Life

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## The Carter Case and Assisted Suicide: A Recipe for Elder Abuse and a Threat to Individual Rights

by Will Johnston, MD, Margaret Dore, JD, Alex Schadenberg

When you read this, the Carter case decision in BC will be on its way to being appealed.

Carter vs. Attorney General of Canada" (Carter) brings a constitutional challenge to Canada's laws prohibiting assisted suicide and euthanasia, seeking to legalize these practices as a medical treatment. In April 2010, a bill in Parliament seeking a similar result was overwhelmingly defeated.

Carter seeks to allow a medical practitioner or a person "acting under the general supervision of a medical practitioner" to assist a patient's suicide. Carter's Amended Notice of Civil Claim states: "physician-assisted suicide" means an as-

sisted suicide where assistance to obtain or administer medication or other treatment that intentionally brings about the patient's own death is provided by a medical practitioner . . . or by a person acting under the general supervision of a medical practitioner . . .".

"[A] person acting under the general supervision of a medical practitioner" would include a family member such as an adult child who administers medication to a parent in a home setting with no doctor present.

(Continued on page 2...Carter Case)

## "It's a girl!" — could be a death sentence

by Rajendra Kale, MD, CMAJ Editor-in-Chief

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When Asians migrated to Western countries they brought welcome recipes for curries and dim sum. Sadly, a few of them also imported their preference for having sons and aborting daughters. Female feticide happens in India and China by the millions, but it also happens in North America in numbers large enough to distort the male to female ratio in some ethnic groups.<sup>1-4</sup> Should female feticide in Canada be ignored because it is a small problem localized to minority ethnic groups? No. Small numbers cannot be ignored when the issue is about discrimina-

tion against women in its most extreme form. This evil devalues women. How can it be curbed? The solution is to postpone the disclosure of medically irrelevant information to women until after about 30 weeks of pregnancy.

A pregnant woman being told the sex of the fetus at ultra-sonography at a time when an unquestioned abortion is possible is the starting point of female feticide from a health care perspective. A woman has the right to medical information about herself that is available to a health care professional to provide advice and treatment. The sex of the fetus is medically irrelevant information (except when managing rare sex-linked illnesses) and does not affect care. Moreover, such in

(Continued on page 5...It's a girl!)

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Canadian Physicians for Life, a  
registered charitable organization.

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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*(Carter Case...continued from page 1)*

Carter argues that laws prohibiting physician-assisted suicide are unconstitutional for patients who are "grievously and irremediably ill." The term "grievously and irremediably ill" is not defined. The Amended Notice of Civil Claim does, however, give these examples of qualifying diseases/conditions: "cancer, chronic renal failure and/or cardiac failure, and degenerative neurological diseases such as Huntington's disease and multiple sclerosis." The phrase, "grievously and irremediably ill" would also appear to apply to chronic conditions such as diabetes and HIV/AIDS. People who have these conditions can have years and sometimes decades to live.

Carter does not seek to require that the death be witnessed or that a medical practitioner be present at the patient's death.

#### *A Comparison to the United States*

In the United States, there are two states where physician-assisted suicide is legal: Oregon and Washington. In each state, assisted suicide laws were passed via highly financed sound-bite ballot initiative campaigns. A ballot initiative is similar to a referendum in Canada. In the United States, no assisted suicide law has made it through the scrutiny of a legislature despite more than 100 attempts.

#### *A Recipe for Elder Abuse*

Elder abuse includes physical, psychological and financial abuse. Financial abuse is the most commonly reported type. Elder abuse is, however, largely unreported and can be very difficult to detect, due in part to the reluctance of victims to report. The Government of Canada website states: "Older adults may feel ashamed or embarrassed to tell anyone that they are being abused by someone they trust."

Elders' vulnerabilities and relative wealth have led to murder with the perpetrators often being family members. An example is Canadian Melissa Friedrich, the "Internet Black Widow." She killed her first husband and is accused of poisoning her second husband and another elderly man in order to get their money. Consider also this comment from Nancy Elliott, a former member of the New Hampshire House of Representatives:

"Assisted suicide laws empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has

money. There is NO assisted suicide law that you can write to correct this huge problem."

Preventing elder abuse is official Government of Canada policy.

#### *Empowering the Healthcare System and steering people toward suicide*

In Oregon, where assisted suicide has been legal since 1997, people desiring treatment under the Oregon Health Plan have been offered assisted suicide instead. The most well known cases involve Barbara Wagner and Randy Stroup. Each wanted treatment. The Plan offered them assisted suicide instead.

With legal assisted suicide, the health-care system, doctors and the government would be empowered, not individual patients.

#### *Legal Assisted Suicide Encourages People to Throw Away Their Lives*

Oregon resident Jeanette Hall, who was told that she had six months to a year to live, states:

"I wanted to do what our [assisted suicide] law allowed, and I wanted my doctor to help me. Instead, he encouraged me not to give up, and ultimately I decided to fight my disease. . . . It is now 11 years later. If my doctor had believed in assisted suicide, I would be dead." [42]

Consider the New Hampshire House of Representatives report in rejecting an assisted suicide bill in 2011: "[T]his bill would legalize state-sanctioned suicide for people with terminal illnesses and that this is an area where government does not belong. People with terminal illnesses who may consider suicide do not need encouragement from the government. . . . The committee also recognizes that doctors' diagnoses and predictions may be incorrect; numerous cases exist where people have lived far beyond their doctor's predictions, some of them having been cured from their terminal disease. For these reasons, the committee strongly believes that this bill represents bad policy and practice and [recommends that the bill be defeated]." It was, 234 to 99.

#### *Suicide Contagion*

Oregon's suicide rate, which excludes suicides under its physician-assisted suicide law, has been "increasing significantly" "since 2000. Just three years

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*(Carter Case...continued from page 2)*

prior, Oregon legalized physician-assisted suicide. This increase in other suicides is consistent with a suicide contagion. In other words, one type of suicide encouraged other suicides. In Canada, preventing suicide is a significant public health issue.

### *Doctor and Heir Protection*

Carter uses a Charter of Rights claim to protect suicide enablers:

"The right to liberty of persons who assist . . . [a] person to obtain physician-assisted dying services [physician-assisted suicide] must necessarily be protected in order to give meaning to the [Charter section 7] life, liberty and security of the person rights of grievously and irremediably ill persons."

With doctors and other assisting persons protected with a constitutional right, a patient subjected to their actions would be left with little or no recourse.

### *Conclusion*

Carter's claim that legalization of assisted suicide will enhance individual rights is untrue. Legalizing assisted suicide would instead be a recipe for elder abuse. Heirs and other predators would be empowered at the expense of the individual rights of older Canadians to safety and security. Legalization would also empower the health care system, doctors and the government to steer patients to suicide. Some individuals with many quality years left would be encouraged to kill themselves. In Oregon, other suicides have increased with legalization of assisted suicide. Canada does not need the "Oregon experience."

*For the full article and references, go to [www.epcbc.ca](http://www.epcbc.ca)*

“

Those who believe that legal assisted suicide . . . ”  
will assure their autonomy and choice are naïve.

**William Reichel, MD, Montreal Gazette, May 30, 2010**

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## **Announcing CPL's 2012 Annual General Meeting**

You are invited to attend CPL's 2012 Annual General Meeting  
in Winnipeg this November.

**Friday, November 9, 2012**

**5:30 p.m.**

**Delta Winnipeg Hotel**

**350 St. Mary Avenue  
Winnipeg, MB**

**Please RSVP:**

**Email:** [info@physiciansforlife.ca](mailto:info@physiciansforlife.ca)

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## Canadian Physicians for Life: Statement on provincial funding of abortion

In these times of strained health care resources, it is more imperative now than ever that government be streamlining spending in the health care sector. A necessary step in doing this is to identify those services which are not medically necessary and delist them. It is our opinion that abortion is never medically necessary and should be defunded provincially.

Under Canadian law, provinces are required to fund all “medically necessary” services. However, it is never clearly defined as to which services should be considered necessary, and which should not. Thus, there is room for discussion about the medical necessity of each individual service. The reasons given for abortion being necessary have traditionally centered around the notions of the emotional well-being of the woman, the potential physical harm to a mother surrounding certain complications during pregnancy, as well as the possibility of fetal abnormalities identified during pregnancy for which termination is the common “treatment”.

“ It is our strong belief that no abortions are medically necessary. Moreover, the funding of this procedure by governments represents extreme waste of health care resources. ”

The emotional health of a woman who finds herself in a crisis pregnancy and does not wish to parent a child is often given as a justification for why abortion is a required medical service. The emotional health of these women is certainly of the utmost importance, however there is no good scientific evidence that says abortion positively impacts mental health outcomes for women in crisis pregnancies. Actually, the opposite is more likely true. There is evidence that abortion *negatively* impacts woman’s mental health with respect to depression, anxiety disorders, and suicidal behavior.

There are infrequent cases in which pregnancy can place the physical health of a woman in jeopardy. Although induced abortion is often heralded as the sole treatment for these conditions, invariably it is not the only option. Rather, treatment of the underlying condition should be the course of action, and although it may

result in the loss of the pregnancy, this situation is far different from an induced abortion which *targets* destruction of the fetus as its end. So even in these difficult situations, abortion should not be considered as a medical necessity, given that other treatments exist which also preserve the physical well-being of the mother.

When it comes to instances of fetal abnormalities detected during pregnancy, an important comment needs to be made: In any pregnancy, there are two patients. One being the woman, and one being the fetus that she is carrying. This principle should be self evident to any physician involved in prenatal care. The practice of terminating pregnancy based on the characteristics of the fetus is tantamount to eugenics and should no longer be accepted. In the first place, identification of adverse health status of the fetus should prompt a physician to pursue appropriate medical treatment if it is possible, not simply “terminate” the patient who has the health concern. Abortion does not *treat* a medical condition of the fetus, rather it simply removes the patient who has the condition. Secondly, the perceived ill health of the fetus does not even need to be based in reality due to the wide availability of abortion on demand. Currently, parents may simply *decide* that the fetus does not meet their skewed requirements of “healthy”, and an abortion can be procured without question. Discussions about sex selection abortion have pervaded both mainstream media as well as medical journals across the country in recent months. Nearly everyone should feel uneasy about their tax dollars paying for such a great offense to the dignity of women. In reality, though, we should encounter the same uneasiness about termination of pregnancy based on a medical diagnosis detected in the fetus. It is discrimination against those with disabilities to selectively abort fetuses simply because they will be disabled, just as it is discriminatory against women to abort female fetuses simply because they are female. For these reasons, detection of fetal abnormalities shouldn’t be considered to constitute a medically necessary abortion, and furthermore, it represents gross discrimination by the medical community.

In conclusion, it is our strong belief that no abortions are medically necessary. Moreover, the funding of this procedure by governments represents an extreme waste of health care resources. These resources could be put to much better use in virtually any sector of the health care system to deliver quality care where it is truly needed.

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*Ryan Wilson is a medical student and a Board Member of Canadian Physicians for Life*

(It's a girl!...continued from page 1)

formation could in some instances facilitate female feticide. Therefore, doctors should be allowed to disclose this information only after about 30 weeks of pregnancy — in other words, when an unquestioned abortion is all but impossible. A similar proposal has been made elsewhere.<sup>5</sup> Postponing the time when such information is provided is a reasonable ethical compromise. It would still allow prospective parents enough time to prepare the nursery.

The College of Physicians and Surgeons of British Columbia states that testing to identify sex during pregnancy should not be used to accommodate societal preferences, that the termination of a pregnancy for an undesired sex is repugnant and that it is unethical for physicians to facilitate such action.<sup>6</sup> The college in Ontario states that it is inappropriate and contrary to good medical practice to use ultrasound solely to determine the sex of the fetus.<sup>7</sup> The Society of Obstetricians and Gynaecologists of Canada says that the problem of the small number of pregnant women who may consider abortion when the fetus is of unwanted sex is best addressed by the health professionals who are providing care for these women, but it does not say how this can be done effectively.<sup>8</sup> These statements do little more than provide lip service to tackling female feticide and a band-aid for the souls of those who draft policy. Fortunately, the Canadian Assisted Human Reproduction Act of 2004 prohibits any action that would ensure or increase the probability that an embryo will be of a particular sex or identifies the sex of an in-vitro embryo, except to prevent, diagnose or treat a sex-linked disorder or disease — thus closing this avenue for sex selection.<sup>9</sup>

The colleges need to rule that a health care professional should not reveal the sex of the fetus to any woman before, say, 30 weeks of pregnancy because such information is medically irrelevant and in some instances harmful. Doing so should be deemed contrary to good medical practice. Such clear direction from regulatory bodies would be the most important step toward curbing female feticide in Canada.

Some readers might be skeptical about whether female feticide is in fact taking place in Canada and the United States. Research in Canada has found the strongest evidence of sex selection at higher parities if previous children were girls among Asians — that is people from India, China, Korea, Vietnam and Philippines.<sup>2</sup> What this means is that many couples

who have two daughters and no son selectively get rid of female fetuses until they can ensure that their third-born child is a boy. These researchers have also documented male-biased sex ratios among US-born children of Asian parents in the 2000 US census.<sup>3</sup> A small qualitative study in the US involving 65 immigrant Indian women documents the pressure they face to have sons, the process of deciding to use sex selection technologies, and the physical and emotional health implications of both son preference and sex selection. Of these women, 40% had terminated pregnancies with female fetuses and 89% of the women carrying female fetuses in their current pregnancy pursued an abortion.<sup>4</sup> Results from this study could be reasonably extrapolated to Indians in Canada. We should, however, avoid painting all Asians with the same broad brush and doing injustice to those who are against sex selection.

The execution of a “disclose sex only after 30 weeks” policy would require the understanding and willingness of women of all ethnicities to make a temporary compromise. Postponing the transmission of such information is a small price to pay to save thousands of girls in Canada. Compared with the situation in India and China, the problem of female feticide in Canada is small, circumscribed and manageable. If Canada cannot control this repugnant practice, what hope do India and China have of saving millions of women?

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## Medical Student Pro-Life Club Awards

Each year, medical students across Canada form pro-life campus groups focused on life issues in the context of medical research and practice. Clubs give presentations, hold debates, and host Hippocratic Oath ceremonies, movie nights and other events that present topics such as abortion and euthanasia in respectful and informative ways that engage fellow medical students in thoughtful discussion.

Canadian Physicians for Life, with the support of members and donors, proudly supports pro-life medical student clubs financially. Beginning in 2012, CPL will be naming awards in honour of one of its founding members, and a dedicated champion of life, Dr. Paul Adams.

To donate to the Dr. Paul Adams Award fund, or to apply for club funding, please contact [info@physiciansforlife.ca](mailto:info@physiciansforlife.ca).

# Access to abortion on PEI:

by Sean Murphy

Sean Murphy is the Administrator of the Protection of Conscience Project. [www.consciencelaws.org](http://www.consciencelaws.org)

While there is nothing to prevent physicians and hospitals from providing abortion on Prince Edward Island, abortions have not been performed in the Garden of the Gulf for almost thirty years. It seems likely that one of the reasons that abortion is not available on the Island is opposition to the procedure among island residents, including health care workers.<sup>1</sup>

In early November, 2011, the P.E.I. Reproductive Rights Organization (PEIRRO) was formed to lobby for easier access to abortion. Proposals least likely to impact freedom of conscience for health care workers involve dropping the requirement for physician referrals, paying for abortions done in clinics and paying the associated travel costs.<sup>2</sup>

However, PEIRRO not only seeks access to abortion from those willing to provide or facilitate the procedure, but targets those who are not. It encourages people to make complaints of professional misconduct against physicians who decline to refer for abortion for reasons of conscience.<sup>3</sup> Its website links to a publication from an American group, the National Abortion Federation.<sup>4</sup> The attempt to characterize the exercise of freedom of conscience by physicians as 'professional misconduct' may surprise Islanders who remember the promises made when abortion was legalized in Canada over forty years ago.

In 1967 the Globe and Mail applauded a government decision "that where religious moralities conflict, the State should support none, but leave the choice to individual conscience," adding that the policy "should also be followed with abortion."<sup>5</sup>

Two years later, in supporting the bill to legalize abortion, the Canadian Welfare Council commented, "At the risk of labouring the obvious, no woman will be required to undergo an abortion, no hospital will be required to provide the facilities for abortion, no doctor or nurse will be required to participate in abortion."<sup>6</sup>

And during the Commons debate, Justice Minister John Turner rejected a protection of conscience amendment - proposed by a "pro-choice" opposition member - because, he said, the proposed law imposed no duty on hospitals to set up committees, imposed no duty on doctors to perform abortions, and did not even impose a duty on doctors to initiate an application for an abortion.<sup>7</sup>

## how not to resolve the controversy



Such statements probably convinced many in the medical profession that they had nothing to fear from legalization of abortion. Forty years ago they could not have imagined that physicians unwilling to provide or facilitate abortion would be called "scum" and told to "resign from medicine and find another job."<sup>8</sup>

Yet this is precisely the attitude that recently led an 'expert panel' of the Royal Society of Canada to recommend that objecting physicians be forced to refer for euthanasia and assisted suicide, should these procedures be legalized. According to the report, physicians who are unwilling to provide what it delicately terms "certain reproductive health services" are obliged to refer patients to others who will. Therefore, physicians who refuse to provide (legal) euthanasia or assisted suicide for patients "are duty-bound to refer them in a timely fashion to a health care professional who will."<sup>9</sup>

The logic of the panel is impeccable, but the conclusion depends on the validity of the first premise: that objecting physicians are obliged to refer patients for abortion. Encountering this serenely confident assertion in the report, one would never know that it is contradicted by the Canadian Medical Association<sup>10</sup> and flatly denied or hotly contested by others. When one of the members of the expert panel, Jocelyn Downie, made such claims in the *Canadian Medical Association Journal*, she was soundly rebuked by physicians, and the CMA responded with an affirmation that referral for abortion is not required.<sup>11</sup>

The response of all physicians to a woman considering an abortion ought to be compassionate, demonstrate care and concern for her and provide sufficient information about legal options to permit her to make an informed decision. An objecting physician must, in addition, do this in a way that does not involve complicity in a patient's decision to choose abortion, something that some may find challenging. Discussion of such difficulties with sympathetic or like-minded colleagues may suggest approaches that will overcome them, benefiting patients and physicians alike.

(Continued on page 7...PEI)

(PEI...continued from page 6)

With some imagination and political will, those who want to provide access to abortion for PEI residents can do so without suppressing the fundamental freedom of health care professionals. In fact, a legislated guarantee of that freedom could contribute to a resolution of the current controversy. In the meantime, the chances of a resolution will not be improved by specious accusations of professional misconduct.

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more than twice what it cost PEI to provide abortions that year. National Abortion Federation, *Annual Report-2010*

([http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_naf/annual\\_report\\_2010.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_naf/annual_report_2010.pdf)) Accessed 2012-12-30).

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## Announcing the

# 2012 MEDICAL STUDENTS FORUM

November 9 - 11, 2012

Delta Hotel

Winnipeg, MB

Canadian Physicians for Life will be hosting this year's Medical Students Forum , November 9 -11, in Winnipeg, MB.

We offer to pro-life medical students a broad range of seminars and workshops designed to not only inform them with regards to sensitive and emerging issues, but to equip them with the confidence to 'make their case' when interacting with colleagues and the public who may question their stance on life issues. Pro-life medical students and residents are encouraged to apply for a scholarship to attend.

We also encourage our physician and retired physician members to attend the forum. This is a great opportunity to network with pro-life colleagues, and interact with some exceptional medical students from across Canada.

Speaker and session information, as well as scholarship applications, will be available on the Canadian Physicians for Life website ([www.physiciansforlife.ca](http://www.physiciansforlife.ca)) at the end of August.

Advance registration is required. Contact KC McLean - D' Août at [info@physiciansforlife.ca](mailto:info@physiciansforlife.ca) or 613.728.5433 for more information.



*Vital Signs will be running a series of cases for reflection on a relevant topic related to medical ethics or challenging scenarios with colleagues in order to spark discussion among our readers and members.*

## Pro-Life Case File #2: Accutane

### Case

A 32-year-old nurse was interested in having a third child but at the moment her cystic acne was distressing her. She had tried topical agents to no avail and she wanted to avoid further scarring and so Accutane was offered. The patient was aware of the high birth defect risk with Accutane and agreed to avoid intercourse and to continue the birth control pill which she had used for years. She began her first month of Accutane with a negative serum hCG and returned at the end of the month delighted with the improvement in her acne. A second month's prescription was given but the pregnancy test was not repeated. The patient suspected she was pregnant three weeks into the second course of Accutane and stopped the medication. Two days later she reported the situation to the family physician. Ultrasound a week later confirmed a 6 week 5 day gestation. This meant that she had taken Accutane 60 mg daily for the first three weeks of the baby's existence, starting about the day of conception.

### Context

Accutane exposure in a series of 154 cases referenced below (1) was followed by 95 induced abortions. Of the remaining 59 pregnancies, 26 babies had no major malformations, 12 miscarried, and 21 had malformations (chiefly ear defects). A subset of 36 of the 154 were followed prospectively and resulted in 8 miscarriages, 23 normal babies, and 5 babies with malformations. In general, Accutane exposure in the first trimester is followed by about 20% miscarriage and 30% malformation rates.(2) Among outwardly normal infants, there is an uncertain but substantial rate (perhaps 30-60%) of neuropsychological problems.(3) There is no data which would allow us to stratify risk based on Accutane dose and gestational age during the time of exposure.

### Response

This information was shared with the patient and her husband. They were firm in their hope that the child would do well and steadfast in their rejection of induced abortion. They were reassured by a normal 20 week ultrasound. A normal labor at 38 weeks gestation revealed a healthy 6 pound baby boy with skin tags beside each ear and atresia of one external ear canal (a dimple rather than an ear canal) but normal hearing on that side as tested by ABR. His growth and development at 9 months of age appears normal. He smiles a lot.

These parents are grateful that they are not among the majority who would have discarded this child.

### Notes

1. Retinoic acid embryopathy. Lammer EJ, Chen DT, Hoar RM, Agnish ND, Benke PJ, Braun JT, Curry CJ, Fernhoff PM, Grix AW Jr, Lott IT, N Engl J Med. 1985;313(14):837.
2. What is the chance of a normal pregnancy in a woman whose fetus has been exposed to isotretinoin? Sladden MJ, Harman KE, Arch Dermatol. 2007;143(9):1187.
3. National Teratology Information Service. *Exposure to Isotretinoin During Pregnancy*. Newcastle upon Tyne, England: National Teratology Information Service, Regional Drug and Therapeutics Centre; 2001.

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