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Top five myths about euthanasia and assisted suicide

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The debate over euthanasia and assisted suicide has resurfaced in Canada. Bill C-384, a Private Member's Bill, is before the House of Commons for debate a second time next week. In order to know the foundational issues of this discussion and regarding this bill, here are the top five myths surrounding euthanasia and assisted suicide.

1. Euthanasia and assisted suicide are all about choice

C-384 gives doctors permission to aid in suicide or kill without fear of prosecution if they and their patients meet certain criteria. The Bill actually protects doctors more than it gives choice to individuals. An individual can only request assisted suicide when they "appear lucid". The appearance of lucidity allows for too many loopholes. And doctors have no manner of ensuring that such a person is not under influence by another. To put it bluntly, if a relationship has soured between a caregiver and a vulnerable person, we have no way of assuring that the vulnerable are not strongly influenced to die early.

C-384 allows anyone who has tried all or refused to try any available treatments to request assisted suicide. This must include individuals suffering depression, because the bill makes no mention of requiring depressed individuals to seek treatment. But even Dying with Dignity Canada thinks that "it would be unconscionable to encourage or support them (people with depression) in a transitory wish to die."

2. Euthanasia and assisted suicide give people control over the time, place, and method of their death

C-384 requires that the individual sign an effective power of attorney to appoint someone to kill them if/when they no longer "appear lucid". It requires the doctor to "(act) in the manner indicated by the person" when assisting in their suicide or killing them. But the reporting mechanism in the bill leaves no room for accountability. Once again, doctors, not patients are in control.

3. It's happening already. We should therefore legalize it

Apparently, bringing euthanasia and assisted suicide out of the shadows and into law will make it safer through regulation. Yet C-384 requires the doctor assisting in the suicide or killing the individual to forward only a copy of that person's diagnosis to the coroner. No record need be kept that the person actually died by assisted suicide; the coroner would have no trace of assisted suicide and therefore no way to test how accountable the doctor is to the law. Hardly safe, hardly out of the shadows.

4. Without legalized euthanasia and/or assisted suicide, people suffer and die a lengthy, painful death

The suffering of those with painful terminal illnesses is emotional and very difficult both for the patient and family members. This cannot be romanticized—and watching a loved one in pain is a terrible burden. However, good palliative care alleviates this pain and palliative care specialists do not wish to keep people alive simply for the sake of it. Palliative care teams seek to walk with the patient and their family on that road to natural death, treating and alleviating individual and family pains of all sorts. To say that death is the only way to deal with pain and suffering is clearly not the whole picture.

5. Euthanasia and assisted suicide are part of palliative care. Making them legal only offers more choice to patients

Currently, palliative care strives to help a patient and their family physically, emotionally, spiritually and mentally to die well, naturally. Euthanasia and assisted suicide interject human action or medical intervention to kill. The two are mutually exclusive. If this confusion is allowed to take root, then terminally ill patients seeking to die well naturally will not want to go to a palliative care ward for fear of being killed too soon.

The following links have more information and resources on this issue:

Euthanasia and assisted suicide terminology

Health issues (IMFC research)