

## **The Unkindest Cut of All: Portrayals of Pain and Surgery in the Tracy Latimer Case**

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*The paper examines the language used to describe pain and surgery in the trials and the media discussions of the killing of Tracy Latimer by her father. Descriptions of proposed surgical procedures, that were planned before Tracy was killed, exaggerate the intrusiveness of surgeries to be performed so as to suggest that surgery would be worse than death. Language was used to make the case that killing Tracy was somehow justified because Tracy was in relentless pain, and the proposed surgery would only have caused even more pain. Therefore, the assumption is made that surgery would have been worse than death for Tracy. In reality, Tracy experienced some pain and discomfort, but her pain was manageable, and would most likely have been eliminated by surgery.*

### **Tracy Latimer's Media-Mediated Medical Mutilation**

The killing of Tracy Latimer became one of the most widely discussed criminal cases in Canadian history. Tracy was a twelve-year old girl in 1993, when her father, Robert Latimer, killed her with carbon monoxide in the cab of a truck on their Saskatchewan farm. Although he initially denied any role in her death, his role soon became apparent and he then claimed that he had killed her to spare her from further suffering as a result of her severe cerebral palsy and the surgery she was scheduled to undergo. The case became the object of widespread national publicity when it first came to trial in 1994 and remained in the national spotlight as numerous convictions, appeals and retrials continued over the

following years. The Supreme Court of Canada finally upheld the second degree murder conviction and sentence of life in prison with no consideration of parole for ten years. Although the intensity of media attention has waned since that time, more than 2,000 Canadian news stories on the Latimer case have appeared between 1993 and June 2007.

Throughout the over-a-decade's worth of media coverage that has been generated by the Latimer case, there has been a constant, predominant focus on Tracy's cerebral palsy as a highly medicalized condition. References to Tracy "suffering from" or being "afflicted with" cerebral palsy abound in the mainstream media's coverage of the case. While terms like *afflicted with*, *stricken by*, and *suffering from* violate media editorial standards (e.g., Tasko, 1999), they continue to be widely used in news media. Lucardie and Sobsey (2005) demonstrated that Canadian news media violated editorial guidelines by using these phrases much more commonly in that cerebral palsy was discussed in relation to so-called mercy killings (40% of stories) and the Latimer case in particular (61% of stories) than in other stories involving individuals with cerebral palsy (18% of stories). By conflating suffering with cerebral palsy, the authors imply that suffering is an inherent element of cerebral palsy and that the more severe the disability, the greater the suffering. Similarly, 95% of these news stories used the terms "mercy-killing" or "euthanasia" to describe the killing of Tracy Latimer, implying that her killing may have been justified by her extreme suffering. In many stories, Tracy Latimer is not mentioned by name and identified only as Robert Latimer's daughter who suffered from a severe form of cerebral palsy. Tracy Latimer's personal identity becomes subsumed by her disability and her suffering. Integral to the mainstream media's pathologization of Tracy Latimer is a consistent focus on the various surgical interventions that were either used or proposed as a means of managing the pain or improving her physical function. This included surgeries that had previously been performed (soft tissue releases to reduce contractures in 1990; inserting rods to straighten her spine in 1992) and surgeries that were considered (inserting a feeding tube to improve nutritional status) or planned (hip surgery to reduce or eliminate pain and increase range of motion). All of these procedures were discussed intensively in the media, because her father's defense for killing Tracy Latimer was that killing her

was the only way to prevent her from suffering the harm that would be done by the surgery.

### **Medical Fact Versus Media Fiction: Examining the Surgical Procedures Performed On, or Recommended for, Tracy Latimer**

It seems to me that an element curiously and problematically absent in much of the public ethical debate surrounding the case of Tracy Latimer is a clear and straightforward discussion of the basic nature, duration, usual outcomes, and potential complications of each of the surgical procedures which were either performed on, or recommended for, her. Therefore, I would like to offer a brief and basic overview of these surgical procedures. A basic, more critical understanding of each of these surgical procedures can, I believe, provide a useful—and oft-missing—contextual framework for a discussion of the ethical implications that the Latimer case continues to have for the lives of children with disabilities and their parents/caregivers.

There were three key surgical procedures that were either performed on, or recommended for, Tracy Latimer. The first of these procedures was Spinal Instrumentation surgery, which was performed on Tracy Latimer to correct a severe curvature of her spine due to scoliosis. Spinal instrumentation is used to treat instability and deformity of the spine. Instability occurs when the spine no longer maintains its normal shape during movement. Such instability results in nerve damage, spinal deformities, and pain. Scoliosis is a side-to-side spinal curvature which can, if sufficiently severe, cause problems with internal bodily functions such as digestion and breathing. Spinal instrumentation provides a stable, rigid column that encourages bones to fuse after spinal fusion surgery. Its purpose is to aid fusion. Without fusion, the metal will eventually fatigue and break, and so instrumentation is not itself a treatment for spine deformity.

The following overview of Spinal Instrumentation surgery is taken from the *Encyclopedia of Surgery: A Guide for Patients and Caregivers*:

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Different types of spinal instrumentation are used to treat different spinal problems. Although the details of the insertion of rods, wires, screws, and hooks vary, the purpose of all spinal instrumentation is the same—to correct and stabilize the backbone while the bones of the spine fuse. The various instruments are all made of stainless steel, titanium, or titanium alloy.

The oldest form of spinal instrumentation is the Harrington rod. While it was simple in design, it required a long period of brace wearing after the operation, and did not allow segmental adjustment of correction. The Luque rod was developed to avoid the long postoperative bracing period. This system threads wires into the space within each vertebra. The risk of injury to the nerves and spinal cord is higher than with some other forms of instrumentation. Cotrel-Dubousset instrumentation uses hooks and rods in a cross-linked pattern to realign the spine and redistribute the biomechanical stress. The main advantage of Cotrel-Dubousset instrumentation is that because of the extensive cross-linking, the patient may not have to wear a cast or brace after surgery. The disadvantage is the complexity of the operation and the number of hooks and cross-links that may fail.

Several newer systems use screws that are embedded into the portion of the vertebra called the pedicle. Pedicle screws avoid the need for threading wires, but carry the risk of migrating out of the bone and contacting the spinal cord or the aorta (the major blood vessel exiting the heart). During the late 1990s, pedicle screws were the subject of several high-profile lawsuits. The controversies have since subsided, and pedicle screws remain an indispensable part of the spinal instrumentation. Many operations today are performed with a mix of techniques, such as Luque rods in the lower back and hooks and screws up higher. A

physician chooses the proper type of instrumentation based on the type of disorder, the age and health of the patient, and the physician's experience.

The surgeon strips the tissue away from the area to be fused. The surface of the bone is peeled away. A piece of bone is removed from the hip and placed along side the area to be fused. The stripping of the bone helps the bone graft to fuse. After the fusion site is prepared, the rods, hooks, screws, and wires are inserted. There is much variation in how this is done based on the spinal instrumentation chosen. Once the rods are in place, the incision is closed. (*Encyclopedia of Surgery: A Guide for Patients and Caregivers*, 2007, online document).

It is an undisputable fact that, even under the best of circumstances, Spinal Instrumentation must be considered very major surgery, simply due to its level of invasiveness. Song (2005) notes that, while the average operating room (OR) time for this surgery is 3-5 hours, the OR time typically increases to 8-10 hours if a combined anterior and posterior spinal fusion is performed. Significantly, a combined anterior and posterior spinal fusion is often necessitated in cases where patients have severe spasticity, as was the case with Tracy Latimer. Given the level of invasiveness and complexity of this surgery, one might be tempted to consider the mainstream media entirely justified in its typical portrayal of the Spinal Instrumentation surgery that was performed on Tracy Latimer as being a hugely traumatic and painful procedure:

Tracy Latimer, who always had trouble eating, was having more difficulty in the final year of her life.

Laura Latimer remembered bathing Tracy shortly before a painful nine-hour operation in 1992 to insert steel rods to straighten her curving spine.

"She was splashing around, enjoying herself and I was just sick because I knew what was coming and she

didn't. After the operation she woke up moaning and crying. She looked at me as if she was asking for help. "I was sick," she said.

A year later, before her daughter had completely recovered from the back surgery which left her "stiff as a board," Laura Latimer learned a new operation to remove the top quarter of Tracy's right leg bone was likely necessary. (Perreaux, 1997, p. A3)

The preceding quotation is very typical of the mainstream media's tendency to portray the Spinal Instrumentation surgery that Tracy Latimer underwent a year prior to her murder, as torturously invasive and catastrophically painful. Rarely mentioned in mainstream news reports, however, is the procedure's ultimate benefit in terms of Tracy's improved ability to sit up, travel by bus/car, and digest food. Yet, these substantive benefits to Tracy's overall health and well-being, which were achieved through the Spinal Instrumentation surgery, were amply documented by Tracy's own mother, Laura Latimer. In the Appendix of her 1999 book, *A Voice Unheard: The Latimer Case and People with Disabilities*, Ruth Enns cites numerous entries that Laura Latimer made in Tracy's communication book in the year following Tracy's back surgery. Many of these communication book entries, which figure prominently in the testimony transcripts of Robert Latimer's second trial in 1997, but were almost never mentioned in the mainstream media's coverage of the trial, clearly illustrate positive outcomes from Tracy's back surgery in terms of increased level of activity, ability to properly digest food, and ability to comfortably tolerate daily bus/car travel:

October 8, 1992: "Tracey<sup>1</sup> was extra cheerful when she got home."

October 22, 1992: "Tracey had a good supper, and had meat and potatoes at bedtime, and I made a square..."

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<sup>1</sup>The transcript of the second trial misspelled Tracy's name as "Tracey."

That Tracey found very easy to eat, and she had about five little pieces, and she looked so happy... She cried once early in the night, and I put her on her back, and she was fine the rest of the night."

December 15, 1992: "Tracey drank when she got home, then slept. She drank well at supper for her dad, but wouldn't eat well. When I got home she ate great and had pudding for dessert. She had half a pudding at bedtime..."

February 23, 1993: "Tracey went to Saskatoon today for an appointment with Dr. Dzus. Tracey will be having surgery on her dislocated hip, but Dr. Dzus wants to give her back more chance to heal because it's not even a year since her back surgery. She has to see Dr. Dzus again in October, and surgery will likely be late in the fall. Tracey was glad to lay down when she got home, but she did fine all day..."

April 3, 1993: "Tracey was the worst girl at the sleep-over, up at ten to seven, laughing and vocalizing. She was really good the rest of the day..."

May 23, 1993: "... Today Tracey stayed in bed until ten o'clock, then had a huge breakfast, two soft boiled eggs and pancakes in the blender. Didn't eat a great lunch though. For supper we had a picnic at Finlayson Island. Wannells picked us up in their motor home. Tracey went in her wheelchair, and we used tie downs to strap her in. She seemed tickled with the outing, ate a very good supper, especially enjoyed lemon pie for desert. She slept in the motor home on the way back, had milk and pudding at bedtime."

(Quoted in Enns, 1999, pp. 166-167, 169)

These entries which Laura Latimer made in Tracy's communication book in the year following her Spinal Instrumentation surgery and preceding her murder, provide a very telling counter-narrative to the highly medicalized, pathologized, and thus sensationalized, descriptions of Tracy's spinal surgery, and its aftermath, which characterized the mainstream media's coverage of the Latimer case. Of particular significance in terms of their disruption of the dominant media depiction of Tracy Latimer's Spinal Instrumentation surgery as a catastrophic event which rendered her totally racked by pain for the rest of her life, are the numerous references to Tracy's ability to travel comfortably—and, in at least one instance, enjoyably—by bus or car. These ostensibly incidental references to Tracy's daily travels to and from her parents' home, her school, and the group home jarringly contradict the mainstream media's portrayal of Tracy as being trapped in a state of permanent stasis and constant pain following her back surgery.

The second surgical procedure which figured very prominently in the public ethical debate surrounding the case of Tracy Latimer is the Proximal Femoral Resection to treat her dislocated hip. Tracy was murdered just two days before she was scheduled to have this surgery, and Robert Latimer has repeatedly stated that he killed Tracy because he wanted to spare her from the suffering of having to undergo this latest medical "mutilation." In fact, a key element of Latimer's defense strategy was that this pending surgery constituted the certainty that Tracy would be subjected to unbearable suffering, and therefore that Robert Latimer was forced, out of necessity, to end Tracy's life in order to spare her from that suffering. Significantly, this line of argument about the "necessity" that Robert Latimer claimed for killing Tracy as the only means to spare her from the suffering of having to undergo further surgery is, to a large extent, validated and reinforced in much of the mainstream media's presentation of the ethical debates surrounding the Latimer case. For example, in an article which appeared in the September 16, 2004 edition of the *Vancouver Sun*, reporter Douglas Todd presents as undisputed fact Robert Latimer's claim that Tracy was experiencing severe and constant pain, and that her pain would have only worsened had she undergone the scheduled hip surgery:



Tracy was a bed-bound quadriplegic with cerebral palsy, a twisted spine, malnutrition, seizures, chronic vomiting and the brain function of a four-month-old infant. Most upsetting to Latimer and his wife, Laura, were her never-ending surgeries and unrelievable pain. (Todd, Sept. 16, 2004, p. B2)

Against the backdrop of a blatantly erroneous description of Tracy Latimer as “bed-bound,” Todd reiterates the standard mainstream media portrayal of Tracy as being in “constant pain” from “never-ending surgeries”—a situation which Robert Latimer and his wife, of course, find “most upsetting.” Later in this article, Todd cites University of Manitoba Ethics Professor Arthur Schafer as demonstrating the ethical unjustness of the punishment that Robert Latimer received for his act of compassion in sparing his daughter from the pain of further surgery:

University of Manitoba ethics Prof. Arthur Schafer, however, believes the Supreme Court of Canada used “feeble reasoning” in denying Latimer the necessity defense. The judges not only misunderstood the state of available pain medication, Schafer says, but came to what he considers the minority philosophical conclusion that there is “nothing worse than death.”

Millions of Canadians who have dealt with terminal, painful illnesses, Schafer says, would disagree. (Ibid)

This article’s unmitigated presentation of Tracy Latimer as a tortured creature whose already unrelievable pain would only have been exacerbated had she been allowed to endure the scheduled hip surgery is entirely consistent with over a decade’s worth of mainstream media portrayals of Tracy Latimer as merely a bundle of unending suffering. I therefore find it of immense significance that the grim post-operative prognosis assigned to Tracy Latimer by the mainstream media seems to be entirely contradictory to much of the actual medical research done in

the field of orthopaedics. For example, Abu-Rajab and Bennet (2007) report:

In our series, 90% of patients with pain preoperatively had significant or complete resolution of their pain, and 100% of patients with seating or hygiene problems reported improvement in their symptoms. This would agree with previous reviews of this technique in the literature. Knapp and Cortes reported on 38 dislocated hips in 29 patients. Only seven of these were painful and underwent proximal femoral resection with all patients reporting an excellent postoperative range of motion and pain relief. Widmann et al. reported on 13 patients with 18 dislocated hips treated by proximal femoral resection. The average age of their patients was 26.6 years. All patients reported improved pain at an average of 5.6 months and had significantly improved seating times and range of motion. McCarthy et al. reported on 56 hips in 34 patients with severe cerebral palsy to allow them to sit. They reported success in 33 of 34 patients at a minimum of 2 years follow up. The only report to disagree with these findings is by Boldingh et al. who quote only a 33% satisfaction rate following femoral head resection in 10 patients. (pp. 181-184)

The argument could, of course, be made that studies on the long-term outcomes of Proximal Femoral Resection, such as the one quoted above, were still in their infancy during Tracy Latimer's lifetime, and that, therefore, Tracy Latimer's parents did not have the benefit of this kind of medical knowledge when confronted by the prospect of having their daughter undergo this operation. I concede that this argument is not without some degree of legitimacy. However, the testimony given by Tracy Latimer's orthopaedic surgeon, Dr. Anne Dzus, at Robert Latimer's 1994 trial indicates that, even at that time, the surgical procedure which was scheduled to be performed to treat the pain in Tracy's hip was generally known to be effective. Dr. Dzus states: "[This is] again major surgery and the results can be unpredictable but we

know that with a resection arthroplasty the goal is to make them pain free and in the majority of children it is successful in decreasing their pain.”<sup>2</sup> Given this clear indication that the surgery recommended to treat Tracy Latimer’s dislocated hip was known, even in Tracy Latimer’s lifetime, to have a high rate of success, the overwhelmingly negative and pessimistic portrayal of this surgical procedure in the mainstream media’s coverage of the Latimer case is both puzzling and disturbing.

The third surgical procedure which was often alluded to in relation to the Latimer case, yet seldom discussed in any kind of meaningful detail in the media, is the insertion of a feeding tube—i.e., a percutaneous endoscopic gastrostomy—that was recommended for Tracy Latimer as a means of addressing her weight loss. In Robert Latimer’s appeal of his second conviction for Tracy’s murder, this procedure is discussed in the following terms: “There was evidence that Tracy could have been fed with a feeding tube into her stomach, an option that would have improved her nutrition and health, and that might also have allowed for more effective pain medication to be administered. The Latimers rejected the feeding-tube option as being intrusive and as representing the first step on a path to preserving Tracy’s life artificially.”<sup>3</sup> In his interviews with the media, Robert Latimer repeatedly referred to this procedure as doctors’ wanting to “cut in a feeding tube” into his daughter (CBC *National* interview with Hana Gartner, October 19, 1998). The great aversion that the Latimers repeatedly and publicly expressed towards having Tracy undergo this procedure gives the impression that this procedure would have been highly invasive, medically risky, and ultimately futile for Tracy. Certainly, this was the notion “spoon-fed” to the public by the mainstream media. However, an examination of the

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<sup>2</sup>Transcript, The Court of Queen’s Bench, Judicial Centre of Battleford, R. v. Latimer, Criminal Trial (Jury), Commencing Nov. 7, 1994, Cross-Examination, Vol. 1, at 183. Dr. Dzus’s testimony was read into the record at the second trial because she was unable to appear personally.

<sup>3</sup>R v. Latimer. 2001 SCC 1. File No.: 26980.

medical research on this procedure indicates that such a bleak portrayal is highly erroneous. To begin with, the average Operating Room time required for this procedure is only 35 minutes. Furthermore, studies by Grant (1993) and Fox (1997) record the incidents of major complications arising from this procedure as a rate of 12.4% to 13%. Apparently, such benign statistics are simply not compatible with the mainstream media's preferred sensationalized portrayal of Tracy Latimer's condition as hopeless, and of the surgical procedures recommended to improve her health and her quality of life as torturous and futile.

**Disability-Ethics Analysis Versus the Traditional Bioethics and the  
Traditional Social-Construction Model Analyses**  
Disability-Ethics  
Analysis Versus a Traditional Bioethics Analysis{ TC \12 "Disability-  
Ethics Analysis Versus a Traditional Bioethics Analysis}

As is readily apparent from the preceding overview of the medical literature describing the surgical procedures which were either performed on, or recommended for, Tracy Latimer, compared with the mainstream media's representation of these procedures, there are several striking dissonances between these two modes of portrayal. At their most fundamental level, these dissonances center around the degree to which the presence of a disabling condition, with its presumed detrimental impact on an individual's "quality of life," is emphasized. For this reason, it seems to me that it would be both edifying and constructive to examine both of these modes of portrayal using a Disability-Ethics lens. Such an examination will, I think, yield an enhanced understanding of the processes by which apparently objective descriptions of phenomena, such as pain and surgery, are manipulated to rationalize and justify homicide.

While it may seem highly counterintuitive to suggest that it is, in this case, the generally pathology-based medical literature, versus the popular media, which can form the foundation of a realistic—and, ultimately, a more humanizing—portrayal of Tracy Latimer, I am prepared, by means of applying some basic concepts and principles of Disability Ethics, to make precisely this argument.

*Quality of Life{ TC \13 "Quality of Life}*

The first, and perhaps the most contentious, of the Disability Ethics concepts that I would like to discuss in relation to the medical and media portrayals of Tracy Latimer is Quality of Life. Within the Social Model of disability, there is a tendency to view the impact of disability on an individual's life chiefly in terms of the social phenomena, such as isolation or stigma, that often accompany disability. Conversely, a bioethics model of disability focuses on corporeal deficits, physical function, and social utility. A disability-ethics perspective, however, reintroduces the validity and significance of the corporeal realities of disability as they impact on and mediate an individual's way of being in the world. Clearly, the medical literature describing the surgical procedures which were either performed on, or recommended for, Tracy Latimer is, by nature, clinical and depersonalized, in the sense of focusing on the surgical procedures and their physiological effects rather than focusing on the psychological, emotional, and social impact of surgery on patients and their families. Nevertheless, the medical literature about these surgical procedures generally tends to follow a three-point trajectory: pre-operative problems, performance of surgery, post-operative resolution of pre-operative problems. Framed in such a manner, the surgical procedures are, in a sense, normalized as reasonable and generally effective solutions to clearly-identified problems. Within this kind of "normalized" representation, surgery becomes the vehicle through which the individual's "quality of life" is, to some degree, restored or improved. Such a construction of surgical intervention is in diametric opposition to the common mainstream media portrayal of surgery as a malevolent medical imposition that would ultimately only add to the suffering that Tracy Latimer is portrayed as having to endure, and thereby further lower her already-poor quality of life. In the same vein, while some bioethicists, such as Arthur Schafer, have argued that Robert Latimer acted ethically by killing his daughter in order to spare her from the pain that further

surgery would have inevitably caused, disability-ethics scholars, such as Catherine Frazee, contend that, "The nondisabled population in this case is most guilty of a colossal failure of the imagination." She describes this "failure of the imagination" in the following terms: "People you know often say to a disabled person, 'I can't imagine how you cope.' The inability to imagine what the disability experience is all about is translated into a kind of collective mythology that a person with a disability lives a tragic life, marked by deprivation and suffering" (Frazee, 1999, online document). I would argue that the process by which disability-ethicists, like Frazee, seek to debunk the collective mythology that people with disabilities, like Tracy Latimer, live necessarily tragic lives of deprivation and suffering is very much akin to the way in which the medical literature, describing the surgical procedures performed on, or recommended for, Tracy Latimer, demystify these procedures, normalizing them as reasonable and generally effective solutions to clearly-identified problems.

*Interdependence versus Autonomy* TC \l3 "Interdependence versus Autonomy"

Autonomy is increasingly considered the cardinal principle of bioethics. Autonomy, as a bioethical principle, can be defined as respect for the individual and his/her ability to make decisions with regard to his/her own health and future. Actions that enhance autonomy are thought of as desirable and actions that somehow impose limitations on an individual and his/her autonomy are undesirable. Despite its general acceptance as a fundamental principle in the field of bioethics, however, the notion of autonomy as being the primary criterion for determining whether or not a certain course of action can be considered ethical, often becomes highly problematic when considered in a Disability Ethics framework. The current consideration of portrayals of surgery in the Latimer case provides a compelling illustration of how and why the almost exclusive focus on autonomy in conventional bioethics is fundamentally incompatible with the principles and goals of Disability Ethics. One of Robert Latimer's primary defensive arguments was that, in order to enable Tracy to escape the pain of further surgery, he, in essence, committed suicide on her behalf. This line of argument essentially asserts

that Robert Latimer carried out an autonomous action on Tracy's behalf. However, when Robert Latimer's actions and arguments are examined through a Disability-Ethics lens, which emphasizes the principle of interdependence over autonomy, they become highly problematic on several levels. First of all, the shift in emphasis from autonomy to interdependence, calls into serious question the common public perception, promoted by Robert Latimer and his supporters, that the severity of Tracy's disability made it impossible for her to formulate—let alone articulate—her own wishes and, therefore that Robert Latimer legitimately acted as her surrogate decision-maker. It does so by effectively transforming Tracy Latimer's identity from Robert Latimer's "severely disabled daughter" into a valued member of a larger community of people with disabilities. Robert Latimer's position as the sole legitimate interpreter of Tracy's experience and wishes thus becomes substantively contested, as Tracy is liberated from the confines of her sole identity as Robert Latimer's "severely disabled daughter" and becomes a student, a classmate, and a client of personal care services. Consequently, Robert Latimer can no longer be legitimately viewed as the only—and perhaps not even as the best—interpreter of Tracy's lived experience, or, ultimately, of her desire to live or to die. Teachers, therapists and paid caregivers all played significant roles in Tracy's life, as members of the community of which *she* was a part. Significantly, court testimony at Robert Latimer's trials revealed that these members of Tracy's community saw her as a basically happy child who engaged with others and enjoyed her life. Such alternative portrayals of Tracy directly challenge Robert Latimer's contention that the pain and suffering that his daughter endured was so constant and so severe that it left him with no other choice but to end her suffering by ending her life. Ultimately, therefore, the shift from a Bioethics emphasis on autonomy as a guiding principle to a Disability-Ethics emphasis on interdependence as a guiding principle clearly problematizes, and indeed undermines, the frequently-repeated argument that Robert Latimer carried out an autonomous action on Tracy's behalf by committing suicide for his daughter in order to spare her from the inevitable pain of further surgery.

*Valuation versus Dignity* { TC \13 "Value versus Dignity}

Just as the Latimer case is illustrative of how the notion of autonomy as a cardinal principle of Bioethics becomes significantly problematized when juxtaposed with the Disability-Ethics emphasis on interdependence, it similarly reveals a fundamental tension between the bioethical emphasis on individual dignity as a core concept as opposed to the predominant concern in Disability Ethics with the valuation of an individual, both in terms of the social roles that he or she occupies and in terms of his or her innate value as a human being. Again, viewed exclusively from a conventional Bioethics standpoint, Robert Latimer's assertion that the succession of surgeries that were either performed on, or recommended for, his daughter were progressively eroding her dignity by—as he typically referred to it—"mutilating" her, seems entirely rational and defensible. This is because conventional Bioethics generally subscribes to the common view that the loss or lack of ability/function automatically results in the lack or loss of dignity. However, when one considers Tracy's life as a person with disabilities innately valuable, regardless of the way in which her level of dignity is externally defined and assessed by others, including her father, Robert Latimer's assertion that he was entirely justified in killing Tracy in order to preserve what little was left of her dignity suddenly seems far less salient. Rather than unquestioningly accepting the premise, put forth by both Robert Latimer and conventional bioethicists like Arthur Schafer, that a life with significant disabilities is necessarily a life bereft of dignity, a Disability-Ethics perspective calls us to identify and examine the able-ist assumptions which undergird such a narrow definition of human dignity.

### **Conclusion**

Thus, as we have seen in the preceding exploration of the medical literature describing the surgical procedures which were either performed on, or recommended for, Tracy Latimer, compared with the mainstream media's representation of these procedures, sensationalized language was often used by the mainstream media to make the case that killing Tracy was somehow justified because Tracy was in relentless



pain, and the proposed surgery would only have caused even more pain. Therefore, the assumption is made that surgery would have been worse than death for Tracy. In reality, as is readily demonstrated by the medical literature, Tracy's pain was manageable, and would most likely have been eliminated by surgery. The application of a Disability-Ethics analysis to the media and medical portrayals of these surgical procedures exposes the able-ist bias of the mainstream media and reinforces the normalization of these surgeries in the medical literature as the probable means of improving Tracy Latimer's quality of life. Ultimately, therefore, it is evident that a Disability-Ethics lens provides the clearest view of the role of surgeries in the life, if not the death, of Tracy Latimer.

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