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Patients Rights Council

Update

Canadian court ruling leaves disabled patients open to death-on-demand

In a landmark ruling, Quebec Superior Court Justice Christine Baudouin declared certain eligibility requirements in the Quebec and Federal euthanasia laws unconstitutional, meaning that they violate the Canadian Charter of Rights and Freedoms.

The Federal euthanasia law, enacted in 2016, limits euthanasia access to patients whose natural deaths are “reasonably foreseeable.” Similarly, the Quebec euthanasia law, enacted in 2015, requires induced death patients to be “at the end of life.”

The case before the Quebec court was brought by two Montreal residents with disabilities who were refused legal euthanasia deaths—referred to in Canada as medical assistance in dying or MAID—because neither was dying.

Jean Truchon, 51, has cerebral palsy and currently is dependent upon oth-

ers for his daily needs. Co-plaintiff Nicole Gladu, 73, has post-poliomyelitis syndrome as well as severe scoliosis. Both plaintiffs claim that their irremediable conditions cause them intolerable physical and mental suffering and that the MAID laws are overly restrictive, discriminatory, and violate their guaranteed Charter rights.

Justice Baudouin agreed. “The court finds that the statutory provision requiring natural death be reasonably foreseeable infringes life, liberty and security of the person guaranteed by Section 7 of the Charter to Mr. Jean Truchon and Ms. Nicole Gladu, in a manner inconsistent with the principles of fundamental justice,” the judge said. “The reasonably foreseeable natural death requirement deprives both the individuals and claimants of their autonomy and their choice to end their lives at the time and in the

manner desired.” Furthermore, Baudouin found, “What the plaintiffs are really looking for is that the law recognizes equally the suffering, the dignity and, ultimately, the autonomy of people who, like them, are affected by serious and irremediable health problems, without any hierarchy, whether death is near or not.” [*Truchon v. Attorney General of Canada*, Superior Court of Quebec, No. 500-17-099119-177, 9/11/19]

While Baudouin stayed her ruling for six months to allow legislators to amend the unconstitutional restriction in the MAID laws, she granted Truchon and Gladu an exemption to seek out euthanasia deaths sooner, if they wished.

Euthanasia advocates praised Baudouin’s ruling. Op-ed co-authors Jocelyn Downie and Daphne Gilbert, both
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Study: US assisted-suicide laws harm patients with disabilities

A new federal study—largely ignored by secular media—has found that US assisted-suicide laws pose significant dangers to people with disabilities as well as other vulnerable members of society. The National Council on Disability, an independent federal agency, issued its study’s findings in the 70-page report, “The Danger of Assisted Suicide Laws.”

While prescribed-suicide laws contain supposed “safeguards” against abuse, those provisions are ineffective, with real oversight of abuses and mistakes nonexistent, according to the report. The laws fail to protect patients in a variety of ways. For example, insurers have denied costly treatment but offered to cover lethal drugs “potentially leading patients toward hastening their own deaths”; terminal misdiagnoses can cause “frightened

patients to hasten their deaths”; and fear and depression often drive assisted death requests, but referrals for psychological evaluations are extremely rare.

Additionally, all the US laws have “unnecessarily strict privacy and confidentiality provisions” that result in “a substantial lack of data,” and the small amount of data collection permitted in earlier enacted laws is diminishing in later enacted state laws that have far less restrictions. Also, the laws fail to give the state any authority to investigate individual assisted-suicide deaths for abuse, even if abuse is reported. The lack of data and the inability to conduct investigations significantly elevates the risks for disabled patients. [NCD, “The Danger of Assisted Suicide Laws,” 10/9/19, pp. 11-12] ■



Targeting People with Mental Illness & Dementia for Euthanasia

By Wesley J. Smith

A few years ago, a Dutch doctor attended her elderly Alzheimer's disease patient at a nursing home. The doctor's purpose wasn't to examine the patient or prescribe new medicines. Rather, she was there to kill.

While competent, the patient asked to be euthanized when incapacitated, but she also instructed that she be allowed to say when. But before she did that, the doctor and her family decided that her time had come. The doctor drugged the woman's coffee and, once she was asleep, began the lethal injection procedure. But the patient awakened unexpectedly and *fought against* being killed. Rather than stopping, the doctor instructed the family to hold the struggling woman down while she completed the homicide.

This would seem to be a clear-cut case of murder. But a judge recently exonerated and praised the doctor for acting in the "best interests" of the patient by merely executing the woman's previously stated wishes. In other words, the judge essentially ruled that the struggling patient was no longer competent *to want to stay alive*.

The only unusual aspect of the "Case of the Struggling Alzheimer's Patient" was the struggle. Even when incompetent and unable to make their own decisions, the laws of the Netherlands and Belgium allows dementia patients to be killed by doctors if they so order in written advance directives.

Both countries also allow mentally ill patients who ask to die to be euthanized. Such procedures are not rare. According to government statistics, in 2017, Dutch psychiatrists and doctors euthanized 83 mentally ill patients. Sometimes these legal homicides are accompanied by consensual organ harvesting after death. One case—reported in an international transplant medical journal—involved a self-harmer (or "auto-mutilator") for whom doctors applied the ultimate harm as a "treatment." Without criticism—or even a moment's reflection about the moral questions raised by such an act—the medical journal reported approvingly that the lungs of the deceased psychiatric patient were well accepted by their recipients.

The Supreme Court of Switzerland, a country that permits assisted suicide clinics—ruled several years ago that the mentally ill have a constitutional right to access death. Accordingly, there are many verified cases of the non-physically ill being assisted to kill themselves—including an elderly woman who wanted to die because she had lost her looks.

Canada, which recently legalized lethal injection euthanasia for those whose deaths are "reasonably foreseeable," now is debating expanding the right to be killed to those whose lives are not in danger. Prime Minister Justin Trudeau is on record as favoring liberalization and has stated his government will not appeal a recent court ruling declaring the foreseeable death limitation to be unconstitutionally restrictive and discriminatory.

Expanding laws

How far is the expansion likely to go? Many Canadian euthanasia advocates are pushing for revisions that would allow people with mental illnesses and dementia to be killed by doctors in the same manner as now allowed in the Netherlands and Belgium. And here's some breaking news: the Alzheimer Society of Canada—which is supposed to advocate for the welfare of such patients—has officially endorsed allowing euthanasia by advance directive. This means that even if the incompetent patient is not suffering—perhaps even if he or she expresses no desire to die—their former self's decision trumps the current self's needs and desires.

Meanwhile, there has already been at least one depressed Canadian apparently euthanized at his request even though his death was not foreseeable. The man's family even *begged* doctors not to kill him, but to no avail.

Threatening attitudes in U.S.

What about the U.S.? Would we ever follow such a course? As of now, the nine states and the District of Columbia that have legalized assisted suicide limit access to patients who are terminally ill. But that's more a political expediency than a principled limitation. Indeed, restricting assisted suicide to the dying is philosophically unsustainable.

Think about it. If the point of allowing suicide by doctor is to eliminate suffering—and if eliminating suffering can include eliminating the *sufferer*—how can facilitated death be forbidden to patients, such as those with dementia and mental illness, who may suffer far more extremely and for a much longer time than the already dying? It makes no sense.

Despite continuing disapproval of euthanasia for mental illness by the American Psychiatric Association, that point is increasingly being made in the media and professional journals. For example, an article just published in the *American Journal of Bioethics* argues that since "the suffering associated with mental illness can be as severe, intractable, and prolonged as the suffering due to physical illness," as a matter of "parity," in "severe" cases, "PAD" (physician-assisted death) should be made available to mentally ill patients with "decisional capacity"—even when they have "a relatively long expected natural lifespan." The authors, University of Utah psychiatry professor Brent M. Kiouss and noted assisted suicide advocate and bioethicist Margaret (Peggy) Battin, go so far as to suggest that "psychiatrists and other mental health professionals" could one day become "gatekeepers for PAD" once "a metric for suffering in both mental and physical illness" is established.

Ponder this for a moment. Instead of being duty-bound to save the lives of all their suicidal patients, mental health professionals would become approvers for and facilitators of self-destruction. That should be unthinkable.

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World Medical Association maintains strong opposition to induced death practices

In spite of pressure exerted by certain national doctors' groups to go neutral on induced-death practices, the World Medical Association (WMA)—an international confederation of currently 112 national medical associations, representing more than 10 million physicians globally—has reaffirmed its long held opposition to both euthanasia and physician-assisted suicide (E-PAS).

In October, during its 70th General Assembly in Tbilisi, Georgia, the WMA adopted a revised declaration that states:

“The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the

WMA is firmly opposed to euthanasia and physician-assisted suicide.” [WMA Declaration on Euthanasia and Physician-Assisted Suicide, adopted 10/19]

“Having held consultative conferences involving every continent in the world,” said WMA Chairman Dr. Frank Ulrich Montgomery, “we believe that this revised wording is in accord with the views of most physicians worldwide.” [WMA press release, 10/26/19]

Earlier this year, the WMA called for the submission of written opinions regarding its E-PAS policy statement in the WMA Code of Ethics. This policy reexamination may have been the result of last year's attempt by the Canadian Medical Association and Dutch

Medical Association delegations to push a resolution calling for the WMA to go neutral on E-PAS practices—practices that are legal in both countries. However, the Canadian and Dutch delegations ended up withdrawing their resolution at the last moment due to a lack of support from other national delegations.

The new WMA declaration also emphatically supports the right of doctors to be conscientious objectors:

“No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.” [Declaration, 10/19] ■

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Alas, the first small legal steps toward permitting the demented and mentally ill to access suicide by doctor have already been taken. After California legalized assisted suicide for the terminally ill, the Department of State Hospitals promulgated a regulation requiring that patients who have been involuntarily committed—and who have become terminally ill—be provided access to assisted suicide despite their mental illness. By definition such people are not legally competent, or else why would they be involuntary hospitalized?

Nevada's new law

Meanwhile, Nevada just enacted a law that allows dementia patients to instruct caregivers to withhold “food and water” once they reach incapacity so they starve and dehydrate to death. Please note that this first-of-a-kind law isn't about refusing a feeding tube or preventing force-feeding. Rather, the law (SB 121) permits patients to order their future selves to be refused “food and water”—even if they willingly eat, perhaps even if they ask caregivers for sustenance.

That's homicide by neglect.

Don't take my word for it. The influential bioethicist Thaddeus Mason Pope wrote about the law:

Even after we stop offering food and fluids, other problems may arise. Most problematically, the patient may make gestures or utterances that seem to contradict her prior instructions [to be starved]. Does such communication revoke the advance directive? A recent court case from the Netherlands suggests the answer is “no.” Once the patient reaches late-stage dementia, she is unable to knowingly and voluntarily revoke decisions she made with capacity. But the answer remains uncertain in the United States.

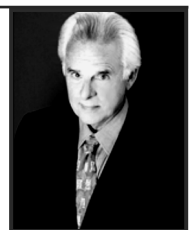
In other words, Pope believes that a court could one day rule that an advanced dementia patient isn't “competent” to want to eat.

Of course, the point of such advocacy isn't really starvation but convincing people to allow intentional, fatal overdosing of these vulnerable patients by doctors. After all, if we are going to end their lives, the reasoning goes, we should at least do it humanely. If we accept the propriety of intentionally ending dementia patients' lives based on their prior instructions, that argument certainly has emotional appeal.

Accelerating advocacy for legalizing euthanasia is pushing us toward making a stark choice. We can decide that assisted suicide is an acceptable response to human suffering, allowing people to die—but also unleashing gravitational forces of logic that will lead inexorably (over time) to a broader killing license, including of the killing of dementia and mentally ill patients as advocated by Kiouss and Battin. Or, we can focus instead on suicide prevention *in all cases*. Such caring takes more time, commitment, and resources, but better exemplifies true “compassion,” the root meaning of which, after all, is to “suffer with.”

Kiouss and Battin are on the mirror opposite side from me in the euthanasia debate, but we agree that there is no such thing as a “little” euthanasia: In for a penny is in for a dollar. Those with eyes to see, let them see.

Wesley J. Smith is a consultant to the Patients Rights Council and a senior fellow at the Discovery Institute's Center on Human Exceptionalism. This is an edited version of his article that appeared in The American Spectator on October 17, 2019. It is printed here with the author's permission.





News briefs from home & abroad . . .

- **Canada:** As mentioned in the article on page 2 by Wesley J. Smith, there has been a disturbing euthanasia case in British Columbia involving a depressed 61-year-old man. Alan Nichols suffered with depression most of his life, but his family said the he was doing well on medication. In 2004, however, he stopped taking the antidepressants after his father's death. Alan had relied heavily on his dad, who managed his son's everyday life.

After his father died, Alan wanted to live by himself, so his brother, Wayne, would visit him every week to bring him groceries and do his banking. A neighbor would look out for Alan as well. He would sometimes be easy to deal with, other times he would isolate himself, refuse to see his doctor, not eat properly, and become severely depressed. His brothers, Wayne and Gary, requested guardianship of Alan in 2015 so they could care for him, but their petition was denied. The brothers said they continued to try to reach out to Alan, but their help was often rebuffed.

Then this year, on June 16, a neighbor called police to conduct a wellness check on Alan. They found him weak, dehydrated, malnourished, and confused. He was admitted to Chilliwack General Hospital. When his brothers arrived soon after, Alan wanted to leave the hospital, but the family felt he needed medical attention. "We thought this would be the best place for him to get back on track," Gary explained. "We would never have allowed this to happen if we knew the outcome."

According to the family, the hospital staff kept telling them that Alan was doing well, but he did not want to speak to them. Then, on July 22, the hospital informed the family that Alan was scheduled to be euthanized in four days. "I started crying," Gary said. "I never thought it would get to

that. Just never thought he would ever be approved even if he applied for it." Alan was not terminally ill or in an irreversible state of decline, and his depressed state of mind, according to Gary, was not conducive to true informed consent. When Alan's sister-in-law told the doctor Alan's killing could not happen because the family opposed it, the doctor simply said, "Well you can't stop this. Alan is the only person who can stop this."

Alan's life was ended on July 26 with his family watching in disbelief. The hospital has refused to give the family Alan's euthanasia medical records or even tell them the reason Alan's death request was approved. The family has asked the Canadian police to investigate the case. [CTV News, 9/24/19; BioEdge, 9/29/19]

- **The Netherlands:** According to a new report, 84% of Dutch pediatricians want euthanasia to be legal for children 1 to 11 years of age. It is already permissible for minors 12 to 16 years-old to be euthanized with their parents' approval. Also, the lives of infants under 12 months-old can be terminated if doctors follow the Groningen Protocol, which was adopted in 2004. The protocol was created by Dr. Eduard Verhagen and other doctors at the Groningen Academic Hospital who wanted doctors who kill disabled newborns to have legal protection. Infanticide clearly violated the law's requirement that euthanized patients be competent to voluntarily request death.

The new report—sent to the lower house of the Dutch Parliament for consideration by Minister of Health Hugo de Jonge on September 28—contains the results of a small survey of 38 pediatricians who collectively treated 359 seriously ill minors in the last five years. The doctors said that, in 46 of those cases, the active termination of the children's lives would have been better for all concerned. The Dutch Association for a Voluntary End of Life said, "There must be no obstacles for courageous doctors who support the child and parents in this." [BioEdge, 10/20/19] ■

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law professors, wrote, "In [Baudouin's] 770-paragraph decision is a damning indictment of the unnecessary cruelty of the 'reasonably foreseeable' criterion." [Policy Options, 9/16/19]

But disability rights advocates condemn the judge's ruling as cruel. "Basically, this decision is saying that as far as society's concerned, it's better to be dead than disabled," explained Amy Hasbrouck, Executive Director of *Toujours Vivant-Not Dead Yet* (Canada). She added that, instead of making death easier to access, society should be improving needed services for those with severe disabilities so they can have an improved quality of life and be able to live in their own homes. [CBC News, 9/11/19]

Dr. Michel Racicot, who represents the Collective of Physicians against Euthanasia, said, "If we remove this criterion [to be terminally ill], we do not transform medical aid in dying into help for the dying person; rather, it becomes almost death-on-demand for people who are suffering, but who may still have a long life ahead of them." [Mercator.net, 9/17/19] ■

The Patients Rights Council is a human rights group formed to promote and defend the right of all patients to be treated with respect, dignity and compassion and to work with individuals and organizations to resist attitudes, programs and policies which threaten the lives of those who are medically vulnerable. To those ends, the PRC compiles well-documented and up-to-date information on a whole range of end-of-life issues, including health care advance directives, futile care policies, health care reform, and doctor-prescribed death.

The *Update* is available to the general public; suggested minimum donation is \$25.00 [U.S.] a year. Add \$3.00 for foreign postage.

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