

Intro

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I am a lawyer, estate and financial planner and director in philanthropy. I have worked with the elderly both professionally and on a volunteer basis for over twenty years.

In addition, I have some personal experience in this area with members of my family as well as with clients and donors.

I feel obliged to contribute my thoughts on the following subjects, and I ask to appear before the committee:

Summary

- 1) The play on words that will inevitably lead to a jurisdictional debate
- 2) The jurisdictional challenge
- 3) The role of law and responsible government, public safety and social justice as an override to individual will
- 4) Inappropriate methodology and availability of the questionnaire to support statistics that will be cited, and possibly lack of good faith in drafting the questionnaire, which is at best biased
- 5) The vocation of health professionals revisited and the quality of the doctor patient relationship at large if this were to pass
- 6) Investment in palliative care resources and formation as opposed to a strategy of abdication before demographic and budgetary challenges
- 7) Informed consent

8) Life insurance - will there be a payout in the event that Quebec legalizes euthanasia and/or assisted suicide? Has the government considered this? Moreover, has the public thought about the implications of this in their estate and "health care" planning?

9) The experience to date in other jurisdictions

10) Personal experiences in the human realm

General Presentation

1) Quebec is treading on delicate ground. Let us call a spade a spade. Health care can never be equated to killing, i.e. deliberately causing the death of a person.

What does dying with dignity mean? Palliative care provides a dignified death by giving patients the pain management and the social, emotional and spiritual support they require to live a good death. It is also limited to ensuring patient relief and comfort.

Health care is rather investing in resources, providing knowledge and ongoing professional development and formation in pain management.

2) There are serious constitutional issues around appropriate application of the federal and provincial powers, the residual or general power and the Quebec, Canadian and Universal Declaration of Human Rights.

The residual or general power remains a potent source of federal power. This is definitely an issue of national concern.

Uniformity of law throughout the country is not merely desirable but essential, in the sense that the problem is beyond the power of the province of Quebec to deal with. S.91 (27), the criminal law power, is intimately associated with health care. By using its power to declare something a crime (i.e. killing), the federal government has the power to restrict or expand health activities. The Supreme Court decision RJR – MacDonald significantly expands the potential for federal reliance on the criminal law power in the area of health.

We need to consider the Canadian and global environment and the protection afforded by the relevant charters of human rights. The Canadian and Quebec Charters speak of respect for human dignity, right to life and security of the person.

Clearly there is an eye to protect the most vulnerable. The Universal Declaration of Human Rights also clearly states that "Everyone has the right to life, liberty and security of person".

I will argue that in order to uphold this right for all Canadian citizens, when faced with the prospect of Quebec attempting to legalize euthanasia and assisted suicide, we need to encourage new research and education on pain relief, provide public funding for more

palliative care centers and units in order to ensure that all Canadians have access to end of life care, and develop fiscal measures to allow primary care givers to commit themselves freely to the support of their sick or dying loved ones.

3) Has the government forgotten the role of law and responsible government? What have we come to if budgetary constraints get in the way of protection of human life? How can the government irresponsibly point to false statistics and make this a numbers game, while abdicating its role as promoter of public safety and social justice?

The first law course I took at McGill was entitled Foundations, the gist of which was that the law should reflect morality, the positive law, not religion, but the natural law embedded in the conscience of every human being, i.e. which commands us to protect life and not to kill.

My sixteen year old was shocked at learning about the possibility of legalizing euthanasia and assisted suicide in Quebec. She quickly pulled out the following inconsistency of approach. As Canadians, we have rejected the death penalty knowing that, among other things, i.e. respect for the dignity of human life, I would imagine, occasional errors could lead to the execution of innocent people. It is a contradiction and an injustice to allow some people to directly and intentionally kill others, especially when they are most vulnerable. This is a question of public safety and social justice.

She also found it ironic how Quebec manages to have such a high suicide rate amongst teens and how much money the Quebec government is willing to invest in suicide prevention and then introduce the legalization of assisted suicide! Would we assist teens in suicide if they deemed their quality of life unbearable or would we rather choose to treat their depression?

4) The province ought to have mailed a questionnaire to all Quebecers if it really wanted to cite accurate statistics in terms of support for the change.

Having sat for hours in questionnaire analysis on governance board committees, I respectively submit that good governance requires better formulation of the questions, so that they are clear and unbiased. Just as one example, it is incorrect to ask the public if, given the choice, they would support a) euthanasia, b) assisted suicide or c) undecided. There is no option for d) neither.

Inappropriate canvassing, inappropriate formulation and inappropriate analysis are a recipe for disaster. I know many people who chose to print the questionnaire and mail it in, because they were blocked if they wished to skip the undecided option.

I also challenge the statistics cited with regard to physicians. Many did not catch the e-mail, many do not themselves understand the nuances in the definitions of therapeutic

obstinacy, cessation of treatment, euthanasia pure and true, refusal of treatment and palliative and terminal sedation.

If they do not understand, how can one imagine the general public would? Not enough effort has gone into educating the public and the professionals on this very serious issue.

5) Health care professionals enjoy the independence of the actual state of the law, where they can take note of directives from patients and family but are not bound to uphold them.

They need to exercise their vocation with professionalism and good judgment. This is not a transactional vocation.

A change in law would jeopardize the role of the medical profession and fundamentally alter the doctor-patient relationship because the so called "right to die" would give doctors the right to directly and intentionally kill. It would undermine the trust between patients and doctors, leading the sick, persons with disabilities and the elderly to fear going to hospitals and other care-giving institutions.

My family law professor predicted that no fault divorce legislation would increase the statistics on divorce. Great prediction! One could also predict that if a physician could carry out euthanasia, he or she would not do everything possible to keep the patient alive.

6) The public needs to be educated in order to offer enlightened responses.

I believe that if everyone understood that there is no legal obligation to receive treatment in Canada your questionnaire would be perceived differently. How many people are unaware that a competent patient or the proxy of an incompetent patient has the legal power to accept or refuse any treatment, or ask that it be discontinued?

Or that the withdrawal or withholding of extraordinary or disproportionate treatment, when its burdens outweigh its benefit, is not euthanasia because the intention is not to cause death but to allow the person to die naturally? There is a great difference between "allowing" to die and "making" to die.

A peaceful death comes from acceptance, not control. It is important that those people who are suffering are given compassion and help on their journey towards acceptance, until their natural death.

Uncontrollable pain is quite rare. In most cases, severe pain can be relieved; if not, it is often because physicians lack formation in pain management. Therefore, let us concentrate on the need for research and training in this area.

We need to eliminate the pain, not the patient. Incorporating euthanasia into palliative care confuses the general public about the true role of palliative care.

In countries where euthanasia and/or assisted suicide are legal, fewer financial resources go towards developing palliative care, which is the truly human answer to end of life challenges. Good palliative care can help the dying find meaning in their pain and suffering and enable them to deal with unfinished business in their lives.

7) Capacity to consent to care refers to a person's capacity to understand the nature of the illness for which treatment is proposed, the nature and purpose of the treatment, and the risks and benefits of receiving or not receiving the treatment.

I question whether it is really possible to make free and informed decisions in an end-of-life context.

In fact, lack of respect of protocol in jurisdictions that have legalized either euthanasia or assisted suicide would confirm the difficulty of respecting conditions that lend a false sense of security.

8) It would be naïve to think that legalizing both of these possibilities would not have an effect on life insurance coverage and the protection or lack thereof for those left behind.

Has this even been considered? What would the effect on life insurance coverage be?

For example: since suicide during the first 2 years a policy is in force (in Canada) will have a negative effect on death benefits, what would a regime supporting suicide do to take this into account? Would/should any affected person during that initial period be asked to sign off, acknowledge understanding of the point, etc etc.

This issue has both ethical/religious and practical/financial implications, either or both areas may well concern many people.

9) I wish to stress that no other province in Canada has gone towards legalization, and I re-emphasize my position as to this being a national concern.

A careful study of the situation in those countries and/or states that have passed such legislation shows that a slippery slope exists. There are no full proof safe guards. They rely on self-report by doctors.

They have on the contrary continued to extend their programs to include the vulnerable members of society.

In the Netherlands, the government has adopted the Groningen Protocol which allows parents to request euthanasia for their severely disabled newborns.

A study showed that between 1990 and 2000 the Swiss euthanasia group Exit Deutsche Schweiz assisted in 748 suicides. 21.1% of these people did not suffer from fatal conditions.

In Belgium, the pro-euthanasia lobby is now demanding euthanasia for minors and for citizens with dementia.

10) My first experience with palliative care and terminal cancer was with my brother's fiancée, Carol-Lise, who was diagnosed with AML, the second worst form of leukemia, at the age of 24.

Her parents, my brother, friends and family accompanied her through a period of fifteen months. During her palliative days, she prepared her eulogy and with acceptance went from the preparation of her wedding to the preparation of her funeral.

The experience undoubtedly entailed suffering for her personally, both physical and psychological, but I witnessed a spiritual journey in her that stayed with me to this day.

I became good friends with her palliative care nurse, who has since become an expert in pain management and who also grew from this personal experience.

My brother swears that, given the choice, he would relive the experience as he did, through to her natural death.

I was at her home the morning of her death and made the call for the disposal of the morphine. There was nothing morbid or unnatural about this sad process. Her death affected so many that were called to "be with" and to "suffer with" Carol-Lise. That is the true meaning of compassion. Her fight and acceptance helped me face life's daily contradictions better, with an appropriate perspective. We made sure we provided proper care, effective pain control, along with social, emotional and spiritual support.

Euthanasia is absolutely opposed to compassion because in the act of killing we abandon the patient when she needs us most. True compassion is about presence, solidarity and love: to become a partner in suffering, helping the other find meaning until death occurs naturally.

Just recently I came to know a donor who was in the fourth stage of cancer and who would frequently phone me to "vent". One day she called me in a fretful state and I re-adjusted my agenda to meet her up at the hospital with a bouquet of flowers. She ran through so many important things in our conversation, a lot of unfinished business that she had to tend to.

On another occasion, during a phone conversation, she cursed Margaret Somerville for her ethical stance on the dignity of human life, and she was challenging her to find dignity in what she was experiencing. She asked me if I knew her and I replied that I did actually, I had taken a comparative medical law course with her in law school. At one

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→ KILL THE SUGGESTION
NOT THE PERSON S.V.P.

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