



Professionalism: The New "Ethics"

by Ugo Nzekwu, Thomas Bouchard and Benjamin Turner

Inside this issue:

Professionalism: The New "Ethics"	1
Impact of new prenatal screening in Denmark	1
2008 Medical Students Forum (in words and pictures)	4
Dying as the last great act of living (Margaret Somerville)	6
Organizational Update (New CPL board members)	7
Whose Life is it Anyway? Assisted Suicide in Canada (response to Dr. Jocelyn Downie)	8

"Professionalism" is the new ethical buzz word in medical education. Despite nuances in individual definitions, all 17 Canadian medical faculties have a professionalism component in their curriculum. Our clinical skills classes have "professionalism" as the fundamental ideal, our ethics classes use "professionalism" as their guiding principle, and even our pledges as physicians are now "professionalism oaths." Its importance is further demonstrated by the presence of a special resource group bearing its name within the Association of Faculties of Medicine of Canada (www.afmc.ca/social-professionalism-e.php).

Unfortunately, in some medical schools "professionalism" has become a bludgeon with which conscientiously-objecting medical students are suppressed into silence. When

respectful disagreement and questioning related to issues of contraception and abortion are labelled as unprofessional, there is clearly a need to re-visit its definition and applications.

No professionalism oath to our knowledge in Canada insists that its students suppress conscience, values and morals in favour of indoctrination. In fact, the International Charter on Professionalism, a guiding document for medical school curricula, states that one of the fundamental principles of professionalism is the "Principle of the primacy of patient welfare," and underlines that "market forces, societal pressures and administrative exigencies must not compromise this principle." It seems obvious that a pro-life medical

(Continued on page 2...new ethics)

Impact of new prenatal screening in Denmark

by Elizabeth Ring-Cassidy and Elaine Zettel

"With giddy amounts being spent on research into stem cell and other therapies and new diagnostic tests for congenital conditions, the Down's story is a reminder that sometimes we can get too carried away with the science of prevention, forgetting that some conditions are only severely disabling because we're not investing enough in supporting families affected by them. Sometimes science isn't everything. In the case of Down's syndrome, if our attitudes changed and our support services were up to scratch, much of it would be simply unnecessary."

- from Simon Crompton, "A New Perspective on Disability", *Times*, Nov 29, 2008

Crompton's insights (see sidebar) are especially timely, considering a recent study¹ published in the *British Medical Journal* in November 2008. Ekelund et al.'s paper is one of today's best examples of a purely eugenic article. Given that the screening programs introduced in Denmark are similar to Canada's prenatal screening program, and that news continues to circulate about new prenatal genetic tests becoming available², now is the time to critically examine the implications of these new screening programs.

New screening guidelines

Denmark is a small country (65,000 pregnancies per year) with a well devel-

oped medical tracking system. This provided them with a unique opportunity to study the new nationwide prenatal screening program. Ekelund's research examines the impact of new guidelines for prenatal screening and diagnosis that were issued by the Danish National Board of Health in September 2004. It is a one-outcome study that focuses on how many children with Down Syndrome are born annually.

Prior to 2004, prenatal screening and testing were offered in the second trimester, and focused on women over the age of 35 or who were at risk of an inherited disease. The new guidelines

(Continued on page 3...prenatal screening)

Vital Signs is published by 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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(new ethics...cont'd from page 1)

student seeking primarily to ensure patient welfare is justified in opposing societal pressures that insist on abortion, euthanasia and other initiatives that involve the taking of human life. Further, the charter principle of "patient autonomy," which advises physicians to "be honest with their patients and empower them to make informed decisions," should elicit a medical student's surprise and indignation when lectures on abortion and contraception are presented with little thought given to their realities or consequences. These are two of many examples contradicting the misleading message given by some professors that being pro-life and being professional are mutually exclusive.

From the time of Hippocrates, physicians have recognized the role of a universal set of principles both to unify the profession and to establish a contract with society. However with the advent of the de-criminalization and subsequent promotion of abortion, many began to question the relevance of the original Hippocratic Oath that was clearly opposed to this societal evolution: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect . . . [similarly,] I will not give a woman an abortive remedy." It is clear to many that medical students cannot profess an oath they do not intend to abide by. Advocating for a return of all medical schools to the Hippocratic Oath when many would profess it falsely would serve little use. In the absence of the Hippocratic Oath, for today's physicians and students, professionalism oaths may encompass our philosophy, responsibilities and competencies. We ask only that the same freedom of conscience which still applies to physicians, and which the Canadian Medical Association still affirms, applies also to medical students. In order that this freedom is maintained, lectures, best-practice guidelines and college rulings that do not support freedom of conscience, or at least that professors claim do not, should be respectfully questioned and opposed.

Far too few of the students who start medicine with moral convictions graduate with those convictions intact. Medical education has become increasingly coloured with deliberate conscience-suppressing messages. To the average pro-life medical student, isolation and marginalization are perhaps the biggest hurdles to retaining morals and values post-medical education. It can appear that everyone -- including the university faculty, peers and patients -- disagrees wholeheartedly with the pro-life ethic. If

one succeeds in retaining ethical integrity to the end of pre-clerkship, clerkship for the pro-life student can be an exhausting obstacle course to navigate.

Confronting differing world-views in interactions with patients and hospital staff is the reality of medicine in even the most ideal situation. However, as some medical students have experienced, tutors, preceptors and supervisors can be the primary sources of persecution. In our increasingly hostile society, pro-life medical students must be able to articulate their position well. However, even the best-formed medical students need role models. There is an urgent need for pro-life doctors to get more involved in the education of the medical students in their community.

The idea of mentorship is a key element of the Hippocratic Oath ("...to teach them this art - if they deserve to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and taken an oath..."). It is true that this concept of mentorship is not always present in more recent translations of the oath, but without it, our cause is most likely lost. It is good for pro-life medical students to take an oath that affirms our respect for life. However without the tools necessary to practice what we affirm, we can become discouraged, and easily swayed from the specialties that first interest us. Anecdotally, there are medical students who choose not to apply for Family Medicine or Obstetrics and Gynaecology because they do not know how they will get around contentious issues. Some students are even discouraged from going into such specialties by well-meaning, experienced physicians who are afraid for the younger generation of doctors. This is not acceptable. We cannot perpetuate this phenomenon of isolation and marginalization.

This year Canadian Physicians for Life will be establishing a medical student's corner on the website to counter some of the effects of the current culture. There will be a forum to help pro-life medical students understand they are not alone, and a mechanism for mentorship so that pro-life medical students can be connected with pro-life doctors. So if we may, here is a rally cry for all pro-life physicians not already involved in some form of medical education:

Please get involved! We need you!

(Continued on page 3...new ethics)

(new ethics...cont'd from page 2)

By way of initiatives like the CPL Medical Students Forum, Hippocratic Oath profession ceremonies for pro-life medical students, and mentorship we are sure to help students correctly incorporate the professionalism mantra within excellent, pro-life medicine.

Ugo Nzekwu, Thomas Bouchard, and Benjamin Turner are medical students from U of Ottawa, U of Calgary, and U of Western Ontario respectively and were elected to the CPL board of directors at last year's AGM.

(prenatal screening...cont'd from page 1)

recommend that all women be offered information about screening methods, and "a combined risk assessment for Down's syndrome in the first trimester based on a combination of maternal age, nuchal translucency scanning, and a biochemical test for serum free β human chorionic gonadotrophin and pregnancy associated plasma protein A, called the double test."³ Women who have a high risk for carrying a child with Down Syndrome are then offered an invasive test – either chorionic villus sampling or amniocentesis.

Impact of the new guidelines

Research indicates that the maternal age in Denmark has risen steadily in recent years. Given a high maternal age, the expected number of children born with Down Syndrome in the whole

Prenatal Screening : An assessment of the developing baby to determine if there is an increased chance for conditions such as chromosome disorders or structural problems. The risks are calculated using a combination of variables including: biochemical serum markers collected from blood work, maternal age, maternal ethnicity, maternal weight, maternal diabetic status, and possibly a nuchal translucency (NT) ultrasound measurement.⁴

Prenatal Testing : Amniocentesis or chorionic villus sampling are invasive tests that are typically done in the second or third trimester. These tests pose some risk to the fetus and the mother, but are also more definitive. Non-invasive blood tests to develop fetal Down Syndrome are currently being developed.⁵

population was benchmarked at 132-135 before the introduction of any prenatal testing. Testing that was done before the introduction of the new nationwide screening program resulted in a decrease to 55-56 born with Down Syndrome annually. Now, as a result of the new guidelines for prenatal screening, **the number of children with Down Syndrome born annually in Denmark dropped from 55-56 to 31-32 children.** In total, now over 100 children with Down Syndrome are terminated before birth each year in Denmark.

In addition, the number of women undergoing screening in the first trimester increased, while the early screening has reduced the number of women who undergo invasive and potentially risky testing later in pregnancy. In this population there was a cohort of women who screened positive for Down Syndrome, but chose not to have an invasive test due to the risk of miscarriage. Also, in 2006 sixteen percent of pregnant women refused the screening and testing entirely.

What the study failed to address

It is unknown whether the new screening program in Denmark tests for other conditions besides Down Syndrome, as only the impact on Down Syndrome was discussed. The Ekelund study made no reference to psychological or sociological implications of the screening program, did not discuss the nature of consent, and also failed to address the factors that might have contributed to the change in the rate of uptake of the screening.⁶

The rate of uptake of the screening increased significantly between 2005 and 2006. It was not discussed whether the change was due to an attitudinal change toward people with disabilities, or whether it was a result of pressure on women to participate in the new nationwide screening program.

Questions around consent and decision-making are essential, especially in light of another Danish study which showed that while 48% of parents indicated prior to prenatal screening that they would consider abortion in the event of a positive test, in fact 98% of fetuses diagnosed with Down Syndrome were terminated. This led the

authors to comment that:

"Health professionals are important sources of information and counseling and their views may have significant influence upon women's decisions to accept risk assessment and to terminate an affected pregnancy."⁷

Conclusions

This study reveals the significant impact that a nation-wide screening program can have on the birth rate of persons with developmental disabilities. It should serve as a warning to those concerned about similar eugenic practices in Canada. While previous testing programs had reduced the children with Down Syndrome born annually in Denmark to 55-56, the new prenatal screening program now facilitates the detection and termination of 25 more children each year. ♦

Elaine Zettel is the executive director of the deVeber Institute for Bioethics and Social Research. Elizabeth Ring Cassidy is a psychologist and senior researcher for the deVeber Institute.

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- ² A new non-invasive blood test for Down Syndrome has been developed, and Sequenom Inc., an American biotech firm, plans to have the test available online by June 2009. <http://www.theglobeandmail.com/servlet/story/RTGAM.20090206.wbabies07/BNStory/National/>.
- ³ Ekelund et. al.
- ⁴ http://www.lhsc.on.ca/programs/rmgc/mss/what_mms.htm
- ⁵ <http://phx.corporateir.net/phoenix.zhtml?c=84955p=irol-newsArticle&ID=1231204&highlight=>
- ⁶ In 2005 the rate of uptake of prenatal screening was 63%. By 2006 the rate of uptake had increased to 84%. The study showed that the children who were born with Down Syndrome came from both groups of women: those who had undergone screening, and those who had refused the screening.
- ⁷ Nordvig L, Secher NJ, Hjort J; "Hunting Down's." *Health Technology Assessment International. Meeting (2nd : 2005 : Rome, Italy). Ital J Public Health.* 2005; 2: 133.

See Newsletters on www.deveber.org for more research and analysis from the deVeber Institute about prenatal testing, perinatal palliative care and much more.

2008 Medical Students Forum

Thank You!

Once again the feedback from this year's Medical Students Forum was excellent! Your generosity enabled over 60 medical students and residents from across Canada to attend two days of pro-life seminars, workshops, and panel discussions.

Informal conversations were just as enriching as the time spent in sessions. Students from different medical schools and the experienced physicians and presenters exchanged ideas and experiences in impromptu talks held over meals, in hallways, and in the lingering discussions that took place after each session.



"The conference was excellent....I found the sessions really useful to provide me with a backbone as I start my career in medicine and holding pro-life views in what increasingly seems to be pro-choice world. The conference gave a lot of food for thought and really evoked important discussions on ethics and how to uphold morals and faith in a secular world. I also gained more insight into the issues surrounding abortion and was able to have important discussions with fellow classmates who were pro-choice around this issue when I came back on Monday from the conference."

(University of Ottawa medical student, Class of 2012)



Dr. Paul Ranalli, Lecturer in Neurology at the University of Toronto, presented his lecture, "A Medical Detective Story: What you felt before you were born" —current anatomical and physiological evidence that the fetus is capable of feeling pain by at least 20 weeks gestation. Slides from Dr. Ranalli's presentation are available on the CPL website: www.physiciansforlife.ca



Dr. Will Johnston, Family physician and President of Canadian Physicians for Life, and **Dr. Delores Doherty**, Family physician and Board member of Canadian Physicians for Life were Masters of Ceremonies.

Dr. Johnston opened the forum with a talk on the Health Risks of Abortion.

Stephanie Gray, executive director of the Canadian Centre for Bio-Ethical Reform, gave students practical tools for discussing abortion and framing the debate in her lecture, "The Abortion Debate: Equipped to Engage."



Communications specialist, **Michael Langlois**, outlined the importance of selecting the right language for credibly addressing life issues. He offered tips and techniques for building confidence in conversations with colleagues, patients, critics and the media.



"Thank you so much for the opportunity to go to the conference this year, it was a truly incredible experience, and I learned so much, and was able to engage certain issues that we would not get in the classroom!"
(University of Alberta medical student, Class of 2012)

Ancaster, Ontario, Nov. 22 - Nov. 23, 2008

"I had a wonderful time getting to know students from across Canada and from my own school. I am encouraged that I have colleagues who share my beliefs and that I now know I can rely on should ethical issues in my education arise."

(University of Alberta medical student, Class of 2012)



Dr. Stephen Genuis, Associate Clinical Professor, Department of Obstetrics and Gynecology, University of Alberta, discussed the evidence demonstrating that many youth are having their lives compromised physically, emotionally, and socially because of the significant impact of unintended teen pregnancy and sexually transmitted infections.



Genevieve Lanigan

shared the very moving and personal story of her family's journey with her infant son Joseph's life from conception to natural death. She detailed their experience with medical personnel before, during, and after discovering the child in her womb was developing with severe abnormalities.

Sharing her own personal experience and using professional anecdotes, Ottawa physician psychotherapist, **Dr. Lise Poirier-Groulx** discussed prenatal genetic screening, the implications of freedom of conscience for physicians, and the implications of both positive and negative results and the stress on the pregnant woman.

(photo courtesy of Dr. Poirier-Groulx)



"I...want to thank the sponsors who year after year make it possible for us students to attend such an important forum. My warmest thanks also to all speakers...they really demonstrate their passion for life."

(University of British Columbia medical student, Class of 2011)

Dr. Larry Reynolds, former head of Family Medicine at University of Manitoba, held an interactive workshop to help students learn how to engage patients in respectful

conversations about abortion; students role-played doctors and patients in real life patient situations.



Isabelle Bégin, researcher and National Secretary of Respect for Life - Education Movement/Respect de la Vie - Mouvement d'Éducation, put abortion morbidity and mortality statistics in perspective in a DVD presentation explaining the findings of her extensive research.

Dr. John Patrick, in his lecture on the cultural consequences of legalising abortion, explored the radically different outcomes of opposing rational, coherent, and ethical paradigms, and the moral foundation of the pro-life position.



A special thanks to Dr. Robert Pankratz for the use of his photos from the 2008 Medical Students Forum

Lawyer **Phil Hogan**, president of the Catholic Civil Rights League, and **Sean**

Murphy, administrator of the Protection of Conscience Project, offered a legal perspective on current developments related to freedom of conscience issues. Students benefitted from Mr. Hogan's participation in the open forum Q&A panel discussion that wrapped up the weekend.



Dying as the last great act of living

by Margaret Somerville

Recently, I gave a speech that explored the impact legalizing euthanasia might have on the possibility of our experiencing death as such an act.

Then, last week, I read Jean Vanier's response to the question, "Are you fearful of death?" He replied, "No, I cannot say I am."

This caused me to explore how Vanier might see the issues I had addressed in my speech -- our fear of mystery and uncertainty; the nature of the "human spirit;" what an ethics of respect for human potentiality and its fulfilment would require in how we treat dying people; and the role of hope in our lives and death.

Traditionally, we have dealt with mystery of death, through religion or spirituality. But, now, many of us are not religious.

Mystery always involves uncertainty, which makes us feel we don't have control and, in the case of death, that causes intense fear and free floating anxiety. We deal with that fear by trying to take control by converting the mystery of death to the problem of death and seeking a technological solution. Euthanasia -- a lethal injection -- is such a response.

It's also a terror-reduction mechanism that operates at both the individual and societal level. Although we can't avoid death, we can control its manner, time and place.

So if we believe legalizing euthanasia would be a very bad idea, we need to develop other ways to deal with our fear of death.

One such way is to enrich our experience of the "human spirit," which Vanier manifests in such abundance. Human spirit is a term I use in a religiously neutral sense, so it's open to people who are not religious and those who are, and, if religious, no matter what their religion.

By it I mean the intangible, immeasurable, numinous reality that all of us need access to in order to find meaning in life and to make life worth living; that deeply intuitive sense of relatedness or connectedness to all life, especially other people, to the world, and to the universe in which we live; the metaphysical -- but not necessar-

ily supernatural -- reality which we need to experience to live fully human lives.

Vanier speaks repeatedly of the deep suffering caused by loneliness. Dying people often encounter "intense pre-mortem loneliness" -- the feeling of disconnection and profound isolation -- the opposite of the human spirit.

Seeing other people as instruments or objects intensifies loneliness and leads to justifications of euthanasia such as that given by an Australian politician: "When you are past your "best before" or "use by" date, you should be checked out as quickly, cheaply and efficiently as possi-



Margaret Somerville

ble." One could never imagine Vanier speaking of people as products to be checked out of the supermarket of life.

The profound wisdom, humanity and humanness of Jean Vanier's approach to disability show us the opportunities that disability provides to "become more human," to experience the essence of our humanness and to share it with others. The same needs to be true of our approach to dying people.

As is true for romanticizing disability, there is a grave danger in romanticizing

death, which is not the same as respecting its mystery -- the latter requires looking tough realities in the face and struggling to live with them and finding meaning in doing so. Vanier does not romanticize disability, but shows us how one can find hope, joy and love despite -- or perhaps in part -- because of it.

His radical, counter-contemporary-culture message is that we "non-disabled" people are the losers in refusing to accept disabled people and rejecting the unique gifts they have to offer us as individuals and societies. He writes: "It's not a question of going out and doing good to them; rather receiving the gift of their presence transforms us."

Vanier's writings gently show that among the many gifts disabled people can offer us are lessons in hope, optimism, kindness, empathy, compassion, generosity and hospitality, a sense of humour (balance), trust and courage. The same can be true of dying people.

But accepting those gifts requires us to accept the suffering, weakness and fragility we see in the people who offer them, which means, as Vanier emphasizes, we must first accept those realities in relation to ourselves. Most of us find that an enormous challenge and flee.

Hope is the oxygen of the human spirit; without it our spirit dies, with it we can overcome even seemingly insurmountable obstacles.

Hope is generated by a sense of connection to the future. Even terminally ill people can have what we can call "mini-hopes" -- for instance, to stay alive long enough to see a grandchild born, to attend a daughter's wedding, to see an old friend the next day or to see the sun rise and hear the birds' dawn chorus.

Like hope, leaving a legacy also connects us to the future, one we will not see. To enable them to leave a legacy we must accept dying people's gifts, especially those gifts that are of the essence of themselves, recognizing that they and the person who gives them are unique and precious, as are their last days on earth.

But often we refuse and for the same reason that we reject disabled persons' gifts. We are frightened: This person is not me and could not be me.

The challenge is to maintain death as the last great act of human life, an act through which we can find meaning and pass

(Continued on page 7...act of living)

(act of living...cont'd from page 6)

meaning on to others. Euthanasia is a predictable response to a loss of meaning in relation to death. Even if we believe that doesn't matter, we should be concerned, because our capacity to find meaning in life may well depend on our being able to find it in death. ♦

Margaret Somerville is the Founding Director, McGill Centre For Medicine, Ethics And Law and The Samuel Gale Professor of Law.

This article appeared in the Calgary Herald on March 9, 2009, and is reprinted here with the permission of the author.

(assisted suicide...cont'd from page 8)

Downie: *Downie sees no difference between withholding/withdrawing life-sustaining medical treatment and assisted suicide; since we allow the former, we should allow the latter, she says.*

Pankratz: Justices McLachlin and Cory agreed that no justifiable legal distinction existed between the withdrawal of medical care and active intervention to take life. The dissenting opinion argued that since patients can refuse life-prolonging medical therapy, this exercise of an individual's autonomy in their medical care should be extended to include PAD, because in both cases the intended result is death. This view confuses the concepts of "preserving" life with "protecting" life and confuses natural death with deliberate life termination. *Preserving* life is the medical prolongation of natural life, while *protecting* life refers to society's obligation to provide the necessities of life and prevent murder. Allowing the refusal of a medical treatment shows a profound respect for natural life. Although natural death *may* ensue from ceasing to attempt to extend life, this is not the intention behind the withdrawal of care; patient autonomy and comfort is the goal. Because death is neither hastened nor desired, the withdrawal of care on request, even when this allows death to occur, is the antithesis of deliberate life termination (PAD). We cannot equate our right to not be violated by unwanted therapy with the freedom to choose our means of death. Curiously, since we have acquired the capacity to extend life we seem to have concluded that we are empowered to shorten life as well. But the ethical use of power must remain within the natural boundaries of life.

Organizational Update:

At the CPL Annual General Meeting in November 2008, a bylaw change was made, enlarging the board of directors from 3 to 7 members. In addition to Drs Will Johnston, Rob Pankratz, and Delores Doherty, the board now includes Dr. Larry Reynolds and three medical students. These students had attended the 2007 and 2008 medical students forums. In view of their ongoing expressions of interest, **Ben Turner, Thomas Bouchard, and Ugo Nzekwu** were invited to participate in CPL's first strategic planning day. Now Ben, Tom & Ugo have joined the board of directors! Their enthusiasm & energy has already made a difference!

Medical students who respect life from conception to its natural end face a hostile environment in medical schools across Canada. The curriculum is not balanced and life issues are ignored. Participants at past and current forums tell us how helpful these meetings are, both in terms of the information conveyed and the opportunity to meet like minded students and doctors.

The new board of directors meets monthly via teleconference call. New projects planned include linking pro-life medical student groups across the country and developing a life-curriculum for students to use.

Downie: *Imperatives like "killing is wrong"/ "do not kill" are not moral absolutes because we permit killing in war and self-defense. Downie maintains if we allow killing in those circumstances we should allow assisted suicide.*

Pankratz: Justice McLachlin argued that because in self defense and in times of war killing is justifiable, the sanctity of life principle is not absolute. However, the taking of innocent life always has been prohibited, the two exceptions mentioned above merely show that the only justification for the taking of life is the protection of something of equal value, another life.

Most values in society today are seen as both personal and relative. Those who would give life an absolute or infinite value, are often portrayed as intolerant bigots who impose their values on those who see autonomy as paramount. But if the right to choice takes precedence over the right to life, the key foundational value in society is removed and life termination becomes justified under vague, subjective conditions. To see life as an instrumental rather than intrinsic good, is to adopt a utilitarian ethic, that in reality (since the values are entirely relative) has no consistent or reproducible standard at all. ♦

Canadian Institutes of Health Research is seeking input for future Café Scientifique topics. Please contact Christian Riel at 613-941-5797 or criel@cihr.gc.ca

For further information on funding opportunities with CIHR's Café Scientifique program visit: www.cihr-irsc.gc.ca/e/39142.html

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Special Thanks:

Director Emeritus, Dr. Paul Adams

Dr. Paul Adams has been a stalwart of the Canadian prolife physician community for many decades, and in recognition of his organizing work, perceptive analysis of the issues, and faithful prolife practice, the Board of Directors of CPL is pleased to proclaim Dr. Adams a "Director Emeritus" of our organization. Dr. Adams is presently retiring from the helm of Manitoba Physicians for Life.

“Whose Life is it Anyway? Assisted Suicide in Canada”

At a March 24 event in Ottawa sponsored by the Canadian Institutes of Health Research as part of its Café Scientifique program, Canada Research Chair and Dalhousie University professor **Dr. Jocelyn Downie** presented her views on why she feels assisted suicide should be decriminalized. Many of her arguments in favour of decriminalization are reminiscent of the arguments made by the dissenting Justices in the Supreme Court Sue Rodriguez decision in 1993. The SCC upheld the constitutionality of the existing law by a slim margin of 5-4.

In an article which appeared in *Humane Medicine* in 1995,* **Dr. Robert Pankratz**, current VP of Canadian Physicians for Life, expressed concerns with several statements made by those dissenting Justices. Excerpts from Dr. Pankratz's unedited manuscript are printed here, since his comments are just as relevant today in responding to Jocelyn Downie's arguments.

*Pankratz HR: The Sue Rodriguez decision: Concerns of a Primary Care Physician. *Humane Medicine* 1995 Jan; 11 (1): 16-22.

Jocelyn Downie claims at CIHR event:

Downie says that one reason attempted suicide (AS) was decriminalized in 1972 was that AS could be considered a “rational choice” in some cases. She says our current law against AS discriminates against individuals who don't have the capability to commit suicide themselves.

Dr. Rob Pankratz's response to dissenting opinion in Rodriguez SCC decision: Justice Sopinka [writing for the majority] outlined several reasons why Parliament removed the offense of attempted suicide from the Criminal Code in 1972. Suicide was seen to be a problem with its roots and solutions in sciences outside the law. Indeed, criminal law was seen to be “an ineffectual and inappropriate tool for dealing with suicide attempts,” but in his dissenting opinion Chief Justice Lamer asserted that the intended result (of the decriminalization of [attempted] suicide) was to increase the self determination of individuals in this realm by the removal of state controls.

Justice McLachlin (at pages 7 and 8) also argued that not only was suicide legal, but there was a “right to commit suicide.” The result of the reasons of these dissenting Judges, according to Justice Sopinka, would be the recognition of “...a constitutional right to legally assisted suicide beyond that of any country in the Western world...” (p.2).

The dissenting opinion that the autonomy of suicidal individuals was now paramount over the state interest in protecting life seems to downplay the following information presented by A.G. Henderson Q.C. at trial. In its 1982 working paper number 28, (at p. 13) the Law Reform Commission of Canada stated “*the decriminalization of attempted suicide in 1972 occurred due to difficulties prosecuting people with mental illness and did not have the effect of legitimizing suicide, or of creating a true ‘right’ to suicide in the classical sense of that word. Suicide remains an act which is fundamentally contrary to human nature.*”⁶

Many experts believe that there is no such thing as a “rational suicide” because a major psychiatric disorder is almost invariably present, as is the common emotion of hopelessness-helplessness.^{7,8,9} Truly free consent does not appear to be present in parasuicides either, since “those who attempt suicide are normally ambivalent.”¹⁰

Downie: *There is a general acceptance of the importance of personal autonomy (i.e. self-determination.) Downie believes competent individuals should be able to freely choose assisted suicide based on informed consent.*

Pankratz: The primary argument that Sue Rodriguez advanced in favor of assisted suicide was her right to self determination. Justice McLachlin summarized this elevation of the principle of autonomy when she stated (at p.13) “what value is there in life without the choice to do what one wants with one's life.” This extreme view sees even minor disability as a potential reason to end one's existence and presupposes that death is somehow better than dependence. From this perspective, dependence alone is clearly classified as suffering.

If a competent patient's request is seen as compelling, the physician loses autonomy, moving from the role of a professional to that of a technician. In the case at

hand, the Victoria Hospice Society's press release (Feb 15, 1994) has shown that immediately prior to Ms. Rodriguez' allegedly assisted death, she was in no physical pain, could manage solid food, and was not near death. From this information, it is questionable whether she required assistance at all. In Holland, the Royal Dutch Medical Society encourages physicians who disagree with euthanasia to refer; in fact “recently a doctor who had refused to apply euthanasia was called to defend his conduct before a ‘medical court.’”²³ Indeed, Dr. C. Schaake of the Netherlands Cancer Institute in Amsterdam, has concluded that the hospital and its staff “could not refuse” a patient's carefully considered request for euthanasia.²⁴

The importance of the principle of autonomy presents a paradox when coupled with the other major consideration in PAD [physician assisted death], namely pain and suffering. “If the principle motive for the physician to act is relief from suffering, why ought self-determination to be required? And why would the duty to relieve suffering not apply to the incompetent just as well as the competent? Conversely, if we hold that self-determination should be the dominant motive, why should suffering be required?”²⁵In addition, there is an inherent fallacy in the argument that this will be limited to freely consenting competent people only. Firstly, cognitive impairment is present in the majority of terminally ill patients, including those with ALS.^{32,33}

And if Canadian law recognizes a right for competent people to PAD, our constitution makes this right available to the incompetent members of society by proxy. Many subtle but coercive pressures are present including social, financial, perceived duty to society, and physician biases. Physicians generally are not well trained in assessing whether consent is truly free and informed, particularly on this issue, where their own existential anxieties may interfere. In my practice I encounter terminally ill individuals who consider themselves a burden to their caregivers. The mere legality of the option of PAD would imply a societal consensus that PAD is appropriate (or even obligatory) under these circumstances and would imply to already fragile patients that they needed to justify their choice to remain alive.

(Continued on page 7...assisted suicide)