



Vincent Lambert Was Saved From Death by Dehydration, For Now

The Vincent Lambert case has been winding through the French and European courts for several years.

Lambert was cognitively disabled from a motorcycle accident in 2008. In 2015, his wife petitioned the court to have treatment and care ceased including food and water. His parents wanted their son transferred to a rehabilitation center. The legal battle concerning withdrawing food and water has continued.

Two weeks ago the [United Nations Committee on the Rights of People with Disabilities](#) intervened stating that denying Lambert food and fluids contravened his rights as a person with disabilities. Section 25f of the [United Nations Convention on the Rights of Persons with Disabilities](#) requires nations to:

25(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

[Euronews](#) reported on May 20 that doctors at a hospital in Reims, France were deeply sedating Lambert as part of the process to withdraw food and fluids to cause him to die by dehydration.

Later that day, [Euronews](#) reported that the Court of Appeal in Paris ordered that Lambert be fed and hydrated. The decision was in response to the UN



Vincent Lambert

Disability Rights Commission appeal. [BBC News](#) reported Lambert's mother as stating:

"They are going to restore nutrition and give him drink. For once I am proud of the courts..."

Lambert is a disabled man who is not otherwise dying or nearing death. To directly and intentionally cause his death by withholding fluids is euthanasia by dehydration because he is not otherwise dying. His death would not be from his medical condition but rather, he would die by dehydration, a terrible death.

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Ontario Court of Appeal Upholds Decision Forcing Doctors to Refer

By Alex Schadenberg

In its [decision concerning conscience rights in Ontario](#), Canada, the Ontario Court of Appeal upheld the lower court decision.

A group of physicians challenged the College of Physicians and Surgeons of Ontario (CPSO) policy requiring physicians to make an “effective referral” for Medical Aid in Dying (MAiD, i.e. euthanasia and assisted suicide). The Court found that their Charter rights were infringed by the policy, but the infringement is reasonable in a free and democratic society.

An “effective referral” means that a physician must refer patients to a physician who is willing to carry out the act. In the case of euthanasia, a physician who opposes killing their patients must send them to a physician who will kill.

There are some interesting comments in the decision. Paragraph 16 emphasizes that the CPSO referral is a policy and not a standard, code or guideline. The Court focuses on how the policy will not lead to professional misconduct for non-compliance, possibly to encourage the CPSO and objecting physicians to find a negotiated outcome.

Paragraphs 183 to 187 emphasize that a physician can retrain or change their specialty. I consider this to be paternalistic at best.

The decision negates the reality that an effective referral does force physicians who oppose killing to participate in the act. The Court suggests that the decision “strikes a reasonable balance between patients’ interests and physicians’ Charter protected religious freedom” but in fact it is not a reasonable limit prescribed by law in a free and democratic society.

The objecting physicians only asked that they not be required to refer and that Ontario bring forth a policy similar to Alberta whereby physicians can inform patients that MAiD can be accessed through a government toll-free number.

What is also missing in the decision is that many patients seek a physician who will not kill them. These people should be able to get medical care from someone who shares their beliefs. **Why should those who believe in killing be the only health care consumers who have “rights” in the medical system?**

The decision assumes that MAiD is health care. Canada’s federal legislation legalized MAiD by defining it as an exception in the Criminal Code.

The decision confirms that we need to convince provincial governments to protect conscience rights or help to elect a federal government that will protect conscience rights through legislation, such as David Anderson’s Bill C-418.

America Moves to Protect Conscience Rights for Health Care Professionals

By Alex Schadenberg

The Trump administration recently announced an order to protect conscience rights for health care workers in America. According to [CNBC](#) on May 7:

In a release last week, the Health and Human Services announced the issuance of its [final “conscience” rule](#), which it said follows President Donald Trump’s May 2017 [executive order](#) and his pledge “to promote and protect the fundamental and unalienable rights of conscience and religious liberty.”

The [CNBC](#) critics of the provision claim that conscience rights will lead to more discrimination. The city of San Francisco has filed a lawsuit claiming that conscience rights, as outlined by President Trump, are unconstitutional.

Roger Severino, from the HHS Office of Civil Rights responded to the critics by stating to [CNBC](#):

“The rule provides enforcement tools to

federal conscience protections that have been on the books for decades,”

“The rule does not create new substantive rights.”

“We have not seen the hypotheticals that some have used to criticize the rule actually develop in real life. Faith-based providers just like all providers should be allowed to serve those most in need without fear of being pushed out of the health care system because of their beliefs, including declining to participate in the taking of human life.”

On May 8, I had the opportunity to speak at a parliamentary gathering in Ottawa on David Anderson’s conscience rights legislation ([Bill C-418](#)). Other than Manitoba, in Canada physicians’ conscience rights are not being respected.

Conscience rights are fundamental human rights that enable medical professionals to work as equal citizens while protecting the rights of patients who seek a physician who shares their values.



HEALTH CANADA PUBLISHES INACCURATE AND INCOMPLETE DATA ON EUTHANASIA



On March 21, we reported that there were 4,235 “Medical Aid in Dying” (MAID) euthanasia deaths in 2018, an increase of 50% over 2017, representing approximately 1.5% of all deaths. This data was obtained from a presentation by Jocelyn Downie, an academic euthanasia activist, on March 15.

On April 25, Health Canada released the [Fourth Interim Report on Medical Assistance in Dying](#) which stated that there were 2,614 assisted deaths between January 1 and October 31, 2018. The report indicated that the data was incomplete for Quebec and the three territories. The report incorrectly stated that assisted deaths represented 1.12% of all deaths in Canada. Richard Egan, a researcher with [Australian Care Alliance](#), indicated that the percentage of deaths by euthanasia is actually 1.46%.

Health Canada is not concerned with the quality of the MAID report. Egan explains:

The report gives a total of 2,614 deaths by euthanasia for the same period Jan–Oct 2018 for Canada excluding Quebec. (And the NWT, Yukon and Nunavut for which there is also no data for 2017 deaths in the Statistics Canada death by months report.)

The report appears to have divided 2,614 into 232,983 to get 1.12%. However the correct calculation should use as its denominator the presumed number of deaths for Jan–Oct 2018 for Canada excluding Quebec.

Dividing 2,614 by 178,299 gives a percentage of deaths by euthanasia of all deaths in Canada excluding Quebec of 1.47%.

This more closely matches the data reported by Jocelyn Downie. She reports 4,235 deaths by

euthanasia for all of Canada (including Quebec) in 2018.

Egan then published further research on the data with the following [information](#):

Euthanasia deaths as a percentage of all deaths varies by province with British Columbia (2.37% of all deaths) nearly three times as deadly as Saskatchewan (0.84% of all deaths).

Other provincial rates are: Quebec 1.54% [Jan–Mar 2018]; Ontario 1.39%; Manitoba 1.25%; Alberta 1.18% and the Atlantic provinces (Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick) 0.98%.

One fact the fourth interim report did get right is what is really involved in what the Canadians euphemistically call MAID—medical assistance in dying: MAID is “an exception to the criminal laws that prohibit the intentional termination of a person’s life.”

MAID includes both euthanasia and assisted suicide. As of October 2018 there were six cases of assisted suicide under the Canadian law compared to 6,743 cases of euthanasia.

This preference for euthanasia over assisted suicide has implications for other jurisdictions considering euthanasia and assisted suicide legislation.

The Euthanasia Prevention Coalition requested “Medical Aid in Dying” euthanasia data from every province since the federal government has been deliberately slow in releasing data. Most provinces have refused to provide it. Egan’s analysis shows how the Health Canada report is inaccurate and incomplete.

WHY I CHANGED MY MIND ON EUTHANASIA

Chris Ford, a socially left researcher and writer in New Zealand explains why he changed his mind on euthanasia. His commentary was published on May 27 by [Newsroom](#) (edited for length):

...The turning point for me came about a month ago. I saw the report of a meeting hosted by People First (a group run by and for people with learning/intellectual disabilities). At that meeting, access to health care was discussed, as this is a key issue for people within this segment of the disability community who find it difficult accessing care for many reasons, including attitudinal issues on the part of some medical professionals. Stories were shared where some people who had gone to hospital for treatment had discovered unrequested 'no resuscitation' orders attached to their files.

This brought home to me one of the key arguments of the anti-euthanasia camp: that people who are already marginalised or devalued would be at high risk from euthanasia. The pro-euthanasia lobby would counter that people will have the right to exercise real legal choice and that the rights of vulnerable people would be better protected within the EOLC (David Seymour's End of Life Choice Bill)...

While I am pleased...that the legislation is expected to only cover the terminally ill with a diagnosis of less than six months—I have become more aware of the counter-arguments to this limitation (which I initially supported).

The counter-argument is that a diagnosis is not a definitive time statement. A person who is given six months or less to live can die tomorrow, next week or last many years. A diagnostic timeframe is simply a clinician's best-informed opinion. Also, people can live for many years with a terminal illness or condition and still enjoy a high quality of life if they have the right supports and treatment.

That brings me to my next point about the choice element. Voluntary euthanasia proponents say that terminally ill people who fall within the law's remit will have to prove that they are under no pressure to die and that the choice will be theirs in the end. This is what drew me to initially support voluntary euthanasia. Yet I have come to learn that there is no definitive measure or mechanism that will ever be able to check if a person is doing this out of their own free will or being coerced. There are too many reports of the abuse of older and disabled people in our society already and this is why even the best safeguards may be prone to failure.

More pertinently, the way that society views disabled people is still largely negative and any introduction of euthanasia laws might further diminish our standing in the eyes of wider New Zealand society. Anecdotal reports from disabled people in other countries suggest how attitudes towards the disability community have shifted. All the above reasons are why Disability Rights Commissioner Paula Tesoriero has cited voluntary euthanasia as a key human rights issue given that I and other disabled people already face barriers to our participation within the Aotearoa community. These include funding constraints on disability supports.

Therefore, the choices that disabled and older people have are largely determined by wider society. If society (through government) starts stripping the supports we need to live while also introducing euthanasia, then the right of disabled people to exist becomes even more questioned...

This leads to my ultimate argument—wouldn't the legislation be an effective weapon in a time of economic austerity when spending on social services would be even tighter than it is now? One could imagine that deeper future cuts to health and disability services, for example, would see many more disabled people placed under even greater pressure by both government and wider society to feel worthless and a burden...

If you don't believe me about the double impacts of the withdrawal of social provision and health care for disabled people, then a disabled man in a Canadian health facility secretly recorded a conversation he had with staff in which he was offered euthanasia as an alternative to receiving funding for ongoing support to live in the community. Listening to that conversation shook me greatly. It revealed the quintessential nexus between euthanasia and neo-liberalism in that if you have less choice through fewer supports, then why not take the quicker, easier and cheaper way out—death!

That is why many progressive left wingers have come out against euthanasia. Essentially, they hold the same position that I do: before we can think about a good death, we need to build fair, equitable and just societies which can sustain good lives for everyone instead.

That is how I have been moved to see things in recent months—how a good life can be lived and once done, a good death can follow. For that reason, Parliament needs to reject the bill and embrace real choice in living for everyone!

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