

# VOICE FOR CHOICE

## DWD SPOKESPERSON ENDS HIS LIFE: TRIUMPH AND TRAGEDY

*Meg Westley, DWD President*

On April 22, 2012, I had the honour to be present when Nagui Morcos ended his life. He died as he had lived, on his own terms. Nagui's journey towards death began eighteen years ago, when he learned he carried the gene for Huntington's disease, the illness that took his father's life. Nagui and his brothers cared for their father during his last painful years, when he had lost not only motor control but also his mental clarity and emotional stability. It was an agonizing time for all concerned. Nagui vowed not to die that way.

Eight years ago, Nagui began to experience symptoms of the disease. He joined DWD's Client Support Program and described the day he talked with Dying With Dignity as "one of the happiest days of my recent life." He knew then he would be able to end his life when he felt it was no longer worth living.

His wife Jan supported him all the way. She wanted to be part of his decision-making, part of his life and his death. They both became ardent and eloquent spokespeople for the right to die. Even as Nagui's condition deteriorated, he spoke with calm conviction about his choice and why others should have that choice. Dr. Brian Goldman, who interviewed Nagui on CBC Radio's *White Coat, Black Arts*,



Nagui Morcos

felt deep unease that anyone could plan his own death, but he could not deny the rational, thoughtful nature of Nagui's decision.

When the day arrived, Nagui faced death with courage and composure. Although clearly sad to leave Jan, he declared the time was exactly right, not a moment too soon or too late. He died in peace and dignity, just as he wanted to. His death was a triumph.

*Continued on page 4*

## NO DOUBT ABOUT IT: CHECKS, SAFEGUARDS, AND DOUBLE-CHECKS

*Dr. Johnna Fisher, DWD Board Member and Client Support Program Volunteer*

As a biomedical ethics instructor, I get to teach future doctors, nurses, and pharmacists about their obligations toward patients. I also get to educate future patients about their rights. I feel good with each class, knowing I'm helping set high ethical standards to safeguard Canadian patients. But I'm not naive. I know there can be a big gap between theory and practice and that people don't always practice what they preach.

I was delighted, therefore, to join the Client Support committee at Dying with Dignity Canada and experience first-hand the ethical safeguards we have in place to ensure clients seeking our assistance get the right help at the right time from the right sources.

The foremost principle of Canadian politics, law, and ethics is respect for the autonomy of the rational, mentally mature adult to make decisions about her life and its course, so long as she is not harming others. Exercising one's autonomy depends on adequate information disclosure as well as respect for privacy and confidentiality. These values are integral to how DWD functions and they are hard at work in the Client Support committee. To be deemed 'competent' or able to make autonomous medical decisions for themselves, patients must be able to understand their diagnosis, prognosis and treatment options, including the risks of treatment and of non-treatment. Health care providers [HCPs] need to make sure that patients' decisions are not significantly

*Continued on page 4*

## BOARD OF DIRECTORS

### **Meg Westley,**

President (Stratford, ON)

### **Deborah Hanscom,**

Vice President (Ottawa, ON)

### **Jim Stephenson,**

Treasurer (Lions Bay, BC)

### **Donald Babey,**

President Emeritus (Yellowknife, NT)

### **Sheila Noyes,**

Past President (Thunder Bay, ON)

### **Catharine Buie,**

(Toronto, ON)

### **Dr. Johnna Fisher,**

(Vancouver, BC)

### **Katherine M. Svec,**

(Toronto, ON)

### **Ruth Von Fuchs,**

(Toronto, ON)

### **John Warren,**

(Lethbridge, AB)

### **Rose Youngblut,**

(Yellowknife, NT)

## STAFF

### **Wanda Morris,**

Executive Director

### **Margaret Johnston-Jones,**

Client Support Program Manager

### **Trudie Ross,**

Membership and Office Coordinator

### **Dying With Dignity Canada**

#802 - 55 Eglinton Avenue East

Toronto, ON | M4P 1G8

Tel: 416-486-3998

Toll free: 1-800-495-6156

Fax: 416-486-5562

Email: [info@dyingwithdignity.ca](mailto:info@dyingwithdignity.ca)

Website & blog: [dyingwithdignity.ca](http://dyingwithdignity.ca)

Facebook: [facebook.com/DWDCanada](https://www.facebook.com/DWDCanada)

YouTube: [youtube.com/user/DWDCanada](https://www.youtube.com/user/DWDCanada)

Printing: Brown Book Company

(BBC) Limited

Comments and feedback on any of the information in Voice for Choice are most welcome!

### **Dying With Dignity Canada is a member of:**

The Canadian Hospice and Palliative Care Association

The Hospice Association of Ontario

The Bereavement Ontario Network

The World Federation of Right to Die Societies

ACE – The Advocacy Centre for the Elderly

Canadian Civil Liberties Association

For more information about these and all our board members, please see the About section of our website at [www.dyingwithdignity.ca](http://www.dyingwithdignity.ca)

## QUEBEC LEADS THE WAY

On March 22, a report from Quebec's commission on Dying With Dignity marked what could be a first step toward legalizing medically assisted dying across the country.

In two years of public hearings, the commission heard from 32 experts in the fields of law, medicine, ethics, philosophy and psychology. At public hearings, it heard from 239 individuals and groups. The commission received 6,558 responses to an online questionnaire – 30% from people under 30 years old. It also received over 16,000 comments by mail, fax and email. Commission members held 21 meetings in Belgium, the Netherlands and France.

We're delighted that the report looked not just at medically-assisted dying, but at the bigger picture of dying with dignity. Three commission recommendations are highly significant:

1. *Quebec should improve access to palliative care to all terminally ill people and increase training of medical staff in palliative care;*
2. *A centralized registry for advance care directives should be created and hospitals should be routinely audited to ensure they follow the directions in these documents;*
3. *The law should be changed to allow medically assisted dying. Doctors who provide medical assistance to help a person die should not be subject to criminal prosecution if the patient:*
  - Is a resident of Quebec
  - Is an adult and mentally competent to make decisions
  - Is in constant and unbearable suffering from a disease which has no prospect of improvement
  - Makes two written requests for medically assisted dying, which are in turn assessed by two doctors

The commission concluded that Quebec society wants these changes and that medically assisted dying is in line with current social values, law and medical practice.

This report will spark some interesting discussions. Under the Canadian constitution, the federal Parliament has jurisdiction over criminal law and our Criminal Code stipulates that euthanasia and assisted suicide are criminal acts. However, it is the responsibility of the provinces to provide health care, administer justice and to enforce the criminal law, so the decisions to charge and prosecute criminal acts are ultimately made by the Attorney General of each province.

Quebec has already established a precedent where provincial and federal views on healthcare differ. Quebec stopped prosecuting doctors for performing abortions 12 years before the rest of Canada.

This all-party report could prompt other provinces to change their health care and the way they administer justice. Hopefully, the recommendations from the Commission will be a catalyst for change across the country.

## EVENTS

**We are now planning our fall and winter schedule of events. Please contact us to help organize an event in your area. New events are being added all the time. Check our website for the latest details.**



## THE TIME IS RIGHT

*Don Johns, DWD Member and Volunteer*

Opinion polls show most Canadians are in favour of appropriate legislation that would offer medically-assisted dying. Many of us, though, do not follow up those beliefs with the actions needed to promote a public conversation.

We are missing the opportunity to get behind a cause that needs our support now. These times are propitious for a cause that calls for voices of compassion and justice.

The silence on this issue rings loudest to me in the churches of our country: those denominations where the scriptures are read as the Word of God, in the words of the people of God. I speak of the silence in those churches where living our faith calls for a witness to those marginalized in society, many of whom cannot speak for themselves.

I refer to the so-called “main-line” denominations. You know who you are. We are Christians who reject the idea that everyone who suffers is experiencing God’s retribution for sin, or that all suffering is redemptive. We know that bad things happen to good people. Some suffer needlessly at the end of life because they are denied a choice in dying while they still have some dignity – they suffer, and their families and loved ones suffer.

Many professional caregivers, when speaking off the record, subscribe to hastening of death when patients are suffering intolerably and an appropriate request is made. Professionals need guidelines to protect all concerned. These guidelines will come as health care workers, legal experts and governments are brought together in a common cause. The voice of the churches in Canada will assist in moving the issue forward.

There are some in our churches who think palliative care is enough. Palliative care in most terminally ill cases is excellent. The majority agree we need more resources in this area. But the pain and suffering of some of those in palliative care cannot be eased, prompting them to call for medically-assisted dying. Why should their personal request for assistance to die be denied? Why do they have to wait on someone else’s timetable?

Seven jurisdictions have legislation in place. A significant number of studies are available on the experiences of these jurisdictions from which we can shape a protocol that takes the Canadian perspective. It may take some

time until all the concerned bodies working together, can present their perspective. The time to use your voice is now. We have the great advantage of public discussion generated around the B.C. court case, the report of the Royal Society of Canada and most recently the excellent report by the all-party Dying With Dignity Committee of the Quebec legislature.



Don Johns

Can you and I raise this concern within the congregations where we worship?

We know there are those who have deep moral reservations about medically-assisted dying, believing that it is up to God alone to end life. We respect that. But I ask, do these people have any business using the coercive power of government to prevent those of us who disagree from doing what we believe is right?

A recent endeavour by the majority of people in the state of Maine to call for a citizens’ ballot to legalize choice in dying was defeated. Over a million dollars was funnelled by the opposition from outside the state in the last

two days of the poll to defeat the issue. It is no secret that the most conservative elements, on both sides of the USA/Canada border, are well-funded and active.

Are there any compelling arguments to justify placing legal road blocks in the way of terminally ill individuals who wish to end their suffering by ending their lives devoid of social pressure? You and I don’t think so. This is what we can do about it.

The first action is to update your Advance Care Directive and let your family members know of your wishes.

Next, encourage the Outreach or Social Issues Committee to contact DWD and ask for a trained presenter to conduct a workshop in your church.

Then request permission to circulate DWD brochures at a service.

As a retired United Church clergy in Guelph, Ontario, I have some availability to speak to individuals or groups in the Kitchener/Toronto area. You may contact me through DWD.

Let those of us in the church find our voice and act now in the cause for furthering death with dignity.

It was also a tragedy. Nagui had deteriorated physically. He could no longer control the actions of his limbs, work out at the gym, drive a car or carry a cup of coffee without risk of spilling it. He suffered pain and constant discomfort, but he remained articulate, mentally clear, passionate. He was not bedridden or comatose. He was fifty-four years old, handsome, with a sparkling sense of humour. Why did he choose to die so soon?

Because he did not dare wait any longer. He could not tell how long it would be until he began to lose his mental capacity. Nagui wanted to be sure he had the ability to end his own life, that he would leave life as himself, not some feeble shadow of himself.

On that final day we talked about the unfairness of his situation. He had to act before the window of opportunity closed for him, while he was still capable of ending his life by himself. He might have had another year or two of life, compromised but not unbearable, before he felt the quality of life had become so diminished he no longer wanted to live. But by then he might not have the physical or mental ability to perform the final act – and in

Canada he could not legally obtain assistance to die. Our laws forbid anyone assisting another to die, no matter how badly the individual is suffering, how poor the quality of his life, how hopeless the case. That is the tragedy: that Nagui had to die earlier than necessary if he wanted to determine the nature of his own death.

Nagui would have been the first one to stand up and fight for the right of any mentally competent, incurably ill adult to take his or her own life. He was an inspiring individual, in all areas of his life – and a deeply moving spokesperson for the cause. His life and death deserve celebration above all.

But his experience is also testimony to the unfairness of our current laws. It was his choice to die, but the timing of his death was forced upon him. Let us not forget Nagui's battle. Let us pay homage to that battle by doing all we can to ensure no other Canadians have to end their lives prematurely. Let us hold Nagui in our hearts and take his fight forward.

Rest in peace, dear man.

## NO DOUBT, continued from page 1

controlled by factors such as coercion, conflicts of interest, power imbalance, etc. Decisions should fit the context of the patient's life, values, interests, and goals to ensure the decision is authentically his own and that he appreciates how the decision will impact his life. HCPs need to be aware of the possibility of patient depression, especially in the chronically ill, and any negative influence it may have on decision making. HCPs need to ensure untreated depression does not cause patients to make decisions they wouldn't have made otherwise and which may cause regret.

### Personal Statements, Screening and Evaluation

The Client Support program offers an environment for clients and their families to make end-of-life decisions which respect their wishes, values, beliefs, autonomy, privacy, and confidentiality. When seeking support from DWD, each client makes a declaration of their medical situation in their own words, whether those words are written by the client herself or dictated to another. This statement establishes two critically important aspects of competence: that the client understands her medical situation and its impact on her life, and that she is making an authentic, un-coerced decision that reflects her own values and interests and is free from the influence of significant depression. The accompanying letter from the client's physician supports the accuracy of the patients' understanding of her situation, its terminal nature, and its significant impact on her quality of life. Before any documentation is sent to the committee, it is stripped of all personal identifying information to protect the client's

privacy and confidentiality. This supplements the strict screening, reference check and aptitude evaluation each volunteer on the committee submits to, and the explicitly dictated set of rules that govern our work. This ensures every client receives the health and community services, information, and support that best match their medical need. This high standard of ethics protects the well-being of our clients and their families and makes this Ethicist proud to be part of such an exemplary group.

### GET MORE NATIONAL & INTERNATIONAL NEWS

Dying With Dignity is very active across Canada and we have 70% to 80% of Canadians supporting our cause of medically-assisted dying. However, the right-to-die movement is also gathering momentum throughout North America, Europe and Australasia.

Check out our blog for recent news and updates from New Mexico, Hawaii, Germany, The Netherlands, The UK and New Zealand. You'll also find more information about the Quebec Report, stories from our members, and links to recent news such as the Globe and Mail's poll about the worst Supreme Court Decision in the last 30 years. Find all this and more at [www.dyingwithdignity.ca](http://www.dyingwithdignity.ca).

This is also a great way to approach others for support. Forward a story or news article to friends and family and you just might recruit some new members!

Thanks to blog-master John Warren, our blog is updated several times a week with the latest news and information. Do you have a link you'd like to share? Send it along to [john@dyingwithdignity.ca](mailto:john@dyingwithdignity.ca).

## AN OVERVIEW OF THE CARTER CHALLENGE

*"I cannot understand why it is permissible for my friend, who is on kidney dialysis, to say 'enough is enough' and make the decision to die. I cannot understand why the law respects his wish and decision to die, but does not do the same for me. We are equally competent. I do not understand how or why it is the role of government to say that his choice results in a 'natural' death, but my choice would not."*

~Gloria Taylor

Gloria Taylor faces a painful death from ALS and is pleading for the right to have a physician help her die peacefully. When Gloria heard about the Carter challenge initiated by Lee Carter, Hollis Johnson, The British Columbia Civil Liberties Association (BCCLA) and Dr. William Shoichet, she wanted to help out, so she added her voice to the challenge and became a key co-plaintiff.

The BC Civil Liberties Association made a 26,000-word submission to the BC Supreme Court summarizing the key points of their case. Here's a very brief summary of that submission. Intrepid folks who are interested in reading the entire submission can find it in the Learn section of our website.

### The Sue Rodriguez case

The Supreme Court upheld the old law in 1993 in the Sue Rodriguez case. Today, the lawyers for the Taylor case plaintiffs' suggest that:

- a. *the facts have changed so much since 1993 that the old rule no longer applies.*
- b. *new laws have made the Rodriguez decision invalid.*
- c. *current criminal law breaches rights in the Charter.*

### Section 7 of the Charter

*"Everyone has the right to life, liberty and security of the person."* Section 7 of the Charter  
The plaintiff's lawyers say that:

- a. *the law deprives an individual of life and of the right to carry out a decision to end it.*
- b. *the choice to live or die, and to control when and how we die, are decisions of profound personal importance. Denying us help in our own death breaches liberty.*
- c. *we should be able to make and act upon decisions concerning our own body, our physical, emotional and psychological integrity, and our dignity.*

### Section 15

*"Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."*  
Section 15 of the Charter

The lawyers point out that the prohibition on assisted dying discriminates against people who are too disabled to take their own life.

### The present law is too broad

The plaintiffs' lawyers acknowledge that the state has a legitimate interest in protecting the lives of patients, but prohibiting physician-assisted dying goes too far.

Terminal sedation, opioids, and the withholding and withdrawal of treatment can all hasten a patient's death. All could also be misused. However, their prohibition is not necessary. The response has not been to outlaw treatment, but to seek improved medical management. This is a realistic balance to strike.

Systems in other jurisdictions that allow physician-assisted dying show it's possible to provide effective safeguards to ensure that access is limited to people who qualify.

### Do state interests override Charter rights?

The Court now has the benefit of years of meticulous study of systems that allow physician-assisted dying. These include the Netherlands, Belgium, Switzerland and Oregon. The systems there work.

The lawyers say that not to allow a similar regime to exist in Canada will cause untold suffering to Canadians who need physician assistance in dying. This outcome is grossly disproportionate to any speculative benefit Canada might get from preventing all physician-assisted dying.



Gloria Taylor



*"Everyone deserves to die with dignity. We now need to extend our compassion and allow each individual all possible choices to end their life in peace."*

Gregory Robinson,  
MD MHScc CCFP FCFP FRCPc



*"We cannot talk about dying with dignity if governments place limits on our autonomy precisely at the moment we are no longer able to stand up and defend it."*

Dr László Bitó,  
Author and Scientist

## KATHERINE'S CORNER *Katherine M. Svec, DWD Volunteer* THE BIG CARNIVAL VISITS OREGON'S DEATH WITH DIGNITY ACT

Director Billy Wilder's controversial 1952 film *The Big Carnival* tells the story of a cynical journalist in New Mexico who yearns for his previous post at one of the major New York newspapers. When a man becomes trapped in an underground cave, he seizes his chance. To sensationalize the story, he thwarts rescue attempts. As the story builds, so do the crowds, the newspapers, the hucksters; and finally the Carnival arrives – all in anticipation of the dramatic rescue. The journalist spins it out too long. The man dies.

What is chilling about this film is not only Wilder's portrayal of unalloyed ambition, human greed and naked voyeurism, but the accurate foretelling of the modern media circus. Prime examples are the stories of Barbara Wagner, Randy Stroub, and the Oregon Health Plan (OHP).

Barbara Wagner, 64 years old, was diagnosed with lung cancer in 2005. Over the next couple of years, OHP paid for extensive treatments, and when 1<sup>st</sup> and 2<sup>nd</sup> line therapies failed, Ms. Wagner requested Tarceva. OHP turned down her request, since she did not meet their 5/5 criteria (at least a 5% chance of survival over 5 years). She was already end-stage, and it was futile. She was advised of options including hospice; palliative care; pain and symptom management; all necessary medical equipment; and all services and medication prescribed under the Oregon Death With Dignity Act. This last was the only option

Ms. Wagner took any notice of. She, and her sobbing daughter Susie May, promptly appeared on ABC television with their predictably sensational story *"I'm not ready to die"*.

The story was carried in media worldwide, with no apparent effort to confirm its accuracy. This released a firestorm of indignation, at the height of which the manufacturers provided the drug free to Ms. Wagner, and later for several other patients. A generous gesture – or good publicity? Note this gushing write-up from a publication opposed to the Right To Die movement.

*"Barbara Wagner's story has a happy ending. But it doesn't come from the heartless, liberal, euthanasia-pushing government. It comes from Big Business – from the pharmaceutical company that makes the drug to treat her."*

### Generosity for \$2 Billion?

There is no mention that Genentech was vigorously promoting Tarceva to compete with Eli Lilly's Alimta, which had sales of almost \$2 billion in the US alone.

Ms. Wagner's happy ending? She died a short time after starting the futile treatment that she, and the media, demanded. The media gave little space to her death.

Randy Straub, a 53 year old uninsured man with terminal prostate cancer, received a similar letter from OHP, turning down his request

for Mitoxantrone. If you've seen the award-winning documentary *How To Die In Oregon*, you may recall watching Randy display the letter, and (like Ms. Wagner) scroll down past all the listed options to focus only on the last: access to medically-assisted dying.

Here was another sensational story *"They are willing to kill me but won't pay to make me better"* and the media descended in a feeding frenzy. Such was the outcry of an emotional public riled up by the misinformation of opponents of the Right To Die movement, that OHP reversed their decision. After three rounds of chemo, and into his fourth week of futile therapy, Randy Stroup died. The media gave little space to his death.

Clearly his letter was insensitive. But in admitting this, OHP went on to make wrong-headed decisions. In future, letters advising of non-coverage will not mention medically-assisted dying. This means patients who may have been comforted by this option will now not be given that information.

Furthermore, by folding under the pressure of a veracity-shy media, OHP opened the door to other patients equally convinced of their personal entitlement regardless of either cost or efficacy, and equally aware that all it takes is one predatory reporter, and The Big Carnival will roll into town.

# VOLUNTARY STOPPING OF EATING AND DRINKING: IT'S YOUR RIGHT

Catharine M. Buie, DWD Board Member

The term Voluntarily Stopping Eating and Drinking, or VSED, may bring to mind television images of starvation and stomachs bloated from malnutrition. That is nothing like VSED.

VSED is a legitimate end of life choice which traces its history from ancient Greece to current times. It refers to an individual not on a feeding tube or IV who chooses to cease taking nourishment and fluids orally.

Over 14 days, the individual experiences terminal dehydration. During the first 24 hours the person will likely experience mild hunger and thirst. Glycerin swabs will alleviate discomfort but will not cause rehydration.

At the end of 24 hours the rising concentration of hydrogen and carbon dioxide in the body will trigger metabolic acidosis, leading the body to Ketosis which causes many people to experience euphoria and well being. The patient, depending on their physical condition before VSED, can engage with visitors in a spirited manner in this period.

In the Journal of the American Medical Association, Dr. David M. Eddy described his 85-year-old mother's last days as follows " ....Over the next few days, my mother greeted her visitors with the first smiles she had shown for months. She energetically reminisced ... She slept between visits but woke up brightly....On the sixth day we could not wake her. Her face was relaxed in her natural smile; she was breathing unevenly, but peacefully."

## **'She Was Breathing Unevenly, But Peacefully'**

The patient eventually slips into a pain-free permanent coma and will likely suffer a cardiac arrhythmia as the heart can no longer pump.

Preventing a person from carrying out VSED requires physical action, by force-feeding or using feeding tubes. The legal basis for a legally competent person to refuse those measures rests within the tort principle of Battery.

Battery is defined in Blacks Law Dictionary as the nonconsensual, slightest touching of a person or his clothes or anything else attached to his person with intent to harm or offend. Consent and non consent may be verbal, non verbal, express or implied.

The three elements of battery are found in force-feeding. It requires the caregiver to have contact with the patient, to act without the consent of the patient and is considered harmful or offensive to the patient who has chosen VSED.

The tort of Battery is not the only legal premise to support VSED. Eating and drinking are arguably medical treatments. Competent adults have the legal right to refuse medical treatment. People have the right to be free from bodily intrusion. The Superior Court in Quebec upheld Robert Corbeil's decision to refuse medical treatment and commence VSED stating it could no more direct Mr. Corbeil to eat than order that he undergo chemotherapy, radiation or dialysis.

In concluding, VSED is available to any legally competent adult whether in a hospital, a retirement residence, at home or in a nursing home.

*At Dying With Dignity Canada, one of our mandates is to advocate for the rights of our members. If you feel your right to voluntarily stop eating and drinking is being violated, please contact our Client Support Program Manager, Margaret Johnston-Jones, for advice and support.*

## **DWD WRITER AND SPEAKER JOINS THE BOARD**

Katherine M. Svec joins our Board after being a long-time member and volunteer with DWD. Besides being a walking encyclopedia of knowledge relating to end-of-life issues, she serves DWD as a speaker, writer (including writing Katherine's Corner for our newsletter) and a member of the Client Support Program Committee. Professionally, until her retirement, Katherine was a Senior Technologist in the Neuro-pathology laboratory of the University of Toronto's Banting and Best Institute. The latter part of her career was as Chief Technologist in the combined Neurology Laboratories of The Wellesley Hospital, Toronto.

She joined DWD to address the urgent issues she saw during her years of working in a hospital environment: the need for patients to have an Advance Care Directive; the need to ensure non-abandonment of the dying patient; and the need to legalize appropriately-regulated medically-assisted dying in Canada.



## DWD'S FINANCIAL TURN-AROUND

*Jim Stephenson, DWD Treasurer*

While our audited statements will not be formally approved until this year's AGM on June 3, we're too pleased to wait to announce the results.

After several years of expenses exceeding income, I'm delighted to announce that we not only broke-even in 2011 – we achieved a surplus of over \$40,000.

Our finances were tight last year. As a Board, we closely monitored cash flows to determine whether we could stay viable. Thanks to the leadership gifts of a number of donors, and the many, many smaller amounts we received, our donation revenue increased five-fold in 2011 and made up almost 80% of our income. We also saw our membership revenues come close to doubling. This also bodes well for this year's fundraising efforts.

### Key financial results:

	2011	2010
Donations	\$277,000	\$54,000
Memberships	61,000	32,000
Salaries and benefits	149,000	123,000
Communications	43,000	20,000
Travel	22,000	6,000
<b>Net Surplus (deficiency)</b>	<b>\$44,000</b>	<b>\$(126,000)</b>
<b>Net Assets</b>	<b>\$253,000</b>	<b>\$199,000</b>

Of course, we spent money to achieve these earnings. With a full year of a full-time executive director (Wanda Morris started part-time in November of 2010) we saw salaries climb by over \$25,000 and our communications and travel spending went up by \$23,000 and \$16,000, respectively. These costs cover a comprehensive quarterly newsletter, our investment in the new website and a cross-Canada program of education and outreach.

In budgeting for 2012, I hope and believe that I've presented our last deficit budget. The board has approved a deficit budget of \$50,000 based on conservative revenue forecasts and contained spending. With increasing membership and a wider donor base, our 2013 forecast calls for us to be back at break-even once more. These increases will move us to a new plateau of activity, effectiveness, and sustainability; just what we need to carry out our mandate.

With over \$200,000 in investments and in our bank account, we have a slight cushion in case our projections are not met. Most importantly, with your continued support and the dedication of our hard-working staff, board and volunteers, I believe we'll continue to see improving financial results.

*Interested members may contact the national office for a copy of our audited statements (subject to membership approval) or our 2012 budget.*

## LIKES, HITS, AND WRITE-UPS: WORD IS SPREADING

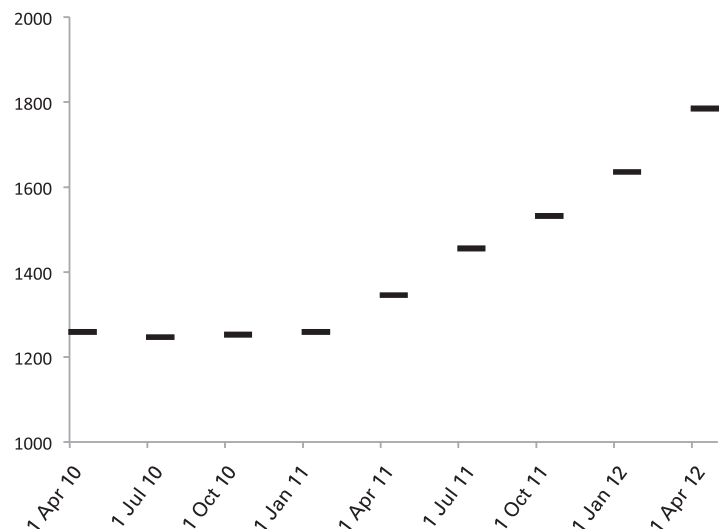
The start of 2012 has seen our member numbers continue to grow. Our new website has helped us reach a large number of people who weren't aware of our services and programs. As we near the site's one year anniversary, 23,000 people have visited it over 38,000 times.

We have also reached a large number of people through public education sessions and the efforts of our members who have in turn reached out to their friends and colleagues to spread the word.

We are reaching a younger audience too – over 450 people have liked us on Facebook and more than 2000 have signed up for our email updates. Our recent media endeavours are also paying dividends; we are increasingly sought out for interviews and our letters to the editor are published in national and regional publications.

And together we can do more! Do you have a location (doctor's office, place of worship, medical clinic, community centre) where you can put up a poster or hand out brochures? Call Trudie at our national office and she'll send supplies. Do you have friends interested in finding out more? Borrow a copy of *How to Die in Oregon* from our library, give them a private screening and see if you can sign them up. Do you belong to a group that hosts regular speakers? Call our national office and we'll arrange for one of our talented speaker volunteers to come out and give a talk on advance care planning, end of life health-care options or the case for assisted dying at end-of-life.

## DWD MEMBERS GROWING





## MAKE YOUR GIFT DOLLARS GO FURTHER

*Bruce Ratford, DWD's Volunteer CFO*

My wife Elda and I are often approached to invest money in a worthy charity. And we do. As a Certified Management Accountant, I might view it differently than many donors.

A common fallacy is to view the donation as an expense. But donating \$100 has less financial impact than, say, buying \$100 of gas.

Every donation to a charitable organization registered with the Canada Revenue Agency, such as Dying With Dignity Canada, can generate a tax credit that reduces your net income tax. Depending on how much you donate, your province and your top tax bracket, this tax credit could be worth 20% for the first \$200 of donations, or between 40.2% and 46.4% for donations over \$200 in a taxation year. The net after-tax cost to you of that \$100 donation could be \$53.60. Gasoline is still \$100.

For a bigger sum, consider the waiver of capital gains considerations on the transfer of marketable securities or tangible property to a registered charity. Securities include publicly-traded shares, mutual funds, bonds and investment certificates.

When such a transfer occurs, or if you sell the property, or at the time of the owner's death, CRA deems there has been a sale or disposition of the asset at fair market value, whether there was actually a sales transaction or not. The net profit or loss (ignoring brokerage fees) is calculated as follows:

**Net profit (loss) = A – B, where**

(A) Proceeds from disposition

(B) Original purchase price

Half of the net profit is normally added to income and taxed. However, if the asset is transferred to a registered charity, the net proceeds are not subject to tax. How does this enhance the value of your donation?

Suppose that you bought 200 shares of XYZ Corporation ten years ago at \$1 per share, for a total cost of \$200, ignoring commission costs. The company has prospered, and those shares now trade at \$10. You decide to donate half to a registered charity.



Bruce Ratford

If the closing price of those shares on the day of transfer is \$10, you receive a receipt for your donation in the amount of  $100 \times \$10$ , or \$1,000. This would give you a non-refundable tax credit of 40.2% to 46.4%, or \$402 to \$464.

If instead you donated the \$1,000 by cheque, and sold the shares as an unrelated transaction, the \$900 net profit would be taxed as income at the inclusion rate for capital gains of 50%. Depending on your marginal tax rate, this would trigger a tax bill (in Ontario) of \$91 to \$209 on the capital gain.

Combined, the tax benefits accruing from your \$1000 donation of shares would range from \$493 to \$673. The real out-of-pocket expense could be as little as \$327.

For more information, consult CRA publication Pamphlet P113 "Gifts and Income Tax 2011" and Form T1170 "Capital Gains on Gifts of Certain Capital Property" or a personal tax professional. The actual tax benefits will depend on where you live and your marginal tax rate.

*Dying With Dignity Canada would like to thank Bruce Ratford, CMA, for not only sharing with us his useful knowledge on this subject, but for applying it for the benefit of DWD. Bruce is Dying With Dignity Canada's volunteer CFO. Anyone wishing to make a share donation to DWD can contact Bruce at our national office for further information.*

## DONATIONS AT WORK – A NEW BEQUEST POLICY

The Board and members of DWD greatly appreciate the past bequests the organization has received. They have directly allowed us to better help our clients and expand our education and advocacy work.

Now that we have achieved a degree of financial sustainability, the Board has passed a new bequest policy that provides assurance to legators and other major donors that their gifts will be used for significant activities and will have a sustained and lasting impact on our work.

You can read the full policy in the planned giving section of our website – or call the office and we'll mail you a copy.

## LIES, DAMN LIES AND THE EUTHANASIA PREVENTION COALITION

Wanda Morris, DWD Executive Director

We were live across Canada. Myself and BC Euthanasia Prevention Coalition head Dr. Will Johnston. He was one of my first opponents in a series of debates not only on the Roy Green Show but in person across the country.

Dr. Johnston had just declared it was not necessary for the patient to be the one to initiate a request for assistance to die under Oregon Death With Dignity legislation.

That is absolutely not true, I said. Yes it is, he countered. Well I have read the legislation. And I am right. Forget carefully considered arguments. Sheer willingness to tell bald-faced lies may be helping the EPC influence the debate.



DWD Board Member and UBC ethics bowl debating team coach, Dr. Johnna Fisher shown here with two team members: Jason Newton and Cory Wilson. Together the three helped hone Wanda's debating skills to a cutting edge.

So I am left with a puzzle – how do I let people know we are truth-tellers and that the face of the religious right, The Euthanasia Prevention Coalition, and others of their ilk, are willing to out-and-out lie to oppose choice in dying in Canada.

This was not the first time I'd seen them lie publicly. The website LifeSite News tells a story about the Dutch Minister of Health, Els Borst, ruing the day The Netherlands brought in euthanasia. Very concerning – and also utter nonsense. When the Quebec Commission met with her directly in The Netherlands, she said she was very proud of what the Dutch had done.

Or take the case of the EPC's Alex Schadenberg in a guest editorial to the National Post. For example, he described how certain individuals had been assisted to die without their consent in the Netherlands. He failed to disclose that the percentage of deaths without consent in The Netherlands had actually gone down since legalization and was significantly lower than countries such as New Zealand and Australia, which did not have legalized assistance to die. Don't newspapers have to check the truth of what they publish, even if in a guest

editorial? To be fair, I too was published when I responded with a sharply worded letter to the editor, but only several days later, and with 150 words to counter his 600.

### Facts Vs Rhetoric

August bodies whose conclusions these zealots don't agree with are painted as having one-sided, close-minded members. Political panels whose conclusions they don't support are said to have operated as conspiracies, suppressing information from those who would dissent, silencing anyone in disagreement. EPC speakers point to lack of legislative change in the US (in the US, dying with dignity legislation has been introduced through citizens ballot initiatives) ignoring ongoing legislative change in Europe.

An academic opposing choice when testifying as part of the Carter challenge had to repeatedly acknowledge flaws in his testimony – whether it was unwarranted conclusions or unverifiable facts. His testimony, complete with numerous recants, is on record. But his erroneous statements continue to be circulated by anti-choice groups.

Before the first debate, in Montreal, I thought I was incredibly well prepared. I brought my knowledge from years in the movement and 18 months as Executive Director at DWD. I'd also put together a comprehensive debate binder – four inches of material separated into over 30 tabs. There was not one study, one statistic, one fact that they could raise that I wasn't prepared to rebut.

Problem was, as I learned, our opposition wasn't very interested in evidence and facts – or even reason and logic. The cornerstone of their debating platform was, and is, fear. Their strategy is fear-mongering. So far my opponents have told stories of children wanting to rid themselves of expensive and seemingly hapless parents, of caregivers too venal to stand up for their patients, and of doctors too disinterested to intervene. They have warned of the extreme danger of giving even more power to doctors and medical authorities. They have repeatedly focused on the current status of elder abuse and have predicted rampant abuse of the elderly in the future if medically-assisted dying laws are changed.

Since the Death With Dignity Act passed in Oregon in 1997 and The Netherlands followed suit in 2002, these laws have been among the most studied health-care legislation ever written. Professor Margaret Pabst-Battin led a team of researchers that looked in detail at the deaths in both these jurisdictions and concluded that the safeguards are indeed working. There will always be polarized views on both sides of the discussion – what we can and must do is educate the neutrals about facts – not overblown fears. We will continue to do so.