



VITAL SIGNS

Summer 2013

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

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Untruths Used to Push for Euthanasia Laws

by Licia Corbella

This article first appeared in The Calgary Herald on February 19, 2013 and is reprinted here with permission.

The case of Ruth Goodman is a perfect example of how confused, illogical, uninformed and sometimes untruthful many proponents of euthanasia or physician-assisted suicide are.

Goodman killed herself on Feb. 2, with no assistance, at the age of 91 in her Vancouver home, in a bid to change physician assisted suicide laws. If you're scratching your head right now and saying, huh? don't be alarmed, you are thinking clearly and are not losing your mind.

In short, Goodman's final act makes no sense. The reason this woman's last act is so strange is because everyone already has the right to die. Suicide is not illegal.

"I am a 91-year-old woman who has decided

to end my life in the very near future," wrote Goodman, who had worked at an abortion clinic and was involved with the B.C. Civil Liberties Association.

"I do not have a terminal illness; I am simply old, tired and becoming dependent, after a wonderful life of independence," she wrote. "By the time people read this, I will have died.

I am writing this letter to advocate for a change in the law so that all will be able to make this choice."

To reiterate, everyone already can make "this choice." It's not illegal to kill yourself. No laws have to be changed. Anyone and everyone can commit suicide as long as they don't endanger anyone else while doing so.

(Continued on page 4...Untruths)

The Blessings Far Outweigh the Sorrows

Finding myself pregnant at 40 was a total surprise, and somewhat of a shock for my husband of 15 years. After giving birth to two healthy daughters and suffering a miscarriage, we were not expecting to have any more children. At 34 weeks gestation, I marveled at the fact that this pregnancy had been my easiest of all with no complications whatsoever. That is, up until then.

At that point, I was going for a routine ultrasound to check the baby's position since my first-born had been an undiagnosed breech presentation requiring a caesarean section delivery. Little did I know that that day was going to be the most significant turning point in my life.

I looked forward to seeing my baby on the screen again. The examination lasted longer than usual and I became somewhat concerned, wondering what the problem was. Being a physician myself, I could easily sense the malaise in the

room although I could not, with great accuracy, read ultrasound images. The technician discreetly excused herself to get the radiologist to come in and check the image she was seeing. My heart started to race, as well as my mind: "There has to be something seriously wrong for her to be doing this," I told myself.

After what seemed like an eternity but was in fact only ten minutes, a colleague I immediately recognised came in to confirm what the technician had suspected. He briefly explained that the ventricles in my baby's brain were enlarged because of too much fluid. I did not believe what I was hearing, and I was convinced that they were wrong.

The doctor invited me to his office to discuss the matter further. I followed in a daze,

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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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Editor's letter

by KC McLean-D'Août

There is a decided advantage to being at the hub of Canadian Physicians for Life: I get to hear from members about how they are walking out their pro-life ethics in practice. In these five years, I have witnessed medical students move from silence about life issues, to becoming active voices in their schools, to integrating pro-life principles into their medical practice. Most recently I have met or spoken to some of you who have been in medicine for years, but are now being stirred to speak up for the vulnerable in our society.

This issue of Vital Signs includes several Canadian pro-life physicians I wanted you to meet. Dr. Lise Poirier-Groulx (*The Blessings Far Outweigh the Sorrow, page 1*) shared her story of doctor-as-patient in a difficult pregnancy, at a Medical Student Forum five years ago. It hasn't left me.

Dr. Rene Leiva and Dr. Thomas Bouchard (*Primary Care Possibilities for Pro-life Physicians, page 5*) – among many other like-minded family physicians – have ideas about integrated pro-life family practice that are innovative and possible. We get a steady stream of requests for names of pro-life doctors from people looking for this kind of care. I wonder how many others of you have been thinking and planning the same approach. Here's an opportunity to collaborate.

I also want you to meet Dr. Laura Lewis (*Back to Life, page 3*) from Ontario. She recently did something extraordinary: she walked from Montreal to Ottawa with 24 other women. Twenty-five women represented each year since the Supreme Court Morgentaler decision that left a legal vacuum in Canada concerning abortion. Dr. Lewis walked shoulder-to-shoulder with post-abortive women and others who had been hurt by the physical and psychological aftermath of abortion. Hers is an emerging strong and compassionate voice for women and for babies.

Dr. Catherine Ferrier is a CPL member and spokesperson for the Quebec group called the Physicians' Alliance for Total Refusal of Euthanasia (PATRE) (*Untruths, page 1*), that is decrying the province's agenda towards physician assisted suicide.

Dr. Will Johnston (*Editorial: Euthanasia and Assisted Suicide, page 8*) has been at the front-lines of the euthanasia and physician assisted suicide issues in Canada for years, as well as leading our own organization (and running his Vancouver practice). It's time for more doctors to join him.

I look forward to meeting more of you and hearing your ideas at LifeCanada's National Pro-Life conference in Charlottetown this October 24-26, and at our own Medical Student Forum in Toronto November 8-10.

Keep sending us your pro-life ideas; let's keep moving forward.



Announcing CPL's 2013 Annual General Meeting

You are invited to attend CPL's 2013 Annual General Meeting in Toronto this November.

Friday, November 8, 2013

5:00 p.m.


Toronto Downtown Renaissance Hotel

Toronto, ON

Please RSVP:

Email: info@physiciansforlife.ca

Phone/Fax: 613.728.5433

 WWW.PHYSICIANSFORLIFE.CA

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Back to Life : Physician walks from Montreal to Ottawa for Life

On April 28, 2013 twenty-five women set out from the area of the Morgentaler abortion clinic in Montreal, en route to the Supreme Court in Ottawa. They were marking the 25th anniversary since the 1988 Supreme Court Morgentaler decision that left a legal vacuum on abortion in Canada. Many of them were post-abortive, walking with regret for their choices and to raise awareness about the physical and psychological aftermath of abortion. Others were pressured to abort, but chose to keep their children. Still others were walking for mothers, grandmothers, friends, husbands, and sisters.

This was not an angry mob. Their message and tone was loving and full of hope for post-abortive healing for women and men, and for Canada. They sang, danced, cried, tended to one another's fatigue and injuries (blisters!), and they sprinted the last portion of each day's 20km trek. When they arrived in Ottawa on May 9th, they spent two days meeting with MPs and Senators to tell their stories and discuss the way to change. They want this side of the abortion story to be heard, and they want to give women back their voices.

I was among them, walking to honour my biological and adoptive families, and the PEI doctor who refused to have me aborted at 7 months gestation. A pro-life doctor, Laura Lewis from Ontario, was also among the 25 walkers. The following commentary is the transcript of a video describing her reasons for walking the 212 km. ~ KC McLean-D'Arçault



My name is Laura, and I'm a family physician. I've been a family doctor for 18 years.

I am doing this walk for three different groups. I'm walking for my profession, for medical doctors, because as a family doctor I spent years really not understanding the impact of abortion on women. I was really somewhat ambivalent to it. Although I counseled women about their choices I never really heard back about the impact the abortion had on a patient.

It wasn't until several years into my practice that I began to question prenatal screening and how we would selectively end the lives of children with Down syndrome or spinal bifida, and I wondered if that was really the best option for families. I would see these kids with Down syndrome and realize how much they brought into a community and into a family and the joy that they walked in. I wondered if this is truly what we should be doing as caregivers: advising that patients end the lives of these babies. I feel that as a medical profession we are truly driven by compassion and care for patients. We do really care about how our decisions impact the lives of our patients and I think we've been lost a bit in the technology and science of what we *can* do and we're not hearing from people about how a decision is impacting them.

My hope is that people will really hear these stories and that it will provoke them to go and speak to their own family doctor; that they will go and tell their physician how abortion has affected them, because these stories need to be told. It wasn't until I began working with a pregnancy center that, I believe, women started to trust me enough to share the deep wound that abortion had caused them. When I started to hear these stories it was hard to hear. And I feel like many of my medical colleagues have no idea that we're not truly allowing women to make an informed choice. They don't understand the decision that they're making.

I really believe that it's time in our country that we have a reformation of how we approach unplanned pregnancies. And I

believe that the medical community, as we begin to understand this issue in greater depth, will be open to changing the way we have handled these situations. I truly believe there are many groups on both sides of the abortion debate that would be willing to work together to change this issue in our country.

I'm also walking for the 15 year old girl who is yet to find she is pregnant. I know that she will be faced with a lot of fear and confusion, that she will feel overwhelmed and that she will look to those in authority to try to find out what is available for her. She will go to her medical doctor and they will say it is safe to abort, she will look to the government and they will say you can have an abortion and it is legal and we will pay for it. And from that place of feeling overwhelmed and scared she will choose that default decision: a decision to abort. Even though if she were to go on a school field trip to play soccer she would need the permission of her parents and yet to have an abortion she doesn't need her parents' consent at all. So she can just slip away for the day and have this procedure and then she is left with a lot of secrecy, possibly shame and emotional hurt that is hers for the rest of her life.

I'm walking for her because I want her to know that she can make a decision from a place of confidence, surrounded by people who will care for her and love her and have compassion for the chaos she is dealing with. I believe that as a country that is what we should strive for and aim for.

In doing this I'm walking for the third group, which is the unborn baby. Even though a pregnancy may not be wanted a child always is, a baby always is. I have sat in my office and listened to women with an unplanned pregnancy wanting to abort their child and in the same day I've listened to the tears of a couple with infertility. I believe that we need to be a voice for the voiceless and we need to protect the vulnerable in our land, speaking up for those babies that don't have a voice. That's why I'm walking. ■



You can view videos of the walkers and some of the daily update footage at www.backtolifecanada.com.



A coherent, clear statement - unlike the letter Goodman wrote. PATRE was formed in the fall of 2012 by a core group of 24 Quebec doctors, including Drs. Patrick Vinay, former dean of medicine at the U of Montreal; Abraham Fuks, former dean of medicine at McGill; Pierre Durand, former dean of medicine at Laval and many other leading oncologists and palliative care specialists.

What's perhaps most astonishing is despite the heft of those who oppose the Menard report's push to legalize physician-assisted suicide, not one mainstream media organization has written about PATRE or called to speak to Ferrier, whose phone numbers were listed on the group's Canada-wide news release.

"You're the first journalist of a major news outlet to call me," revealed Ferrier.

As a journalist friend from Montreal said to me about the lack of attention PATRE received, "our confreres have quaffed the Kool-Aid from the promoters of medical killing, Journalism as Jonestown."

It really is shameful how the side in favour of physicians killing their patients must rely on suppression of the other side of the debate and misinformation to push their insidious agenda.

Next month, the federal government will challenge to the B.C. Court of Appeal a B.C. Supreme Court ruling that said the federal law prohibiting suicide assistance discriminates against people with disabilities and doctors should be allowed to help terminally ill patients end their lives.

B.C. Civil Liberties Association lawyer Grace Pastine, who is arguing in favour of legalizing euthanasia, said about Goodman's case: "None of the countries in the world, or the U.S. states that have legislation permitting physician-assisted dying, would allow for it, in this situation," because she was not terminally ill or in pain.

Pastine is wrong. In the Netherlands, physicians are killing mildly deformed infants, depressed teenagers can request that they be killed, and recently in Belgium, deaf twin brothers were euthanized after they learned that they were going blind. They were not terminally ill or dying and yet they were assisted in their suicide by a physician who has not been charged with their deaths.

Euthanasia proponents must rely on misinformation to sell their deadly end goal. Too few people are killing their untruths and that threatens the lives and worth of society's most vulnerable. ■

(Untruths...continued from page 1)

What so-called right-to-die activists are actually seeking is the right for people to help other people to die - they want the right to kill other people and to have other people kill them, making legal what has been illegal in most sane places, since time immemorial. In countries where euthanasia and physician-assisted suicide are legal - like the Netherlands - it is documented that thousands of people have been killed involuntarily by their physicians without their consent, even when a full recovery was possible.

Alas, this illogical and discordant story about Goodman has garnered much media attention, and that in itself is disturbing when you consider another story about euthanasia that has not received any mainstream media attention.

On Jan. 21, a Quebec group called the Physicians' Alliance for Total Refusal of Euthanasia (PATRE), sent out a news release exploring the Quebec government's commissioned report, that advocates for making physician-assisted suicide legal.

More than 300 Quebec physicians provided their signed support, beseeching all Quebecers to become aware of the dangers the report poses to their well being and urging them to implore the opposition majority in Quebec's National Assembly to condemn it.

"This report is the work of some hand-picked lawyers who present the act of doctors killing patients as if it were part of a natural continuum with good end-of-life care," said PATRE spokesperson Dr. Catherine Ferrier. "They and the politicians who appointed them introduce the term 'medically assisted dying' as if it were something different from killing patients. This act is abhorrent to us as doctors, and should appall Quebecers who care about social justice and building communities that care about the most vulnerable."

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Announcing the 2013 MEDICAL STUDENTS FORUM

November 8 - 10, 2013
Downtown Renaissance Hotel
Toronto, ON

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.

Full speaker and session information, as well as scholarship applications, will be available on the Canadian Physicians for Life website (www.physiciansforlife.ca) at the end of June.

Advance registration is required. Contact KC McLean-D'Août at info@physiciansforlife.ca or 613.728.5433 for more information.

Primary Care Possibilities for Pro-Life Physicians

by Thomas Bouchard, MD and Rene Leiva, MD

As pro-life family physicians, we are grateful to be a voice to affirm the sanctity of life in our patient population. Many of our patients have a worldview consistent with ours, and have found us specifically because they were looking for a pro-life physician. Others have become patients because they lived near the clinic, though they may not share our worldview. Regardless of how we came to know each other, our patients have learned about the value we place on life from conception to natural death.

There are many different models for family physicians to practice primary care and have a positive influence in their patients' and colleagues lives. One very valuable model is in the usual setting of joining a practice with other family physicians who may or may not share the same views. In this context, when others do not share the same views it can be an opportunity for collegial and respectful dialogue - respecting each others' differences and acknowledging our strengths and weaknesses.

Another model that is being explored is that of a clinic with a distinctive pro-life vision. Such a clinic would bring together like-minded physicians who have in the background a vision statement that affirms the sanctity of life from conception to natural death. It would be important for such a clinic not to be "exclusive" in the way it attracts patients - i.e. that it would not solicit patients who share the same vision only. The point of such a clinic would be to provide care for the community at large, but with the specific goal of promoting and ensuring the health of all patients at any age (including the unborn). The physicians involved should care to be excellent in their discipline, excelling as family physicians in general, in addition to being leaders and role-

models of pro-life physicians who can cooperate with colleagues in a non-confrontational manner. Furthermore, new symbiotic models could be created with other like-minded organizations, bringing together physicians' clinics, pregnancy-crisis institutions, nursing homes, palliative care support groups, or social services agencies to name a few.

We see the importance of primary care providers in both situations - collaborating with colleagues with differing views, as well as supporting one another in a setting with a common vision. Both models are necessary to promote a consistent life ethic, but in certain environments there may be a greater need to have strength in numbers: pro-life physicians provide support for each other so that there is a sense that we are not alone.

Patients may also have a preference for one model or another, and they should be free to choose a physician in either setting. Given Canada's emphasis on diversity and the College of Family Physicians of Canada's emphasis on new models for the "medical home," we think pro-life Family doctors will be able to find a home for themselves and their patients in a variety of different settings. Currently, many Canadian Physicians for Life are exploring these different possibilities. Certainly the proposed models will take effort and commitment, however, if we want to become a light for our nation among a culture of death, the challenge is worth it! ■

Canadian Physicians for Life board member Dr. Bouchard is a family physician in Calgary; Dr. Leiva has a family practice in Ottawa.



(Blessings...continued from page 1)

repeating to myself angrily: "They are wrong; my baby does not have hydrocephalus."

My colleague, who was obviously quite uncomfortable to be the one giving me this information, was nevertheless very compassionate. He spoke in medical jargon, speaking to the doctor in me as the mother's heart in me was breaking. I was having a hard time hearing what he was saying.

I managed to understand that my baby was too small for gestational age, that the amniotic fluid around him was inadequate and that he had hydrocephalus. I called my husband immediately after I came out of the office and, for the first time in my life, I could not talk because I was crying too much. All I could manage to say was that there was something seriously wrong with our baby and that I would explain later.

The following days were a blur as we kept ourselves busy, waiting to have a second more detailed ultrasound to further evaluate our baby.

We were finally given an appointment five days later. I was hoping that all of this was just a mistake, that the results of this second ultrasound would come back normal. Not only were the first results confirmed, but a severe congenital heart malformation incompatible with life outside the womb, was also detected. My head was spinning by then; this was becoming a nightmare that I could not get out of.

The neonatologist brought my husband and I into a private room to talk. She was courteous in explaining that our baby was suffering from a complete outflow tract obstruction, which meant that no blood could be pumped from the heart to the lungs. This was not a problem as long as the fetus remained in the mother's womb where breathing was not necessary to oxygenate the blood. Most of these cases ended with either the baby dying in utero, or during delivery, or shortly after birth. She continued by saying that she had contacted my OB/GYN and had discussed the results with her; everything could quickly be arranged to terminate the pregnancy. Inducing premature labour on a fetus of 750g with severe multiple congenital birth defects would do what mother nature usually does and had not done in this case. I was shocked. I had not seen this coming. I felt naïve and betrayed.

I did not even need to consider what she was proposing to us because I knew that neither my husband nor I would entertain this possibility. We had made the decision early on in the pregnancy not to undergo the routine amniocentesis because we knew we would not go through with an abortion if the baby had been diagnosed with a handicap. With very few words (as I was stunned) and no justification, I told her so. Her attitude abruptly changed; she became distant and cold. She advised us that she had arranged an urgent prenatal echocardiogram with a pediatric cardiologist at the children's hospital in Ottawa in order to have a precise diagnosis of the heart malformation.

Within half an hour we were seated in the waiting room in the Department of Cardiology. My husband and I spoke very little; the depth of our sadness overwhelmed us.

“ He spoke in medical jargon, speaking to the doctor in me as the mother's heart in me was breaking. ”

After the echocardiogram, we met with the cardiologist who explained to us with detailed drawings the two different types of outflow tract obstruction which occur in approximately 1 in 8000 births. They had been unable to identify which one our baby had; the prognosis, however, was the same for both. We again reiterated our choice not to terminate the pregnancy. In view of this, he went on to propose two different scenarios in the event that our baby would be born alive. One was to let nature take its course and not to intervene, in other words enjoy what little time we had with our baby. The second was to give our baby a drug to "buy time" in order for investigations to be done. Fearing that we would cause unnecessary suffering and knowing that we would still not change the unavoidable outcome of death, we chose the first option.

Next, we were summoned to the geneticist. She told us that an amniocentesis was indicated to attempt to identify a syndrome which could explain the multiple birth defects from which our baby was suffering. We already knew this test could not be performed because there was insufficient amniotic fluid. For us, in any case, having that extra information would not have changed our decision of going on with the pregnancy. At that time, it was speculated that the most likely diagnosis was either Trisomy 13 or Trisomy 18. Both these syndromes are comprised of multiple birth defects associated with a very poor prognosis as described previously. Since we insisted we did not want to terminate the pregnancy, the geneticist gave us a pamphlet of testimonies of parents who had gone through what we were about to go through.

Our coping strategy at the time was to concentrate on the present moment; our baby was alive now. We could at least let ourselves enjoy him for whatever time was left. This was extremely difficult as we tried to go on with the task of « normal » living. Our intense grief was compounded by the worries of how we would prepare our two daughters (three-and-a-half and seven at the time) for the death of the baby they had been waiting for all these months. We planned a christening in the operating room and set a date for the funeral one week after the delivery. The four weeks preceding the baby's birth were horrendous for all of us.

Finally the day arrived when the membranes ruptured one week prior to the date set for the caesarean section. With anxious trepidation, we rushed to the hospital. We had paged our doctor, who met us in the delivery room. Everything was arranged with thorough efficiency and we soon found ourselves in the operating room. My husband was given permission to remain by my side for the whole procedure. Without delay, under spinal anesthesia, our





(Blessings...continued from page 6)

baby was delivered. Dead silence prevailed as everyone waited, not daring to move, in order to hear whether this little one would actually take his first breath and cry. To the pediatrician's amazement, he was found to be more vigorous than expected, with APGARs (a recording of the physical health of a newborn infant) of 4 and 6, and he weighed 1.9 kg at term, 38 weeks gestation.

As I am writing this, everything is flooding back to me with such intensity: the memories of the first minutes with him...how adorable and fragile he appeared with his tiny cream-colored cap, swaddled warmly so that only his small face was visible. Just looking at him, he seemed so perfect; only his pale purplish skin color hinted at how seriously ill he was. This precious bundle was placed in my husband's arms; I could not move to touch him. Emotions overwhelmed me as I started to cry and felt I would faint.

Immediately, I was medicated to help me deal with the whole situation. The christening proceeded as my brother-in-law videotaped every solemn moment; these pictures could be the only memories we had of our baby alive. The atmosphere was thick with apprehension.

My husband followed as our baby was transferred to the neonatal intensive care unit (NICU) in an incubator with 100 percent oxygen. I feared my baby would die before I was able to leave the operating room and before I could see him again and hopefully hold him.

After barely an hour in the recovery room, I was brought to the neonatal unit. As I saw my son Christian, so vulnerable, lying in his incubator with the different monitoring equipment attached to him. I was overcome with love. I could not have enough of stroking him. It was so hard, lying on my stretcher, reaching to touch him through the openings of the incubator. Seeing my predicament, a compassionate nurse broke protocol and took him out of his sterile environment and placed him gently into my arms. I was so grateful for her gesture; tears flooded my face as I kissed my little one. The time was too short. He had to be transferred to a tertiary care centre. I had to let him go. The fear of losing him, the fear of the decisions to be made, the fear of the unknown, was overwhelming.

Because Christian appeared so much stronger than expected, we reconsidered our initial plan and decided to go ahead with the second scenario, which was to treat him with a drug called prostaglandin. It tricks the heart into thinking that it is still in the mother's womb. In doing so it « buys time » to investigate further and if possible do cardiac surgery. Because of the risk of serious side-effects, it could only be used for one week.

The echocardiogram revealed the heart anomaly to be Tetralogy of Fallot with pulmonary atresia. In lay terms, it means there were four major problems with his heart:

1. The malformation of the pulmonary artery/trunk prevented any blood from going from the heart to the lungs;
2. a large hole existed between the two lower chambers of the heart;
3. the aorta (which carries blood from the heart to the rest of the body) was in the wrong position;
4. the right lower chamber wall was too thick and therefore not contracting well to pump blood.

An ultrasound of his head revealed no evidence of hydrocephalus. (In my denial, I had been right after all!) A chromosomal study revealed Trisomy 21 (Down syndrome). Although this information was hard to take, it was still better news than what we had been given during the pregnancy. We decided to go ahead with surgery.

Christian spent eight-and-a-half months of his first year in hospital. He underwent four major surgeries during that time, three for his heart and one for his stomach (reflux problem). He was in and out of intensive care and spent the greater part of his time on the surgical ward in an oxyhood (similar to an oxygen tent). At ten-and-a-half months of age, he was finally transferred to The Hospital for Sick Children in Toronto where he had a total repair of his heart. This included the use of a human tissue graft from a donor to replace the malformed pulmonary trunk. His recovery was truly miraculous, as witnessed by the doctors and nurses.

He has need 8 cardiac catheterizations for diverse medical reasons since then. Although he requires continuous medical follow-up, he has surpassed all expectations in regards to his growth, development and his quality of life.

Christian is now 14 years of age. He started school in August 2004. What a celebration that was – we never thought he would make it that far! He is presently totally asymptomatic from a cardiac standpoint and does not take any cardiac medications. He did undergo repeat cardiac surgery in July 2006 to replace the human tissue graft, which does not grow with him as he matures. He is a very loving, happy, active boy who continually gets himself into trouble and annoys his older sisters.

Although the journey has been incredibly difficult for the entire family, we have absolutely no regrets. The blessings which accompanied this little one into our lives far outweigh the sorrows we have experienced. We have grown and learned so very much through him. Every day, we witness how he touches people's hearts, and people's lives are changed just because of who he is. Everyone who knows him loves him! ■



Lise Pouier-Groulx, MD, has a medical psychotherapy practice in Ottawa, ON.

Editorial: Euthanasia & Assisted Suicide

Will Johnston, MD, practices the full spectrum of family medicine in Vancouver. He is President of Canadian Physicians for Life.

Last summer a provincial court judge in BC legalized assisted suicide and euthanasia in the “Carter” case.

The linchpin of the Carter decision is the judge’s strange discovery of a right to assisted *suicide* from the right to *life* proclaimed in Section 7 of our Charter of Rights, because someone who commits suicide sooner, out of fear that necessary assistance to commit suicide will not be available later, has forfeited some living time.

In other words, a suicide committed in anticipation of a feared future life condition is claimed to prove that laws which would contribute to the feared condition must have violated the life interest of the suicide victim. It is not evident why the feared future life condition must be restricted to the condition of loss of power over the timing of one's death.

Why should only a predicted future incapacity to control the time of one's suicide be the trigger to endow a tragically early suicide with the power to claim that one’s Section 7 right to life has been violated? Would a suicide prompted by a predicted future incapacity to access a certain illicit drug indicate an infringement of Section 7 by the laws against dealing in certain drugs? Would the state not become hostage to the claims of any suicidal person who could blame existing legislation for their motivation to destroy themselves earlier than they would die of natural causes? Should the Charter be used to force the state to bow to those who utter threats of self-destruction? The concept of a “life interest” should be distinct from whether the life is wanted by the citizen in the moment. It is the state's duty to avoid killing its citizens, not to inquire about how their day is going. Beware the assumption that suicide is okay and that all we're dickering about is the timing of it.

Pull out the perverse use of the “right to life” and the Carter case collapses like a house of cards.

Suicide is being promoted by talk about “autonomy.”

We should question whether your autonomy is necessarily enhanced by assisted suicide. Suicide is not illegal, but assisting suicide has been illegal until this case. If the law is changed, all the legal effort would go into protecting suicide providers from prosecution. You are giving power to people in contact with you or your vulnerable family member to kill them or steer them towards assisted suicide - and get away with it. The choices opened up by assisted suicide may belong to others, not you.

The claim that only rational competent adults will be eligible for assisted suicide is just question-begging. The concept of rational suicide has not been accepted by any major psychological or psychiatric organization. In fact, the use of “rational” in this context means a suicide that the activist approves of, generally because of a horror of the disability of the suicide victim. In the suicide activist world, *rational* is just code for *acceptable*. The debate is not over whether the suicidal person is capable of cognition. The debate is over whether what the suicidal person proposes – to kill themselves – is a goal which should be shared and facilitat-

ed and promoted by the state. I suggest there are alternate goals, like the treatment of depression and other symptoms, to which the state should limit itself.

The Death penalty analogy

Picture 10 prison cells on death row. In some places there is a system which allows the state to approve and facilitate the killing one of those death row cell occupants after a lengthy and, one hopes, exhaustive review of the evidence. Now consider 10 hospital rooms inside an assisted suicide or euthanasia system. How likely is it that a deliberation process equivalent to a murder trial will be focused on every patient who is purported to want to die? If we rejected capital punishment for the mere possibility that the law would, even once, be misused, why are we considering legal assisted suicide? If we rejected capital punishment out of the conviction that the state should never use killing as the solution to a problem, why are we proposing a system where some would be steered not away from suicide but toward it?

The bleak world of suicide

Let’s step back to observe the strangely shrunken world of the assisted suicide seeker and the assisted suicide activists who surround her or him. The suicidal person and his or her advocates have adopted a constricted and contracted problem-solving process which has come to see only death as a solution. This overwhelming monomania has induced a sort of Stockholm syndrome in the suicide advocates, who have become captive to, and admiring of, the zero sum reasoning and death fixation of the suicidal person. “Death with dignity” societies seem the most obviously entrapped by a tunnel vision which buys into the hopeless outlook of the distressed person and becomes indignant on their behalf. It would be best to turn on the lights and banish this nightmare and get on with the difficult but worthwhile treatment of all distressing symptoms, including suicidal depressions in the context of severe illness. The claim that guidelines can make a Canadian assisted suicide system safe suggests the analogy of a sniper trying to assassinate someone in a crowd. The aim is not always perfect. As interdependent as we all are, we would always be, with our loved ones, in that crowd.

Tellingly, despite testimony warning of problems in foreign jurisdictions, the assisted suicide guidelines set down at the end of the Carter judgment contain subjective criteria sure to encourage an expansion of the indications for assisted suicide, and which direct the victim’s doctor to falsify the death certificate by specifying the underlying illness, not the suicide or direct killing, as the cause of death. Canada's inaugural assisted suicide system appears to have been an immediate failure of stringency and transparency. Its only rigor would be rigor mortis.

My challenge to the assisted suicide and euthanasia movement is this: can you imagine end of life care so good that you would set aside your demand for assisted suicide? If you can, let's continue to create such care. If you can't or won't, your focus would seem to be on suicide rather than the relief of suffering and you are likely to do more harm than good. ■