The Euthanasia Debate: International Experience and Canadian Policy Proposals

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Abstract

This thesis examines the problematic prospect of the introduction of euthanasia and physician-assisted suicide into Canadian society. The thesis argues that euthanasia is too simplistic an approach to address the complexities of end of life issues. The policy proposal under active discussion is profoundly mistaken. The language of euthanasia is examined in relation to the choice of words used, drawing attention to how words, when used loosely, can distort reality in this matter. Historical experience from other jurisdictions is presented to provide a context for this discussion. A "slippery slope" argument emerges via the claim that, in practice and in principle, euthanasia can neither be contained nor managed upon its introduction into a society. A theoretical model based on virtue theory is then used to interpret these findings and to frame a constructive response. The policy alternative of enhanced resources for palliative care is presented. It is concluded that the risks associated with euthanasia are momentous and grave while the benefits are few.

Keywords: euthanasia, physician-assisted suicide, virtue theory, palliative care
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Chapter 1

Introduction

It is better for humans to shape rather than to be shaped by their circumstances. Humans do this mainly through the use of technology, and yet paradoxically, today there needs to be limits on the power of technology, in view of its own dehumanizing potential. Technological efficiency, in and of itself, is not the goal of human life, and we encounter its limitations in a myriad ways in our world. In higher education, to take one case in point, there is no substitute for the humanizing role of face-to-face interactions between teacher and student in traditional classroom and seminar settings, however much the efficiencies of impersonal on-line media might be trumpeted by government and industry. The list of problem areas could be multiplied, but one particular question arising in relation to current policy debates about the use of medical technology in Canada provides the particular rationale for this thesis.

In our time, advances in medical technology and scientific knowledge are providing humanity with an unprecedented ability to actually manipulate life and death.¹ The current euthanasia and physician-assisted suicide debate is a result of these medico-technological advances. The argument of this thesis is that the proposed introduction of euthanasia and physician-assisted suicide in contemporary Canada places us at risk of becoming the servant of

technology, and in the position of needing to clarify the centrality of our common humanity in medical ethics. A key point is that alternatives to euthanasia and physician-assisted suicide exist. These have proven successful in other jurisdictions, and their use could be extended in Canada in response to most, if not all, of the issues that the demand for assisted death involves.

Scientific innovation has placed people in our society in the position of being “technological giants but ethical infants.”\(^2\) We have an almost infinite capacity to uncover new knowledge but only limited wisdom concerning how best to apply this knowledge. New medical situations and innovations pose unfamiliar problems for which traditional ethical principles and historical moral standards are ineffective. End of life issues, specifically euthanasia and assisted suicide, raise such questions in a particularly acute form. Humanity can, however, apply its wonderful resourcefulness, creativity and compassion to finding solutions and alternatives to end of life issues. Our resourcefulness, which has brought about this debate in the first place, can thwart this circumstance of medical technology placing humanity in the dangerous position of being its servant. Current medical technology means that death is now preceded by an ever-lengthening period of physical and mental decline.\(^3\) Scrupulous attention to this balance of technology and the issue of end of life is demanded.

The euthanasia debate is momentous and necessitates honest dialogue. Consequently, the language employed in this debate is extremely important. The importance of our language and consequent understanding of our intent is underscored by the philosopher Ludwig Wittgenstein’s


quote “The limits of my language means the limits of my world.”⁴ The language of the euthanasia debate may well define the earthly limits for our most vulnerable; the ill, the elderly, the poor and disabled amongst us. Clear and concise words are needed so that clear thinking and accurate critical analysis may be applied to this complex issue.

The proposed legalization of euthanasia and physician-assisted suicide represents a potential sea change in the foundation of our society. Such action will alter key aspects of the normative foundation of Canadian society. Part of the normative foundation of our society is found in the principle that it is wrong to kill. In fact, one of the most important rules on which we base our societies and their legal systems is that we must not kill each other.⁵ This is, at bottom, the reason that capital punishment is no longer legal in Canada, and yet we now propose to introduce forms of medicalized killing that conflict with that prohibition. Yet there is an important parallel between the two: as with capital punishment, euthanasia, were it to be legalized, would fall outside the traditional justification for taking life. In other words, people would be killed but not for the purpose of saving another life as with self-defence for example.⁶

The proposed euthanasia legislation will furthermore grant certain members of our society the right to kill. This debate is complex and involves issues which stem from our past which involve the ethical, legal and cultural norms handed down to us from previous

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⁶ Ibid, 300.
generations; our present and whether or not we change those norms; our future and what such changes will mean to future generations.\(^7\)

### 1.1 The Question of Values

The endeavour to die a hastened death through euthanasia or an assisted death appears to be the product of the combination of a number of prevailing forces. The availability of certain medical technologies is clearly one of these forces. However, current proposals for a shift in public policy on euthanasia and physician-assisted dying also rely heavily upon recent changes in the operative moral (and political) environment of our society. Moral choices, choices which carry a connotation of right or wrong, have traditionally been guided in large measure by religion. As religion and religious institutions began to lose their guiding moral authority in society, however, laws governing the conduct of individuals have become increasingly secularized, as individual freedoms and choices instead attained greater and greater importance. Although there is insufficient scope to explore the question in this thesis, the influence of the “rights revolution” in contemporary Canadian history on the proposed policy change is clear.\(^8\)

Nevertheless, the conflict of the euthanasia proposals with traditional religious values is profound and important. According to Pope John Paul II, who made one of the classic interventions in this debate in his 1995 Encyclical *Evangelium Vitae*, the euthanasia option is rooted in nothing less than a “culture of death” that reigns in the modern West, a culture which is further “actively fostered by powerful cultural, economic and political currents which encourage

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\(^7\) Ibid, 105.

\(^8\) Scherer, introduction, viii.
an idea of society excessively concerned with efficiency.”\textsuperscript{9} In this same document, Pope John Paul II consequently singles out what he sees as a disintegrating value system in health care as an issue of special concern.\textsuperscript{10} Likewise, Wesley J. Smith describes a disintegrating value system in healthcare.\textsuperscript{11} Smith states that such a system defines the sickest and most disabled among us as having lives not worth living.\textsuperscript{12} These are powerful accusations, accusations that are, as we shall see, not without a foundation in the current debate.

Euthanasia has, in short, a foundational base in values as well as facts and knowledge.\textsuperscript{13} The particular combination of the philosophical questions surrounding euthanasia with the question of human frailty and suffering based in our actual physical reality makes the whole discussion very difficult. What tends to occur is that particular interest groups, opinions and moral theories tend to dominate in debates that seem polarized and polarizing. Not all of these perspectives can be examined within the limits of this thesis, and in particular, no full-scale treatment of the question of moral theory will be attempted. Briefly, however, we can note that, in much discussion of the question, two voices are especially dominant among those who undertake an ethical analysis of euthanasia. Typically, people belong either to the camp of principle-based or deontological ethics on the one side or that of utilitarian ethics on the other side.\textsuperscript{14} Both approaches no doubt have strengths and weaknesses. I shall maintain, however,

\begin{itemize}
  \item \textsuperscript{9} Pope John Paul II, “Evangelium Vitae (The Gospel of Life)” (Addressed by the Supreme Pontiff Pope John Paul II to all the Bishops, Priests, and Deacons, Men and Women, Religious, Lay, Faithful and all People of Good Will on the Value and Inviolability of Human Life), #12.
  \item \textsuperscript{10} Ibid.
  \item \textsuperscript{11} Wesley J. Smith, Culture of Death. The Assault on Medical Ethics in America. (San Francisco: Encounter Books, 2000), 3.
  \item \textsuperscript{12} Ibid.
  \item \textsuperscript{14} Ibid, 4.
\end{itemize}
that each of these standard approaches is too simplistic, because the narrative character of the values embedded in human experience and existence is not sufficiently expressed in either of these approaches. The particular combination of the physical and philosophical aspects of the question that come together at this point means, I will suggest, that meaningful discussion of the question must be sensitive to what we might here refer to as our “moral history”. On its own, the utilitarian argument simply does not go deep enough and likewise, the deontological approach is too limited and does not take into consideration one of the fundamental features of human nature. This is better handled, I suggest, by an alternative moral theory that will be used in what follows. That approach is virtue theory.

In every society, and in every moral philosophy, appeal is made ultimately to some ordering principle. This can take the form of a categorical imperative, or a principle of utility, or for that matter an agapistic love of humanity, whether without God or because of God. In each approach there is an act of faith in some ordering principle. The character of any moral philosophy will lead to characteristic approaches to the question of right or wrong behaviour. This applies to euthanasia. Virtue theory, however, takes a very particular approach to the question of right and wrong that, I suggest, is especially appropriate to the current debate about euthanasia. It asks the questions, “What will be the consequences of our doctors being taught to kill?” What will be the consequences of our doctors having the authority to determine the value of someone’s life?” And most importantly, “What will be the consequences for the character of individuals and of the social whole of their doing so?” Virtue theory allows us to see, in a uniquely important way, why it is that the proposed position of the physician as euthanizer

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represents such a deadly contradiction. One cannot heal, after all, by making nil. Healers cannot annihilate if they are truly to heal.¹⁶

There are, of course, other moral theories and standpoints that are relevant to the euthanasia debate, and though none can be discussed in any detail within the limits of this thesis, aspects of a variety of arguments will need to be considered. Some researchers such as Lawrence Kohlberg (1927 – 1987), for example, consider the central concept of morality to be that of justice. He believed that philosophers of the deontological and utilitarian strands are in general agreement on the principles of justice, and so that agreement between the two in this matter is in principle possible.¹⁷ The justness of euthanasia and physician-assisted suicide will accordingly be discussed. Alternatively, the French philosopher Paul Ricoeur (1913 – 2005) maintains that a version of the Golden Rule is needed: “Every person has the right to be cared for, regardless of social condition, race, ethnicity, religion, customs or beliefs”.¹⁸ Ricoeur stresses that every increase of power increases situations of fragility, and further, that every time there is an asymmetry in power, there is also the threat of not respecting others.¹⁹ The question of the asymmetry in power that is latent in physician-assisted suicide will accordingly also be discussed.

The relevance of the Golden Rule is especially interesting at this point. Ricoeur presents the Golden Rule as a means of protection. The Golden Rule stipulates that one treats another as one would like to be treated. By putting oneself in the place of another, one can imagine oneself

¹⁸ Christopher Cowley, Reconceiving Medical Ethics (New York: Continuum International Publishing Group, 2012), 34.
¹⁹ Ibid, 35.
as the victim of one’s own actions and so can be led to prevent the manifold possibilities of violence.\(^{20}\) Hence, by imagining that the other must be ourselves, the issue of considering ourselves as ruling over a subordinated person or population can to some extent be avoided. The selfish tendency which could lead us to consider only our own interests is overcome and we treat the other with respect.\(^{21}\)

The nature of the healing relationship between physicians and patients brings into sharp relief the application of this Golden Rule. In fact, the nature of the healing relationship is in itself the foundation for the special obligations of physicians as physicians.\(^{22}\) Consider that any serious illness and its healing so often involve an emotional as well as a physical crisis, especially at end of life. Additionally and importantly, seriously ill persons are vulnerable and exploitable physically and emotionally, which carries with it moral and spiritual vulnerability as well.\(^{23}\) This raises important questions concerning how the option of euthanasia may damage the doctor-patient relationship, and impact on the question of how physicians behave in medicine generally.\(^{24}\)

The Golden Rule as presented by Ricoeur offers protection both for the patient and for the physician. Not only is the patient protected from potential paternalistic actions by their physician, but also crucially, the physician is protected from becoming paternalistic. Here we see something of the special importance of virtue ethics in the current debate. Virtue ethics

\(^{20}\) Ibid, 35.
\(^{21}\) Ibid, 35.
\(^{23}\) Ibid.
expands on this principle by speaking of the formation and subsequent expression of moral character through one’s actions. In other words, one becomes what one does, and if part of what one does is to kill (albeit medically), then this cannot be a “neutral” matter for the moral character of the doctor-patient relationship, or for medicine in general.

One of the leading representatives of virtue ethics in contemporary theological ethics is Stanley Hauerwas, who states that morality is first and foremost a matter of seeing, rather than doing. “The basis and aim of the moral life is to see the truth, for only as we see correctly can we act in accordance with reality”.25 This thesis will use virtue theory as a theoretical model, by which to consider the question of euthanasia and assisted suicide not in the abstract, but in connection with the impact on the moral life of physicians, caregivers, patients, their families and even society itself. Virtue theory to this extent provides a vehicle by which we can see the reality of euthanasia and bridge the chasm between theory and reality. This model is capable of applying a reasoned and thoughtful analysis to a subject so often explained and analyzed in public discourse according to superficial cultural expectations and mores. The virtue theory model, by contrast, helps us to see, to use Hauerwas’s term, in such a way as to discern the potential impact of euthanasia and assisted suicide on people’s lives and character. The advantage of virtue theory is that it can finally assist us in behaving in accordance with this “seeing”.

Our medical expertise and advancements are a result of the cumulative advancements of our predecessors and contemporaries working in the varied fields of science. Science as we

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know it, however, originated in Judaeo-Christian and Muslim societies, among people who believed that the earth is a good creation of God. This includes medicine, and certainly includes medical practice. In fact, the Judeo-Christian tradition decisively influenced the origin and shape of medical ethics down to our own times.\textsuperscript{26} Such is the influence of religious tradition that the theologian Paul Ramsey hopefully writes, “Whether our moral outlooks are inspired by a humanistic vision of life or by religious perspective, there may be a convergence between these points of departure on the place of special moral problems.” It is in the light of this kind of confidence that Ramsey states that “we need to hope for and search for a fruitful meeting between various ultimate “good reasons” put forward in support of moral judgements as we move into the area of specific dilemmas such as euthanasia.”\textsuperscript{27} This thesis proposes that the virtue theory model provides important resources for the emergence of such a point of convergence for discussions pertaining to the rightness or wrongness of euthanasia and physician-assisted suicide.

1.2 Summary of the Argument

This thesis will examine the euthanasia debate supported by the following lines of thought. First, the argument will be that there is need for recognition of the importance of honest vocabulary and of the danger of loose concepts in the euthanasia debate. This will be the substance of the case presented in Chapter 2 of this thesis, which will also point out that much of the language used in the debate and in proposed Canadian legislation actually does the opposite: it obfuscates the reality of euthanasia and unfortunately hinders people’s understanding of that

\textsuperscript{26} Paul Ramsey, \textit{Ethics at the Edges of Life. Medical and Legal Intersections.} (USA: Yale University Press, 1978), xiv.
\textsuperscript{27} Ibid.
realities. Chapter 3 will examine the history of euthanasia and the lessons to be learned from this history. This will be followed by an appeal to the “slippery slope” argument as it pertains to euthanasia and the new moral boundaries euthanasia introduces to a society in Chapter 4. Once euthanasia has made its appearance in a society, and becomes acceptable, it becomes something very, very difficult to control. The claim will be made that we ought to know this from the experience of euthanasia in other jurisdictions. In Chapter 5, by contrast, the option of enhanced resources for palliative care will be examined in the light of virtue theory. The main argument will be that a renewed emphasis on palliative care represents the “virtuous” alternative to the euthanasia option, as it is one that would do markedly less damage to the moral character of families, society and medicine itself. In Chapter 6, finally, a summary statement of the argument will be offered, presenting euthanasia and physician-assisted suicide as a dangerous social experiment, and one not worth the genuine risks it entails.

The thesis will thus argue that the proposed euthanasia and physician-assisted suicide legislation in contemporary Canada is too simplistic a way to deal with the complexities and realities of end of life care. The theory of euthanasia is far different from the reality of euthanasia. This manifold difference must be clarified if people in our society are to have a clear understanding of how euthanasia will impact their lives, their children’s lives and their grandchildren’s lives. This debate involves problems that range from the nature and meaning of human life to the most fundamental principles on which our society is based.28 This debate, therefore, involves far deeper considerations than the usual arguments presented for autonomy

and relief of suffering. These arguments of course are part of the debate but they are not all of the debate, and they are not even necessarily the most important facets of the debate.

Among the most important of these issues, as we shall see in what follows, is our common humanity, in which the discussion of the virtues is rooted. For the virtues are ultimately related to what it means to be fully human. In fact, Aristotle pointed out a long time ago that we do hold persons accountable, not only for particular actions performed, but for what sort of persons they become. So, virtue theory can frame the discussion of our history and past, our present and, finally, what our grandchildren and future societies can expect, including what we, and they, should expect should euthanasia be introduced.

In this introductory Chapter, then, the complexity of the euthanasia debate was been summarily presented. Several related areas of discussion have been identified which will organize the strands of reflection required in subsequent chapters. Now, let us begin our examination of this issue by focusing on the importance of the words used in the discussion.

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Chapter 2

Euthanasia: The Importance of Words

“Euthanasia is a long, smooth-sounding word, and it conceals its dangers as long, smooth-sounding words do, but the danger is there nonetheless,” a quotation by American author Pearl S. Buck from the website www.euthanasia.com. On this same website, Wesley J. Smith in 2013 states “Beware movements that feel the need to resort to feel-good euphemisms to hide the reality of their agendas and goals. Assisted suicide is suicide. The term is descriptive and accurate. And when it is legalized, it amounts to state-approved suicide. Let’s deal with that reality and stop the pretense.”

On the whole, I suggest that we need to take these kinds of warnings seriously. This chapter will accordingly discuss the language of euthanasia and present how the choice of terms and words used in relation to it can distort the reality of the practice.

The language of death talk, the language of euthanasia, is emotionally charged. This makes the importance of clear and honest language even greater. An honest debate and discussion of this issue is not possible without honest vocabulary. And yet, the lexicon used to frame this discussion often confuses and obfuscates the facts of euthanasia.

The choice of confusing vocabulary appears to be a condition caused both by accident and by design, since an important and extensive way of promoting the legalization of euthanasia is through various types of confusion.31 For the purposes of this discussion, however, we will

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avoid the political issue and deal more generically with the issue of confusing semantics which includes confusion around definitions and choice of language.

2.1 Euthanasia: A Term in Transition

The importance of the use of words is highlighted by the transitioning of the meaning of euthanasia. Originally, euthanasia meant the condition of a good, gentle and easy death. Eventually, it took on an aspect of performativity or helping someone to die gently. An 1826 Latin manuscript referred to medical euthanasia as “the skillful alleviation of suffering” in which the physician was expected to provide conditions that would facilitate a gentle death but “least of all should be permitted, prompted either by other people’s request or his own sense of mercy, to end the patient’s pitiful condition by purposefully and deliberately hastening death.” This understanding of euthanasia is closely mirrored in the philosophy and practice of contemporary palliative care. Its practitioners have strongly rejected euthanasia.

Today, the noun euthanasia has transitioned into the transitive verb “to euthanize”. The application of this transitioned meaning, the request for an active and intentional hastening of one’s death, is a modern phenomenon. The word euthanasia has come to mean choosing death as one of life’s choices. The first sample sentence illustrating the use of the verb in this sense is found in the Oxford English Dictionary in 1975. This nomenclature reflects, therefore, a...
new concept and new boundaries. As Ian Dowbriggin noted, in the 1970’s, “euthanasia ceased being defined as an active mercy killing, with its disturbing overtones of coercion and social usefulness, and increasingly became viewed as personal freedom from unwanted interference in one’s own life.” 38 The right-to-die movement was thus commenced.

2.2 Euthanasia: Let’s Call It What It Is

Figure 1, an organizational chart of the terms of euthanasia with accompanying definitions, illustrates how easily meanings can be blurred. It is imperative, however, that in our discussions we employ the appropriate terms here. In fact, it has been recommended that the terms *active* and *passive* euthanasia be removed from our vocabulary as these qualifying adjectives confuse discourse. 39 This writer concurs with this recommendation. Passive euthanasia after all includes the withholding of life-sustaining medical treatments and allowing nature to progress to its natural end. Given the sense that the word euthanasia has been given in recent decades, it can be argued that there is no such thing as *passive euthanasia* and that this withholding of treatment could best be seen simply as medicine’s recognition of life’s finitude.

An organizational chart of terms used in the euthanasia debate is found below with accompanying definitions. This chart and accompanying terms will assist in keeping our arguments and thoughts clear throughout this discussion.

The definitions would be as follows:

“Euthanasia”: One person’s deliberate killing of another, not because they are threatening injury or have committed a crime, but because their lives are reckoned not to be worth living.\(^\text{40}\)

“Voluntary Active Euthanasia”: Intentionally administering medications or other interventions to cause the patient’s death at the patient’s explicit request and fully informed consent.\(^{41}\)

“Involuntary Active Euthanasia”: Intentionally administering medications or other interventions to cause a patient’s death when the patient was competent but without the patient’s explicit request and/or fully informed consent (i.e., the patient was not asked).\(^{42}\)

This is arguably homicide.

“Non-voluntary Active Euthanasia”: Intentionally administering medications or other interventions to cause a patient’s death when the patient was incompetent and mentally incapable of explicitly requesting it (i.e., the patient is in a persistent coma or similar).\(^{43}\)

“Passive Euthanasia”: The withholding or withdrawing of life-sustaining medical treatments from the patient to let him or her die.\(^{44}\)

“Suicide”: This differs from all forms of euthanasia in that the killing is performed, not by someone else, but by the one to be killed.\(^{45}\)

“Assisted Suicide”: In this scenario, another person provides help. This may take the form of instructions about how to commit suicide efficiently, or the means with which to do it, but the act of ending one’s life is still performed by the one to be killed.\(^{46}\)

“Physician-Assisted Suicide”: Where the assistance to end one’s life is provided by a physician.\(^{47}\)


\(^{42}\) Ibid.

\(^{43}\) Ibid.

\(^{44}\) Ibid.


\(^{46}\) Ibid.

\(^{47}\) Ibid, x.
In addition to these definitions, we now have many different terms used by different sources for these acts of medical killing. In addition to the terms above, we now are encouraged to think of euthanasia in terms of “a good death”, “death with dignity”, “planned death”, “assisted death”, or “aid in dying”, to mention a few.\textsuperscript{48}

For the purposes of this argument I will generally use the terms *euthanasia* or *physician-assisted suicide* or *hastened death*. Sometimes the term *medical killing* will be used because this word too is an accurate and descriptive term. These, I submit, are not loose concepts but correspond to the reality of the actions in question.

2.3 **Loose Language: Loose Concepts: Loose Boundaries**

Paul Ramsey points out in a book written in 1978 that he believes loose language to be at the source weakening the principle prohibiting choosing death.\textsuperscript{49} This is worrisome. The finality of death demands the kind of discussion that can be formulated only in clear, definable and unambiguous terms. Policies on euthanasia currently under discussion in Canada propose new moral and legal boundaries. Loose language describing loose concepts leads to reasoning with definitions and descriptions which are inherently arbitrary.\textsuperscript{50} This inherent arbitrariness then is further exacerbated by the subjective application of the varied opinions of doctors and decision makers. What is unbearable pain for one person may not be unbearable for another. Logically there does not appear to be a way of firming up the boundaries of what does and does not

“qualify” a person for euthanasia. One must question if euthanasia should even be debated other than on a case by case basis.

What is also clear is that such use of loose language and loose concepts, concepts which will establish new moral and legal boundaries around end of life issues can lead to a slope without brakes since the “brakes” in question could only be supplied by clear thinking about the issue. The “slippery slope” implicit in the current euthanasia debate will be discussed later in this thesis.

The vocabulary of the euthanasia debate contains plenty of examples of loose language and loose concepts. The final report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, dated November 30, 2015 is a fine illustration of the vocabulary of euthanasia employed by Canadian policy makers. This vocabulary is rife with loose concepts which promotes a superficial rendering of which is at issue in medical killing. First, let us consider the title of this pro-euthanasia report, Provincial-Territorial Expert Advisory Group of Physician-Assisted Dying. To begin with, the use of the word “dying” rather than “suicide” is misleading since “dying” connotes a natural death. This wording is deceptive. Let us be clear. “Physician-Assisted Dying” is a form of euthanasia and is the same as “Physician-Assisted Suicide.” The definition of Physician-Assisted Suicide is provided on page 16 and states that “where the assistance to end one’s life is provided by a physician.” So, “Physician-Assisted Dying” is an example of a non-specific euphemism which masks the reality that this is euthanasia.

Deliberately or not, our policy makers have thus attempted to remove the stigma of suicide from this process by the use of the word “dying”. Such nomenclature assists in the
normalizing of a medicalized death, with the attendant participation of our doctors, nurses and care-givers. It falsely presents euthanasia as nature taking its course, when it simply is not nature taking its natural course. The term “medically-assisted death” successfully removes the moral connotations attached to a suicide. There is, as it were, no right or wrong attached to such “death” because we are all going to die. Hence, such nomenclature successfully removes any consideration of the moral status of the act, or the moral status of the life that will be taken. Such verbal sleight of language unfortunately masks the reality of the actual agenda and goal of these policy makers. When physician-assisted dying is legalized it will be the very same as state-approved suicide. That is the reality.

This attractive and morally acceptable connotation of euthanasia does not stop with the title. The document actually presents euthanasia as something desirable so that anyone should be able to request it. Recommendation 17 of this report states that, “Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based on competence rather than age.” But how does one determine competence? What does a proper assessment for vulnerability look like? The concepts and language used by policy makers are loose and will be based on the subjective opinion of doctors and family members. This means that children, for instance, might request their death, and be considered competent by a given physician in making such a request.

Aside from any issues of morality, can children be competent to understand death and its finality? We protect our children with laws that don’t allow consumption of alcohol until the age of eighteen, the age of competence for drinking alcohol. We protect our children by enforcing
the age of competence of sixteen years and a rigorous licencing routine before one can drive. Very sick children and their families are very vulnerable and need protection and care rather than access to a hastened death. It is difficult to determine whether or not such ill children can competently understand the reality of euthanasia and that it is terminal.

The National Post on Wednesday, December 16, 2015 reported Arthur Caplan, one of the world’s foremost medical ethicists, as stating that, “It’s a slippery slope argument, and this is a slope I worry about. Sometimes I don’t, but this one I do.” He argues that such a proposal to grant terminally ill children the right to die by euthanasia could put some of Canada’s most vulnerable at risk.

In the same article, Arthur Schafer, one of the architects of the Provincial-Territorial report, is reported to have stated that “the issue really is competence: are you able and capable of making that decision for yourself?” The implication is that if you are, then for that purpose you’re an adult. The logic of this argument simply does not stand. If the state protects children from drinking until an age of competence and, similarly, driving at an age of competence, then it follows that the state should also protect children from medicalized killing.

Caplan, for his part, goes on to argue that this “really opens the door to helping people die who really have questionable competence.” This includes people cognitively disabled by stroke or dementia, the severely depressed or those who have simply lost their zest for living. Caplan recommends a court review for such cases, on a case by case basis. In his opinion, that would be a suitable check and balance for such a qualification.
The application of loose language and loose concepts continues with Recommendation 18 of this Report. This recommendation encompasses the qualifications necessary to request a hastened death. The proposed qualifications present a vast ambiguity: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not, however, be delineated in legislation or regulation.”

The core issue in this recommendation is the grievous and irremediable medical condition. Most people think of euthanasia as being available only to the terminally ill. However, in the proposals as they stand, this is simply not the case. “Grievous” and “irremediable” are loose and dangerous concepts which provide no boundaries for euthanasia. Anyone, in principle, will be able to request medical killing. Terminal illness is not required, nor is a waiting period proposed. As Andrew Coyne put it in the Thursday, December 17, 2015 *National Post*, “suicide for everyone is on the way.”

The lexicon of this report succinctly and profoundly illustrates Paul Ramsey’s concern, noted earlier, that loose language is at the source of any weakening of the principle prohibiting the choice of death. Such broad language is detached from the reality of euthanasia and couches the euthanasia discussion in an aura of a progressive society doing what is best for its citizenry. The reality of euthanasia is being presented as the route to a more compassionate and caring society, when in fact it is anything but that.
2.4 The Romanticization of Euthanasia

The use of such broad language in the euthanasia debate is highly deceptive. In particular, a profound transformation of the health care ethic is being advanced by this lexicon. Euthanasia is being smuggled into the medical arena under the guise of “a peaceful death” cloaked in a revisionist idea of healing or relief of suffering.\(^\text{51}\) Euthanasia is not healing and relief of suffering is not medically obtained. Suffering is ended by death. This language presents euthanasia as a medical alternative which is medicalized killing. The concept of death is shifted from that of a natural part of living to a medical procedure.

This transitioning of “dying” to “death” again, I submit, is deceptive. The experience of peaceful dying encompasses that essential part of caring for the living which includes the process of dying. The achievement of a peaceful death, on the other hand, medicalizes the natural process of death. Now medicine is being enabled to produce or achieve death itself.\(^\text{52}\) This represents a dramatic shift in our health care ethic of healing.

The case for euthanasia is emotionally and evocatively presented by mass media and makes for dramatic and emotionally gripping television. Mass media communicates the case for euthanasia with ease. Margaret Somerville speaks to this in an *Ottawa Citizen* article on June 27, 2008, when she states that, “what appears as especially dangerous is the difficulty of communicating the case against euthanasia and the ease of communicating the case for it.”\(^\text{53}\)

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\(^{52}\) Ibid.  
\(^{53}\) Margaret Somerville, “The Case Against Euthanasia”, *The Ottawa Citizen*, June 27, 2008.
thinking required by society, policy makers and care givers. She further goes on to explain that when personal and societal values were consistent, widely shared and based on a shared religion, the case against euthanasia was simple: God commanded “Thou shalt not kill”. On the other hand, in a secular society based on intense individualism, the case for euthanasia is simple: Individuals have the right to choose the time, manner and place of their death.

Another layer of difficulty lies in the enormous successes of medicine these past fifty years which have made both doctors and lay persons less prepared than ever to accept the finitude of our existence. This is an aspect of the euthanasia debate that often goes unnoticed, especially in media discourse, and though it is something that we are not able to deal with here in any detail, that fact that it is itself a pressing issue needs to be acknowledged.

The proponents of euthanasia use the argument for compassion often. In fact, compassion for the suffering is one of the most common of the reasons heard in support of euthanasia and physician-assisted suicide. All of us naturally want to be treated compassionately when we need help. Without compassion, a society cannot be humane. Compassion softens the reality of life. However, it is this attention to compassion which enables the mass media and policy makers to present the case for euthanasia so emotionally and so powerfully. Nevertheless, not to temper the emotional arguments made for euthanasia with reason is to misrepresent the reality proposed by euthanasia.

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The emotion of compassion is powerful, necessary and ubiquitous. The power of the emotion of compassion needs the restraint of reason. Without reason, compassion can become something distorted and even harmful. Reason and compassion need each other; one without the other can become self-justifying. The human soul and psyche are at risk of domination of one or the other without this coupling.\textsuperscript{58}

When compassion is applied then to human suffering, especially when death is near and inevitable, most of us desire to relieve that suffering. Compassion is an emotion accompanied by a desire to act. So, those in support of euthanasia and physician-assisted suicide use compassion as a sufficient moral ground for the decision to hasten death. Those not in support of euthanasia and physician-assisted suicide, by contrast, present such unrestrained compassion uncoupled from reason as dangerous.\textsuperscript{59}

Compassion is the foundation of the argument that patients should be allowed to choose an intentional death. Physicians who comply would not violate their professional ethic but would be replacing the outmoded precept contained within the Hippocratic Oath with commendable compassion.\textsuperscript{60} However, the fact that we experience the emotion of compassion does not give moral legitimacy to any and every action motivated by compassion.\textsuperscript{61} Compassion without reason is blind, and it is certainly no self-evident substitute for reason in discussions of law and policy, and since one physician’s or family’s “compassion” will be to another physician or family intolerable. Compassion is not enough.

\textsuperscript{58} Ibid.
\textsuperscript{59} Ibid, 42.
\textsuperscript{60} Ibid, 47.
\textsuperscript{61} Ibid, 45.
This is the problem with the application of compassion without reason. To exalt compassion over traditional professional obligations or to make it one of such obligations is seductive but dangerous. Without the application of reason to compassion, the good which is hoped for through the hastening of death actually blinds us to the risks and harms. Moral limits established by the application of reason to the argument of compassion, especially regarding end of life issues must be clear. Otherwise, physicians will convince themselves that their actions are moral, just and good, when in fact, they are not. As is often said, after all, “To persuade good and moral people to do evil…it is not necessary to persuade them to become evil. It is necessary only to teach them that they are doing good.”

There is a fundamental error in this argument from compassion just as there is with any ethic based solely upon love. That error is the conversion of an emotion into a moral obligation to act in any way that the emotion dictates. The disengagement of emotion from moral reasoning distorts compassion, just as reason without emotion similarly distorts the reality of human moral experience. In concrete moral experience, we need both.

The presentation of the euthanasia debate in such emotional terms is misleading at best and pernicious at its worst. Compassion is not a self-justifying reason for relieving pain or suffering at any cost, including that of taking the life of the sufferer. There are serious limitations to the compassionate argument as a sole basis for professional or personal ethics.

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62 Ibid, 47.
63 Ibid.
64 Ibid, 48.
65 Ibid, 51.
Similarly the application of an argument for autonomy to assisted suicide is inappropriate. Advocates of assisted suicides overlay this fundamental moral and philosophical issue with legal and political terms which results in avoiding the much more difficult moral question involved.\(^{66}\) It is deceptive to frame this question of the moral rightness or wrongness of suicide to whether it is right for the state to prevent such action. For there is a large leap between freedom to take one’s life and the freedom to request assistance to end one’s life or to be euthanized.\(^{67}\) In reality, state assistance is being called upon in order for people to exercise their autonomy. This is not logical. Especially when one considers that a suicide itself is not encumbered by laws and that we are already free to take our own lives.\(^{68}\) Not only is this argument not logical, the reality is that assisted suicide will render us all complicit in these deaths. When a society advocates and supports euthanasia, then the members of that society participates in these actions. It will not be of any consequence that some of us do not support this legislation, our participation will be complicit nonetheless.

The most important undermining factor of the autonomy argument for assisted suicide is that of inconsistency. There is not a genuine justification for providing autonomy for some and not for others. How can the legalization of assisted suicide be promoted for some and not for all? If personal autonomy demands that assisted suicide be a right for all, then it needs to be available to all. If laws rejecting assisted suicide are considered paternalistic, then laws preventing assisted suicide for all must be considered paternalistic.\(^{69}\) It would appear that this


\(^{67}\) Ibid.

\(^{68}\) Ibid.

\(^{69}\) Ibid, 57.
application of the argument from autonomy does not hold and that the limit of the individual rights argument has been reached.

It has already been stated that the euthanasia debate involves a momentous issue. Margaret Somerville has argued that the outcome of this debate will establish a “death tone” in our society. Not one Canadian will escape the effects of this legislation. Therefore, we need to engage in this debate with honest language and clear motivation and reject the appeals that are actively made to confusion rather than clarity. We need honest debate tempered with reason.

One aspect of a reasoned approach to euthanasia would be facilitated by an understanding of the history of the practice. What does the history of euthanasia offer to those of us involved in this discourse in contemporary Canada? What can be learned from the experience of jurisdictions which allow euthanasia? What can be learned from the experience of jurisdictions which do not allow euthanasia? We now turn our attention to these questions.

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Chapter 3

Euthanasia in Historical Perspective

History shows us that the concept of euthanasia has been a subject of debate for a very long time. Residents of Athens, with official permission, could obtain a dose of poison allowing them to choose death, while Romans did not punish those who attempted suicide unless they were considered irrational.\(^71\) On the other hand there was an attitude of condemnation of euthanasia by Pythagoreans, their condemnation being based on the spiritual notion that only the gods had the right to take life.\(^72\) This dichotomy has remained in place throughout much of Western history, showing us that this debate is not isolated within our own particular society.

What factors are contributing to this debate at this particular point in time? First of all, as has been stated already, new medical technology is raising new end-of-life issues. In reality, however, even this is not new. Our medical technologies are a result of new technologies throughout the ages, being built upon each other and added to incrementally. These new technologies have historically and unexpectedly wrought new issues which each respective society has worked to address.\(^73\)

Secondly Canada is experiencing an aging population. The September 29, 2015 Statistics Canada report entitled Canada’s Population Estimates stated that “for the first time, the number of persons aged 65 years and older exceeded the number of children aged 0 – 14 years. In

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\(^{72}\) Ibid.

\(^{73}\) Ibid.
2014/2015, the growth rate of the population aged 65 years or older was 3.5%, approximately 4 times the growth rate of the population.\(^74\)

So, although it is never expressly stated in any of the resources used in the composing of this thesis, it is only logical to assume that this aging of our society with the concomitant increases in health care costs would be an important factor contributing to this debate in the minds of policy-makers at this time. Euthanasia, it is widely assumed, represents a cost-effective and efficient way of dealing with such an increase in elderly people availing themselves of health care services.

Thirdly, unprecedented changes in our society are contributing to this debate. In modern urban societies, many people have a sense of loss of community and of dislocation from family which contributes to the fear of dying alone or unloved. Familial and intimate relationships have been converted to relationships amongst strangers.\(^75\) In a very real way death has been dehumanized, allowing the introduction of euthanasia to seem an attractive option that is easier to accept than life.\(^76\)

As context for our ongoing discussion, the remainder of this Chapter will provide a brief overview of the history of euthanasia with some reference to ancient and historical perspectives, but concentrating heavily on euthanasia in the twentieth and twenty-first century. Jurisdictions embracing such policies will be examined as will jurisdictions rejecting such policies.


\(^75\) Margaret Somerville, “The Case Against Euthanasia”, The Ottawa Citizen, June 27, 2008.

\(^76\) Ibid.
3.1 The Philosophy of Suicide

As we have just seen, suicide was an issue much debated in the ancient world of Greece and Rome. In the sixth century BCE, Pythagoras rejected suicide on the grounds that “we are all the chattels of God…and without his command we have no right to make our escape.” 77 Plato similarly rejected suicide because “man is a soldier of God and must stay at his post until he calls.” 78 Aristotle also rejected suicide, though on the civic grounds that a man owes a duty to the state. 79 All three, nevertheless, accepted euthanasia in cases of incurable disease.

Plato was a younger contemporary of Hippocrates. Aristotle said that Hippocrates was called “The Great Physician”, but that he was small in stature. These are the only extant contemporary, or near-contemporary, references to Hippocrates. Hippocrates was a historical figure and a great physician who exercised a permanent influence on the development of medicine and on the ideals and ethics of the physician. 80 Hippocrates was the first to give the physician an independent standing, separate from the cosmological speculator, or nature philosopher. Hippocrates confined the medical man to medicine. His concern was with the physician’s duties rather than his “rights.” Hence, the greatest legacy of Hippocrates: the Hippocratic Oath. 81 It is commonly speculated that Hippocrates did not compose this oath although it has been the exemplar for medical etiquette for centuries, and, in fact, endures in modified form to this day. There remains uncertainty though around the date this oath was composed.

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78 Ibid.
79 Ibid.
composed, this purpose of the oath and the historical forces which shaped its composition. The date of composition is argued as between the sixth century BCE to the fourth century CE.\textsuperscript{82}

Perhaps Sophocles was the first to accept suicide as a more general cure for life’s burdens and most of the Stoics followed enthusiastically.\textsuperscript{83} Death was considered morally neutral in these circles, and sometimes it was preferable to life. After the Roman conquest of Greece, Stoic philosophy gradually became accepted throughout the empire and suicide gained an exalted status.\textsuperscript{84} The Stoic teaching of \textit{necessitas} taught that when a man felt he must leave life, he should do so.\textsuperscript{85} On the edges of Stoicism, Cicero rejected suicide in most circumstances. However, in cases of extreme suffering, or dishonour, or \textit{where God himself has given a valid reason}, he thought suicide would be permissible.\textsuperscript{86}

Such more and less favourable attitudes to suicide are characteristic of the philosophical traditions of Greek and Roman antiquity, and illustrative of the cultural assumptions that were normative for approximately the first two centuries after the death of Christ, when such diverse attitudes towards suicide prevailed. Christianity gradually acquired an increasingly intransigent attitude towards it however, which finally culminated in complete prohibition.\textsuperscript{87} This shift in attitude occurred in spite of the fact that Christian sources accepted suicide in some circumstances, and despite the fact that there is no evidence that Christ himself rejected suicide.\textsuperscript{88}

\textsuperscript{82} Ibid.
\textsuperscript{84} Ibid, 212.
\textsuperscript{85} Ibid.
\textsuperscript{86} Ibid.
\textsuperscript{87} Ibid, p. 213.
\textsuperscript{88} Ibid.
In the third century after Christ, the Neo-Platonist school associated with the philosopher Plotinus added a new argument against suicide: that it perturbed the soul and delayed its passage to the after-life. Plotinus was a major influence on Christian theologians in the patristic period, and as this argument held against any form of suicide, it may be that Christian thinkers similarly prohibited it. At any rate, any form of suicide came to be seen as contrary to the good of the soul and this doctrine prevailed almost unquestioned within Christianity for over a thousand years.

In the fifth century, for example, the Council of Arles embodied this thinking in church law and denounced suicide as diabolical. In the thirteenth century, similarly, St. Thomas Aquinas laid down the orthodox Catholic attitude still widely influential today, with the Sixth Commandment against killing forming the basis of his argument.

Aquinas also called upon arguments used by Plato (that man is a soldier of God and his own best friend), by Aristotle (that suicide is contrary to man’s civic duty), the Neo-Platonists (that it perturbs the soul), and that suicide is contrary to natural law. He also added his own argument that it precludes repentence.

In the Western world, consequently, Christianity had a profound effect on views associated with euthanasia because Christianity was the religion officially associated with the state. In fact, there is little gray area in terms of Christianity’s teachings; one of the legal terms for suicide, felo de se, means being a felon in relation to the self, i.e., being guilty of self-

89 Ibid.
91 Ibid.
92 Ibid.
93 Ibid.
murder. This terminology, and the attached philosophy, did not include a distinction between suicide as a result of emotional issues and suicide as a result of terminal illness. Suicide of any type was strictly forbidden on the grounds that making determinations regarding life and death was solely and completely the purview of God. In fact, those who committed suicide were denied a Christian burial.

When Christianity linked suffering with spiritual growth by citing, as it regularly did, the spiritual virtues of martyrdom, euthanasia came to be cast in a new and further stigmatized light. The Catholic Church even declared that euthanasia was grounds for excommunication. Judaism provided no gray areas either, as there also it was considered murder to cause a death, even if the person was already dying.

The Hippocratic Oath has remained steadfastly the symbol of the physician’s pledge. The prohibition against abortion and suicide were, and in great part remain, in accord with the principles of the Christian Church although not in postmodern Western secular societies. Specifically, the oath states that I will apply dietetic measure for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will

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96 Ibid., 4.
97 Ibid.
not give a woman an abortive remedy. In purity and in holiness I will guard my life and my art.⁹⁸

Given the complexity of the 21st century, this ancient oath cannot possibly encompass current values. Hence, the significance of the Hippocratic Oath is not found in its specific guidelines, but rather, in its symbolism of an ideal which is the selfless dedication to the preservation of human life.⁹⁹

3.2 Changing Views of the Human Body

During the Renaissance and early modern periods, quantum leaps in terms of scientific discovery occurred. The notion developed that the human body is something understandable, at least to a certain degree, rather than something that is a mystery of a sacred nature.¹⁰⁰ The practice of dissecting cadavers, for instance, became common, and; the dead provided a heretofore unavailable means to understand diseases, learn more about the organs and systems within the human body and determine the source of illness.¹⁰¹ Similarly, scientific, mathematical and medical instrumentation, which performed acts we now take for granted, became available. Examples of such instrumentation are the thermometer and the slide rule.

The human body was moving from a place of sacred mystery to that of a scientific object which could be understood by observation and experiment. This shift gave rise to renewed

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¹⁰¹ Ibid.
debate about euthanasia, so that by the early modern period, some dared to suggest that perhaps euthanasia was not such a grievous sin after all.\textsuperscript{102}

The Age of Reason in the 18\textsuperscript{th} Century saw the invention of the stethoscope, ophthalmoscope and laryngoscope which furthered the understanding of the human body. Concurrent with this increased understanding of the human body, was an increased sense of responsibility among many physicians of that time. Many doctors throughout Europe and North America began talking about previously unexplored topics such as human death.\textsuperscript{103} The rise of the Enlightenment and its association with human-rights philosophy, allied with the technological prowess available through science, produced many zealous movements to legitimize medical suicide or euthanasia.\textsuperscript{104}

Philosophers and other figures operating outside the practice of medicine too began to examine this concept and to consider the idea of some degree of choice in death. A shift from the ideal of spiritual authority to that of legal authority grounded in human reason itself was occurring and by 1798, to take one example, six of the thirteen states in the newly-minted U.S.A., no longer mandated legal penalties for those who attempted suicide.\textsuperscript{105}

Suicide itself as a phenomenon began also to be examined scientifically in the latter half of the 19\textsuperscript{th} century when a growing curiosity about the biological causes of suicide was

\begin{thebibliography}{9}
\bibitem{102} Ibid.
\bibitem{103} Ibid, 5.
\end{thebibliography}
occurring. At this time speculation ranged from a genetic defect to a chemical imbalance of the brain.  

3.3 The Birth of Eugenics

Corresponding to such scientific examination of suicide was the origination of eugenics with the English mathematician and statistician Francis Galton. Francis Galton was a cousin of Charles Darwin and believed that heredity governed *talent and character* just as it does eye colour and facial features. Galton was profoundly influenced by Darwin’s theory of natural selection and so, he proposed in 1865, that humans should take control of their own evolution. This would be accomplished by using selective breeding techniques meant to improve society’s physical, mental, cultural and social well-being. In 1883 he coined the term “eugenics” to apply to his theories, a word derived from the Greek for “good in birth”.

By 1910 eugenics was one of the most frequently referenced topics in the “Readers Guide to Periodic Literature.” During the 1920s, in its boom days, eugenics became a serious and influential social and political movement. The eugenics movement clearly sought to reject the idea of equal human worth. Eugenics as a movement was utilitarian, seeking to improve overall human happiness and reduce human suffering, and was capable of doing so sometimes at the expense of individual human rights.

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106 Ibid, 4.
108 Ibid.
109 Ibid, 35.
110 Ibid.
111 Ibid.
Eugenics policies were first instituted in the United States. In 1899, the Journal of the American Medical Association published an article advocating the use of the newly developed vasectomy as a “surgical treatment” to keep undesirables such as habitual criminals, chronic inebriates, imbeciles, perverts and paupers from reproducing.\footnote{Wesley J. Smith, Culture of Death. The Assault of Medical Ethics in America. (San Francisco: Encounter Books, 2000), 36.}

In 1902, an Indiana physician by the name of Dr. Harry Sharp, urged passage of mandatory sterilization laws. Such laws would apply to all men in prisons, reformatories and pauper’s houses.\footnote{Ibid.} In 1907 Indiana became the first State to pass a eugenics-based sterilization law. By 1912, eight states had sterilization laws. Nearly thirty states followed suit.\footnote{Ibid.}

At the same time, discussion of euthanasia and suicide formally entered the legislative forum at the beginning of the 20\textsuperscript{th} century with the introduction of a bill in support of euthanasia in Ohio in 1906.\footnote{Jennifer Fecio McDougall and Martha Gorman. Euthanasia. A Reference Handbook, Second Edition. (Santa Barbara, USA: ABC-CLIO Inc., 2008) 4.} Although it was ultimately defeated, it did receive almost 25\% of the committee vote, indicating that the general populace was becoming increasingly concerned with the circumstances of the terminally ill patient and the dying process.\footnote{Ibid.}

Concurrently with such developments, suicide was being debated and studied in academic disciplines beyond medicine. In 1897, the sociologist Emile Durkheim examined suicide as a social fact. He correlated it with particular socio-economic aspects such as being Protestant or residing in a certain geographic locale. His work was influential in altering the way
suicide was studied and forced researchers to consider the possibility that the act of suicide was subject to forces of society beyond the control of the individual.\textsuperscript{117}

Sigmund Freud, similarly, believed that suicide was a result of an inversion of the thanatos (death) instinct in emotionally immature individuals. He himself was a recipient of euthanasia after a 16 year ordeal with oral cancer, a result of a 20 cigar per day habit.\textsuperscript{118}

The juxtaposition of eugenics laws and euthanasia discussions is important. The harsh ethos of social Darwinism, the exploitation of the weak as a natural process, fed the discussion of eugenics. Social Darwinist theories worked seamlessly with eugenic notions of hierarchies of human worth which classified marginalized people as inherently inferior and, therefore, in some sense, deserving of their fate.\textsuperscript{119}

3.4 Euthanasia and the Holocaust

Then, as we know, the world met Adolf Hitler. The die for the Nazi killing machine was cast, however, long before the Second World War. The American physician and Nazi hunter, Michael Franzblau states; “Physicians in the pre-Nazi period began to view their skills as appropriate for killing as well as healing.”\textsuperscript{120} In fact, half of Germany’s mental patients were starved to death during World War I.\textsuperscript{121} The emergence of eugenic theories, the promotion of social Darwinism and the deprivations of war all contributed to this ghastly occurrence.\textsuperscript{122}

\textsuperscript{118} Ibid.
\textsuperscript{119} Wesley J. Smith, \textit{Culture of Death. The Assault of Medical Ethics in America.} (San Francisco: Encounter Books, 2000), 36.
\textsuperscript{120} Ibid, 37.
\textsuperscript{121} Ibid.
\textsuperscript{122} Ibid.
In 1920, a book entitled *Permission to Destroy Life Unworthy of Life (Die Freigabe der Vernichtung lebensunwerten Leben)* was published which contained a full-on assault on the Hippocratic tradition and the sanctity/equality of life.\(^{123}\) In brief, the authors promoted and accepted the concept that some humans had greater intrinsic worth than others.\(^{124}\) For the purposes of this discussion, a judgement could therefore be made as to which lives are worthwhile and which are not worthwhile and are therefore expendable. Those considered unworthy included humans with terminal illnesses, people who were mentally ill or challenged and deformed children.\(^{125}\) The authors, Karl Binding and Alfred Hoche argued that physicians ought to be allowed to kill people deemed unworthy of life, and thus that it was appropriate to *professionalize* and *medicalize* the entire concept of euthanasia. The killing of those deemed unworthy of life was promoted, interestingly, as *purely a healing treatment*. Euthanasia was justified as a way to divert money being spent on the ill and disabled to other more important societal needs.\(^{126}\) This financial focus in this infamous work from 1920 has already been mentioned with a view to the current debate in Canada.

Interestingly, the German eugenicists who followed Binding and Hoche held the U.S. programs of sterilization as their model for change. By the time the German eugenics law was passed in 1933, the U.S. had *already* carried out approximately 20,000 sterilizations, most of them involuntary.\(^{127}\) America was looked to by the Germans for both a justification and for a model for the sterilization law. In fact, German social hygienists throughout the Weimar period

\(^{123}\) Ibid.
\(^{124}\) Ibid.
\(^{125}\) Ibid.
\(^{126}\) Ibid, 38.
\(^{127}\) Samuel I Greenberg, introduction to *Euthanasia and Assisted Suicide*, by Ralph Slovenko (Springfield: Charles C. Thomas Publisher, Ltd., 1997), ix.
expressed their envy of American achievements in the field of eugenics. They feared, that unless their German society started to make progress in this field that America would become the world’s racial leader.\footnote{Ibid.}

In 1806, the German physician of a different era, Christoph Wilhem Hufeland, wrote presciently, “It is not up to (the doctor) whether life is happy or unhappy, worthwhile or not, and should he incorporate these perspectives into his trade…the doctor could well become the most dangerous person in the state.”\footnote{Wesley J. Smith, \textit{Culture of Death. The Assault of Medical Ethics in America.} (San Francisco: Encounter Books, 2000), 37.} This concept of the role of a physician in society will be returned to in our conclusions.

His point was that the ethics of medicine are a good indicator of the moral health of society and that when medical practice is corrupted, society is soon to follow.\footnote{Ibid} And, in a macabre illustration, German doctors did become society’s most dangerous members. According to Dr. Franzblau, between 1933 and 1945, German physicians did not take the Hippocratic Oath. Instead they took an oath to the health of the state, known as \textit{Gesundheit}. Thus, doctors had a dual loyalty, to their patients, yes, but their first loyalty was to Germany.\footnote{Ibid, 41.}

By the time the Nazis came to power in 1933, much of Germany, including rather more of the medical establishment than some might care to admit, had already internalized the notion that some human beings represented “life unworthy of life.”\footnote{Ibid, 39.} This shift in attitude from that of protecting and caring for life to that of determining what lives are worthy of living was

\footnote{128 Ibic.} \footnote{129 Wesley J. Smith, \textit{Culture of Death. The Assault of Medical Ethics in America.} (San Francisco: Encounter Books, 2000), 37.} \footnote{130 Ibid} \footnote{131 Ibid, 41.} \footnote{132 Ibid, 39.}
contributed to by the growing acceptance of social Darwinism, anti-Semitism, racial hygiene and eugenics, before the Nazis came to power.

The stage was, however, set for the assault of euthanasia under Nazism after 1933. The new Nazi rulers of Germany immediately sought to legalize voluntary euthanasia. Vehement opposition from Germany’s churches ensued and so these proposals were eventually withdrawn. Mandatory sterilization, however, was enacted officially within six months of Hitler becoming Chancellor of Germany.¹³³

These laws were based on then-current eugenic theories which included the mentally challenged, the mentally ill, epileptics, alcoholics and people with grave body malformations as unworthy of continuing life through childbearing.¹³⁴ Such sterilizations were imposed on some 350,000 disabled and other supposedly undesirable people between 1933 and 1945.¹³⁵

The die was cast, however, well before Hitler actually came to power and euthanasia was quietly introduced. Hitler’s secret executive order in early 1939 which permitted infanticide based on disability was highly “successful”. He next issued an executive order expanding the categories of those to be medically cleansed to include disabled and mentally challenged adults.¹³⁶ This was the infamous ‘T-4’ Program. It was officially secret and death certificates listed fabricated causes of death as a cover for the policy.

¹³³ Ibid.
¹³⁴ Ibid.
¹³⁵ Ibid, 40.
¹³⁶ Ibid, 42.
T-4 was highly bureaucratized, like the Jewish genocide just on the horizon. The murders of about 250,000 people were “coldly and calculatingly organized”. With so many people involved, this euthanasia program could not stay a secret, however, and Hitler finally rescinded the T-4 Program due to public pressure. This did not apply to the infanticide directive, however, and indeed, in spite of the shift in official policy, German doctors continued to kill disabled and ill infants and adults in a process known as “wild euthanasia” until stopped by the Allies at the end of World War II.

It is essential in our considerations to keep in mind that the Holocaust started from these beginnings. Leo Alexander, who investigated crimes committed by members of the German medical profession states;

Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of an attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted and finally all non-Germans. But it is important to realise that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude towards the non-rehabitable sick.

The slippery slope which began with sterilization and infanticide, in short, readily expanded to euthanasia, which finally extended to the extermination camps.

Hitler’s use of euthanasia-related terminology had, of course, a tremendously negative impact on the euthanasia movement. In fact, his actions forever changed the meaning of the

137 Ibid.
138 Ibid, 43.
word euthanasia. Additionally, medical ethics in the U.S. has been deeply shaped by Holocaust memories and Nazi medicine atrocities. Kenneth L. Vaux posits that one of the reasons for the power of this memory in our North American medical ethics is the generation of medical men and women who fled the Third Reich as Jewish émigré scientists-physicians, for example, Paul Heller, Max Samter and Alex Tulsky.

On the other hand, Holland, though deeply affected and offended by the Nazi atrocities, has not enjoyed a sizeable Jewish community. Vaux states that the euthanasia policy of Holland reflects “the liberal and permissive spirit of secularized Protestantism, renewal Catholicism, and humanism.” In his view, the U.S. has over-reacted to the same danger that Holland has slighted.

3.5 The Resurgence of Euthanasia

Since roughly 1960, when CPR became a wide-spread, medical intervention for the critically ill and dying, medical care has moved into more and more intensive settings; the ICU, burn units and NICU’s. We all know of the magnificent results possible from an ICU (Intensive Care Unit) or an NICU (Neo-Natal Intensive Care Unit); one thinks, for instance, of the 2.5 lb. baby girl who successfully completes her gestation safely ensconced in her incubator in the NICU and who can finally go home to live with her parents and siblings after reaching a weight of 5.5 pounds. Other results, of course, are not so magnificent. The battle may be won

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142 Ibid.
143 Ibid.
144 Ibid, 14.
but the war is sometimes lost as family members and loved ones are sadly left wounded and with diminished capacities, by virtue of the same kind of technologies.\(^\text{145}\)

The 1970s saw the history of euthanasia become a matter of having personal and individual choice over dying, and this has surfaced and resurfaced ever since in intense public debate. Now we are not only dealing with the conundrum of beginning life supports, but when can they be discontinued? In fact, the mechanical respirator, the entire cardio pulmonary resuscitative activity, were created to carry people through a temporary breakdown. These modern instruments were created for rescue and carry-through purposes, to be withdrawn when normal function resumed. They were not meant to become permanent appendages.\(^\text{146}\) There has developed, however, a moral and legal impasse which allows physicians to begin life supports but not to discontinue them.\(^\text{147}\)

Importantly, at about this same time in 1972, the Canadian Federal Government decriminalized attempted suicide, while at the same time, a guarantee of the legal right to turn down medical treatment emerged as technological advances in medicine allowed doctors to keep patients alive longer. In a series of court cases in Canada in the 1970s, complainants won a mentally competent person the right to refuse medical intervention.\(^\text{148}\)

It is also significant that at this time the concept of medicalization emerged. This can be defined as an historical trend towards understanding moral, political or psycho-social issues as medical problems. Kevin Yuill argues that this trend towards medicalization forms the basis of

\(^{145}\) Ibid, 15.  
\(^{146}\) Ibid, 33.  
\(^{147}\) Ibid, 34.  
the right to die movement. The assisted suicide movement reflects in many ways increasing concern about the dehumanizing implications of the over-use of technological, life-prolonging machinery. The movement thus reflects a legitimate concern that medicine can sometimes act not in the best interests of the patient but the interests of medicine, as if the goal of medicine was the triumph of medical science over death. The assisted suicide movement then appears to be a reaction to humanity serving technology. So within this medicalized perspective, suicide becomes a treatment option. Death is being made a medical rather than a spiritual, existential or philosophical issue. Death is now a treatment option.

It appears to this extent, that the assisted suicide movement has evolved as a corrective to the advent of modern life-saving innovations. Modern interventions such as antibiotics, respirators and dialysis machines save lives, but they have also created ethical dilemmas, and so the perceived need for assisted suicide underlies the bioethical perspectives which arose concomitantly with the assisted suicide movement.

3.5.1 Watershed Medical Cases

Attempted suicide was decriminalized in Canada in 1972, in an act based on compassionate grounds, and which provided impetus for strong public debate on both sides of the border (Canada and the U.S.A.) around individuals and their right to determine their end of life scenario. There are a number of well-known medical cases which illustrate this shift towards such a view including those of; Sue Rodriguez, Gloria Taylor and the case of Robert Latimer and

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150 Ibid, 61.
151 Ibid, 61.
152 Ibid, 62.
his daughter Tracy in Canada. U.S. history similarly offers to public scrutiny the well-publicized accounts of Karen Ann Quinlan, Nancy Cruzan and Terri Schiavo.

In April of 1975, Karen Ann Quinlan was admitted to hospital in a coma induced by drugs and alcohol. After several months her doctors concluded that she was in a persistent vegetative state (P.V.S.) and that she had suffered irreversible brain damage. Her parents decided that it would be in Karen’s best interests to remove the respirator which was breathing for her. This request became a legal fight when the courts disallowed the Quinlan family request. Eventually the courts agreed with the Quinlan family to have the respirator removed. By this time however, Karen’s nurse had successfully weaned her off of the respirator, Karen was breathing on her own and remained in a P.V.S. for eight years, only finally dying of pneumonia in 1985.\(^{153}\) *Compassion and Choices*, a mainstream pro assisted suicide organization in the U.S. claims that:

Karen was one of the first victims of medical technology, a confluence of doctors and science coming together to prolong a life that would otherwise be lost. The dilemma that faced the Quinlans would not have occurred just 50 years earlier. At the beginning of the 20th century when someone sustained an injury or became ill, they either recovered or died.\(^{154}\)

*Compassion and Choices* further states that:

With longer life spans came the emergence of degenerative age-related diseases such as Alzheimer’s, stroke and arthritis, creating a need for hospitals and nursing homes where people were sent to die rather than be cured. As medicine and technology continued to advance there came the haunting realization that futile prolongation of life was often going too far. Living longer was not always living better and the demand for the quality of life, versus quantity, was beginning.\(^{155}\)

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\(^{155}\) Ibid, 63.
As a consequence of this young person’s catastrophic health circumstance, ethics committees began to be established at hospitals through the U.S. The original responsibility of these committees was to examine the decisions made by guardians to verify that each decision was in the best interest of the patient in question.\(^{156}\) However, the therapeutic ethos of allocating responsibility for death and the way we die to other people was thus established. Daniel Callahan refers to this as “technical monism”, the tendency to erase the difference between human action and independent, natural biological processes.\(^{157}\) In other words, medical technology, or life prolonging technology, is blurred with our natural biological processes. Technology and biology are not the same, whereas this state of affairs suggests that human biology is now in some sense at the service of technology. Concurrently, with these developments, and clearly in response to them, the number of requests for living wills increased dramatically. Karen Ann Quinlan’s medical situation served to heighten people’s awareness of the potential for personal end-of-life issues and the necessity of making one’s wishes known.

In Canada in the early 1990s, citizen Sue Rodriguez forced the right-to-die debate into the Canadian spotlight. Rodriguez was diagnosed with amyotrophic lateral sclerosis (A.L.S. or Lou Gehrig’s disease) and was requesting that a physician be allowed to help her kill herself. Ms. Rodriguez was not physically capable of taking her own life due to the ravages of this disease, hence her request. The Supreme Court of Canada narrowly disallowed her request in September of 1993 in a 5 to 4 vote. The court ruled that society’s obligation to preserve life and protect the vulnerable outweighed her rights. In her plea for an assisted death, Rodriguez argued


long the theme of autonomy, “If I cannot give consent to my own death, whose body is this? Who owns my life?” Rodriguez committed suicide in 1994 with the help of an anonymous doctor.\textsuperscript{158}

Since this vote, this issue has been in and out of Canadian headlines, especially now due to the Quebec government introducing Bill 52, an Act respecting end of life care, in June of 2013. Under this Bill, a doctor who receives the repeated request and consent of a patient could administer medication to cause death. The patient must merely be a Quebec resident with a valid provincial medicare card.\textsuperscript{159} This Bill was to be the first of its kind in Canada to legalize physician-assisted suicide.

The most recent challenge to assisted suicide legislation is the Gloria Taylor case. Gloria Taylor was also stricken with A.L.S. Her request for an assisted death was backed by the B.C. Civil Liberties Association and two other plaintiffs. B.C.’s Supreme Court in June of 2012 ruled that the Federal ban on assisted suicide contravenes Section 15 of Canada’s Charter of Rights and Freedoms. In fact, Judge Lynn Smith awarded Taylor an immediate exemption from this law which was not, however, used by Taylor. She died on October 4, 2012 of complications from her illness.\textsuperscript{160} At the same time, the B.C. court ruled that the federal government must draft new legislation within a year that conforms with Canadian rights under the Constitution. Judge Smith deemed the existing law unconstitutional because it unfairly deprives people with

\textsuperscript{159} Ibid.
\textsuperscript{160} Ibid.
degenerative illnesses of their liberty, and because it discriminates against those with a physical
disability who might need assistance to exercise their right to take their own life.\textsuperscript{161}

The Federal Government under Prime Minister Stephen Harper took this battle to the
B.C. Court of Appeal and appealed this ruling. That court held hearings in March of 2013 and
overturned the lower Court’s ruling seven months later. The current status of this case is that the
Supreme Court of Canada has been asked to hear an appeal of this ruling, arguing that criminal
laws that deny seriously ill Canadian the right to choose an assisted death are unconstitutional.
This request also states that the issue is of profound national importance.\textsuperscript{162}

Another watershed Canadian account concerns the actions of Robert Latimer, a loving
father who killed his 12 year old daughter, Tracy, on October 24, 1993. His actions have been
termed “compassionate homicide.” He told police that he loved his daughter and could not bear
to watch her suffer any more. Tracy had a severe form of cerebral palsy, was a 40 pound
quadruple and functioned at the level of a 3 month old. She had undergone repeated surgeries,
and at the time of her death was due for more surgery to remove her thigh bone. She could not
walk, talk or feed herself and was in constant excruciating pain. The cause of death was carbon
monoxide poisoning. Robert Latimer had placed Tracy in the cab of his truck and ran a hose
from the exhaust to the cab.\textsuperscript{163}

\begin{thebibliography}{99}
\bibitem{161}Ibid.
\bibitem{162}Ibid.
\bibitem{163}“Compassionate Homicide”: The law and Robert Latimer, \textit{CBC News}, December 6, 2010, accessed April 8,
\end{thebibliography}
In 2001, Robert Latimer was ultimately convicted of second degree murder with a life sentence and no parole for ten years. In 2008 his appeal to the National Parole Board was successful and he served his day parole in Ottawa. He was granted full parole in 2010.164

The issues arising from the Latimer case are momentous. Questions are asked such as: “Should courts abide by the letter or the spirit of the law? Would a decision favourable to Latimer legalize euthanasia, mercy killing? Would it put the disabled in danger? Would it mean the end of mandatory minimum sentences for convicted persons?”165 If the killing of Tracy Latimer is considered an act of “compassionate homicide” and Robert Latimer is shown leniency through a constitutional exemption, would this ruling demonstrate that the disabled are regarded as second class citizens?166 This is what is termed a “slippery slope” or “wedge issue.” So important in this discussion is the slippery slope argument, Chapter 4 of this thesis is devoted to that discussion.

People are living longer which is exacerbating these end of life issues. Consider the current case in Winnipeg, of Ron Siwicki who, acceding to his mother’s wishes, dutifully left her on her bedroom floor where she had fallen for five days. She was 89 years old. He provided the blanket which she requested and the occasional protein drink. He is facing charges of criminal negligence causing death and failing to provide the necessities of life.167

164 Ibid.
165 Ibid.
166 Ibid.
Wanda Morris, CEO of Dying with Dignity, advises that under Canadian law, Ms. Siwicki had the right to deny all forms of medical care, including resuscitation. If she was incapable of this due to Alzheimer’s or dementia, her son could have denied it on her behalf. Therefore, it would have been entirely possible for Ms. Siwicki to access comfortable end of life care, or comfort care, which would not include undesired medical treatments. At the time of writing, Mr. Siwicki is out on bail and awaiting trial.¹⁶⁸

Our final example of the “state of the euthanasia nation” concerns the horrifying account of Gill Pharoah; she was a healthy woman in her 70’s living in Britain. Pharoah availed herself of the services of Lifecircle, another assisted-death clinic in Basel Switzerland. In fact, 126 other British citizens have done just this between 2008 and 2012. Pharoah feared having a stroke like her friend. She feared being too infirm to kill herself, so rather than live with this unknown, this fear, she chose to end her life despite the fact that she had no pressing medical issues.¹⁶⁹ How have we arrived at such a circumstance? This writer also wonders how this woman’s partner, family and friends feel about her taking herself out of their lives. Her decision impacted many more people than just herself.

These recent debates concerning euthanasia and assisted suicide, began in the 1960s and 1970s when the use of CPR became widespread. Then, in 1972, the Government of Canada decriminalized attempted suicide. At the same time, the legal right to turn down medical treatment emerged as technological advances in medicine allowed doctors to keep patients alive

¹⁶⁸ Ibid.
longer. Then, a series of court cases in the 1970’s won a mentally competent person the right to refuse medical intervention.

### 3.6 After the Holocaust

Once the atrocities of the Holocaust came to full public view after World War II, therefore, euthanasia movements across the world lost much of their earlier public support. Voluntary euthanasia survived, but supporters scrambled to distance themselves from the involuntary euthanasia of the Third Reich.¹⁷⁰

At the same time however, a paradoxical sea change in the nature of the euthanasia and assisted suicide cause occurred. At this point Western societies began to look to scientific and technological solutions to problems previously seen as religious, moral or even political in character.¹⁷¹ And, to a great extent, death began to be seen as an issue of technology; death became medicalized.

The huge technological strides of the post-World War II years presented people with the dilemma of being unable to defend traditional moral and political positions. Hence, many difficult moral and religious questions were re-framed as technological and, therefore, resolvable problems.¹⁷² Margaret Somerville, for example, has characterized assisted suicide and euthanasia as a technical solution to a human dilemma:

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¹⁷¹ Ibid.
¹⁷² Ibid.
Euthanasia converts the mystery of death to the problem of death, to which we then seek a technological solution. A lethal injection is a very efficient, fast solution to the problem of death – but it is antithetical to the mystery of death.\textsuperscript{173}

Not only has technology been looked to for answers to what had previously been political, social and moral issues, the accompanying economic growth in the period in question encouraged what Robert Collins has termed \textit{growth liberalism} that buried the social, moral and political concerns of the past in dollars.\textsuperscript{174}

The age of the experts had arrived, as entire spheres of life became medicalized and moral issues faded into the background. Thus, for instance, suicide, which had been understood in largely moral terms, became a \textit{medical} problem.\textsuperscript{175} What was once unthinkable became more acceptable in this way. The right to choose death over life as exhibited by an apparently healthy Gill Pharoah represents a terrible shift from a culture of life and hope to a culture of death and despair. A shift away from a recognition of the sanctity of life and of human dignity, away from a common morality towards an, at best, utilitarian ethic shrouded in talk of “efficiency” thus came to the fore, placing relative rather than absolute values on human life.\textsuperscript{176} Following the reasoning of Pope John Paul II, Wesley Smith speaks of this new reality as a \textit{Culture of Death}. After all, the physical realities of euthanasia and assisted suicide have not changed. It is a termination of human life with external assistance, now seemingly sanctioned by the state. What has changed are the attitudes towards and the ethics of such actions. Now, rather than assisting

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{173} Ibid, 70.
\item \textsuperscript{174} Ibid.
\item \textsuperscript{175} Ibid, 72.
\item \textsuperscript{176} Wesley J. Smith, \textit{Culture of Death: The Assault of Medical Ethics in America} (San Francisco: Encounter Books, 2000), 10.
\end{itemize}
\end{footnotesize}
life people are seeking to assist death. Physicians especially, I wish to suggest, should not be expected to make such a choice.

3.7 Alternatives to Euthanasia

It is noteworthy that the historical period most recently under review also provides us with an instance of a society which has chosen *not* to grant life and death power to its physicians. In December of 2005, Israel enacted a new law entitled the “Patient Nearing Death Act”. This law represents a compromise reached by secularists and religious conservatives, the framework which is the balancing of three fundamental values; the importance of quality of life; the autonomy of the human will; and the sanctity of life.¹⁷⁷

This law is perhaps the first in the world to explicitly state that it is a citizen’s right to have access to palliative care. This means that the patient and family should not have to suffer at the end of life and are entitled to have access to expert assistance in pain symptom management. Furthermore, there is a legal requirement that terminally ill patients should be informed about their condition by their doctor, if the patient so chooses, and patients are encouraged to express preferences regarding their care.¹⁷⁸ Needless to say, the architects of the recent Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying did not review the Israeli experience, or consider the possibility that the right to palliative care could be a viable alternative to euthanasia.

Another interesting social policy experiment comes to us from the Northern Territory of Australia. During 1996-97, euthanasia was a legal medical treatment in the Northern Territory

¹⁷⁸ Ibid, 180.
for nine months. The intention of the law was that the person’s usual doctor would occupy the role of the first medical practitioner. Instead, in that jurisdiction, this position became filled by one particular doctor only who was a public advocate for euthanasia and who volunteered to assist these patients. This doctor held in his hands the power of life and death over his patients. Some people become so afraid of this capability, they refused medical assistance. People who needed to go to hospital would not for fear of being medically killed by this doctor.

Despite considerable legislative efforts to draft safe regulations protecting vulnerable patients, this simply was not possible and the law was repealed. David Kissane goes on to conclude that given the level of error that occurs in medical practice, the Australian experience suggests it would be impossible to safely legislate for doctors to kill.

This historical lesson also points indirectly to the option of developing capacity in palliative care rather than turning to euthanasia and physician-assisted suicide as the easy solution. The Australian experience emphasizes that it does not appear possible to safely legislate to grant autonomy for the few without creating danger to many other vulnerable individuals in society.

Other lessons come to us from the U.S.A. The opposition of the National Conference of Catholic Bishops was a major factor in the defeat of the referendum on assisted suicide in California as well as the defeat of the “Death With Dignity” initiative in Washington State in

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180 Ibid, 209.
181 Ibid.
1991. They also opposed the Oregon referendum in 1994 but did not succeed in defeating it there.\textsuperscript{182}

More recently, the Archbishop of Canterbury and other faith leaders in the U.K. urged their Parliament to oppose an assisted dying bill. Their opposition was successful, perhaps in part due to a robust palliative care system available to the dying in Britain, especially in the Hospice Movement. This social policy also was not examined in the context of the Canadian report. The UK experience will be re-visited later in this thesis.

The problematic historical experience of euthanasia and physician-assisted suicide cannot be denied. This history shows us how difficult it is for euthanasia to be contained or controlled upon its introduction into society. This is something that I will refer to as a slippery slope. Slippery slope arguments are commonly employed in the rejection of a newly proposed moral or legal boundary such as those currently in view in Canada concerning euthanasia. The slippery slope objection is not merely directed at the proposal but to the undesirable consequences which may arise out of it.\textsuperscript{183} An understanding of the slippery slope response to euthanasia policies is key to understanding why euthanasia is not safe. The next chapter is devoted to promoting such an understanding. However, as we shall see, slippery slope arguments are not sufficient in themselves. Of crucial importance in this matter are insights emerging from virtue theory, which deepens the slippery slope argument – and which can be used in the argument against euthanasia and physician-assisted suicide as a policy option in Canada.


Chapter 4

Euthanasia: The Slippery Slope Argument

The historical overview of the last chapter reveals in part, that there is an apparent inability to contain and control euthanasia once it has been introduced into a society. This was certainly the case in the first half of the twentieth century, but more recently, an Australia-State government was forced to repeal its euthanasia legislation due to this issue. The difficulty presented by euthanasia is that such practice presents new moral boundaries. These new moral boundaries involve a range of ethical, philosophical, theological, historical and sociological concepts which can be difficult to coalesce into a meaningful whole. Responsible dialogue leading to wise and meaningful policy on the question is difficult. The slippery slope argument will assist in the organization of these diverse strands of thought.¹⁸⁴

The strength of the slippery slope argument in assessing the euthanasia debate is two-fold. First of all, given an appropriate social situation, it shows how euthanasia forces upon us a discussion of potential abuses implicit in the newly proposed moral boundaries.¹⁸⁵ In this context then, the door is opened for a discussion around the potential undesirable consequences these new moral boundaries can mean for a society and its members. To use the language of virtue theory to be discussed in the next chapter, we are made aware that our actions will determine what we become and we do not always like the result.

¹⁸⁴ While it is recognized here that some slippery slope arguments are mere scare-mongering, and that others must be judged logically fallacious, not all slippery slope arguments are similarly emotive or invalid. In particular, what are called “empirical slippery slope arguments” do have merit, and the argument of this thesis at this point is that there is indeed empirical evidence that warrants the slippery slope argument in the case of euthanasia policy. The slippery slope argument also dovetails neatly with key aspects of virtue theory. Cf. Anneli Jefferson, “Slippery Slope Arguments,” Philosophy Compass 9/10 (2014): 672-680.
Secondly, the slippery slope argument underscores the error of analysing indeterminate concepts with methods which are really only appropriate for the analysis of determinate concepts. It is essential that we be precise about those concepts that we can be precise about and that we are careful to recognize those concepts that we cannot be precise about.\textsuperscript{186} The critique of “loose language” has already been introduced and in this context refers to the arbitrariness of the stopping point once the euthanasia slope is embarked upon. David Lamb notes this fact in stating that “the slope argument serves as a warning against reasoning with loose concepts.”\textsuperscript{187} When reasoning with loose concepts, it must be recognized that definitions and descriptions are inherently arbitrary.\textsuperscript{188}

Abortion represents another liminal human event which has presented our society with the establishment of new moral boundaries. Hence, abortion provides us with a credible representation of what the slope argument with regards to euthanasia could look like.

\textbf{4.1 A New Moral Boundary - Abortion}

The end-of-life moment can be objectively determined. There are conceptual guidelines which are based on clinical criteria. When determining the beginnings of human life however, there is little consensus about these very guidelines.\textsuperscript{189}

The voluntary termination of pregnancy, like euthanasia, presented new moral boundaries to Canadian society when first introduced in the late 1960s, and the subsequent history of debate about the question shows how difficult it is to resolve such issues when debate is based on

\textsuperscript{187} Ibid, 6.
\textsuperscript{188} Ibid, 7.
\textsuperscript{189} Ibid, 115.
ambiguous concepts. When first introduced, it was assumed that abortion would be a relatively rare medical procedure. However, what amounts to “abortion on demand” has been available in Canada since 1988 when the Supreme Court of Canada rejected key aspects of the previously existing abortion legislation in the R v Morgentaler decision. Subsequent parliaments have, of course, declined to face the challenge of legislating again in such a contentious area. Available statistics indicate that the Canadian health care system now performs approximately 100,000 abortions per year effectively unregulated by law. Although there is no possibility of entering into a detailed discussion of the ethics of abortion per se, the history of abortion in recent Canadian history is an important and revealing parallel to what is proposed in relation to euthanasia. In what follows in this discussion, the focus will be on the potential and realization of abuse that lay in the loose concepts once the abortion slope had been stepped upon. The argument will serve to advance the argument that there is potential for abuse in relation to new moral boundaries when we reason with loose concepts.

In the case of abortion, it is of course, the moment of the beginning of human life which is the problematic concept. The slope argument here, however, nevertheless draws attention to both the empirical and logical difficulties in the maintenance of conceptual boundaries around definitions of significant and insignificant life. For whatever reason Canada has chosen not to protect children in the womb at any stage of pregnancy. The defacto conclusion is that an unborn child cannot be deemed under the law to be a human being until the moment of birth. At first blush it appears that there is not a slippery slope here as the conceptual boundary around when life begins has been assumed. In Canada, life begins at birth.

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The conceptual boundary provided by such a simplistic interpretation does not protect the unborn from destruction according to their sex or health. Medical technologies now allow prospective parents to determine many traits and health issues of their unborn child. Traits such as sex can be determined pre-birth. Health issues such as certain kinds of genetic disorders can also, of course, be determined pre-birth. Parents are essentially allowed to decide upon the significance or insignificance of their unborn child, or, put another way, the approval or non-approval of this life in potentiality is now largely a matter of personal choice and even preference.

Abuse resulting from these medical technologies is manifested in a number of ways. The *National Post* reported on February 19, 2014, that “Canada’s pregnancy specialists and the nation’s radiologists are calling for a halt on using ultrasound for the sole purpose of determining the sex of an unborn fetus”. This statement relates to mounting concerns that in Canada, prospective parents are using ultrasound to determine the sex of a fetus early in pregnancy and aborting the unborn child if it is a girl. The *Canadian Medical Association Journal*, in an editorial published in 2012, said research in Canada has found the strongest evidence of sex selection among people from India, China, Korea, Vietnam, and the Philippines. According to this editorial, “What this means is that many couples who have two daughters and no son selectively get rid of female fetuses until they can ensure that their third-born is a boy”.

Similarly, amniocentesis allows prospective parents to determine whether the fetus is genetically satisfactory. This allows parents to terminate a pregnancy should the fetus be, for example, diagnosed as having Down Syndrome. The consequential aspect of the slope argument can be seen in the question asked by Margaret Steinfels:
Will it become so unusual for a baby to be born with Down Syndrome that there will be no support or sympathy for a family with such a child? Society will say, ‘Well, you’ve chosen this. You live with the consequences of having brought such a child into the world.’

Providing credence for and pointing to the societal implications of this argument, is the fact that it is now estimated that something in the order of 67%-85% of Down Syndrome fetuses are aborted. Parents are clearly determining that the lives of such children are less worthy and less significant than healthy babies – that there is in such potential human being “life unworthy of life,” to use the fateful phrase from the early twentieth century. This in spite of recent research indicating that individuals with Down Syndrome can experience much happiness and significant success. In fact, as the *National Post* reported on August 30, 2014, studies have suggested that families of these children exhibit levels of well-being that often are greater than those of families with other developmental disabilities and sometimes equivalent to those of families with non-disabled children. These effects are prevalent enough to have coined the phrase, the “Down Syndrome advantage”.

The point of this is not to argue against abortion as such, but rather, it is to acknowledge that these examples of sex-selective and genetically-selected abortions underline the argument that, once the concept of a life not worth sustaining has been introduced, the slope argument with its attendant borderline problems must be taken into consideration. In this case the boundaries of permissible termination are determined by the parents (strictly speaking by the mother). We know that parents are terminating healthy fetuses because their sex is undesired or because a

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Down Syndrome child is not deemed to be perfect. Such borderline cases makes the slope argument relevant to the ethical problems surrounding voluntary induced termination of pregnancy.\textsuperscript{194} Further, it is reasonable to say that there may be an important analogy here to the slippery slope argument concerning voluntary euthanasia to be discussed next. If what we see in one case is evidence of societal changes in attitude towards the evaluation of the worthiness of a life, it is a reasonable inference to suppose that what we will see in the other is evidence of a similar shift in outlook. This aspect of the question will be discussed and developed as we move toward the conclusion of this thesis.

4.2 Euthanasia: The European Experience

Outside of North America, only four countries openly and legally authorize assisted suicide; the Netherlands, Belgium, Luxembourg and Switzerland. The Netherlands introduced specific legislation to legalize assisted suicide and active euthanasia in 2002, but the country’s courts have actually permitted these actions since 1984. Initially, the Dutch laid out narrow guidelines for doctors. The patient, who must be suffering unbearable pain and have no hope of improvement, must ask to die. The patient must clearly understand the condition and prognosis and a second doctor must agree with the decision to help the patient die.\textsuperscript{195} The consequences of the loose concepts of “unbearable pain” and “no hope of improvement” will be considered shortly.

Belgium similarly legalized euthanasia and physician-assisted suicide in 2002, at the patient request. Two doctors must be involved as well as a psychologist if the patient’s competency is in doubt. The doctor and patient negotiate whether death is to be by lethal

\textsuperscript{194} Ibid.
\textsuperscript{195} Ibid.
injection or prescribed overdose. In February, 2014, Belgium passed legislation to extend the country’s law to include the euthanizing of children under certain conditions.\(^{196}\)

Switzerland has allowed physician and non-physician-assisted suicide since 1942 but prohibits euthanasia. Three right-to-die organizations in the country help terminally ill people by providing counselling and lethal drugs. Death by injection is banned. Switzerland does not bar critically ill foreigners from seeking assisted suicide.\(^{197}\)

Luxembourg, for its part, passed a law legalizing euthanasia and assisted suicide in 2009 with conditions similar to those in the Netherlands.\(^{198}\)

When the slippery slope argument is considered now in view of euthanasia and assisted suicide, the concept of reasoning with loose concepts looms large. The consequences of reasoning with loose concepts have significant social outcomes, appear to provide little protection for the most vulnerable in a society and appear to lead to serious abuses.

Let us consider euthanasia policy in the Netherlands for example. The slope was “officially” engaged in 2002, although the country’s courts had been permitting euthanized deaths since 1984. Strict guidelines were supposedly established, in that suffering must be “lasting and unbearable” in order to request an assisted death. In this way, Dutch euthanasia advocates could state that patient killing would be limited to the competent, terminally ill who requested it. However, as has already been suggested, concepts like “lasting and unbearable” pain are loose. Indeterminate concepts which when applied to end of life issues lead to

\(^{196}\) Ibid.
\(^{197}\) Ibid.
\(^{198}\) Ibid.
unforeseen consequences. The next step down the euthanasia slope in the Netherlands was to include competent people with incurable illness or disease. The next step down the euthanasia slope included the killing of physically healthy people who were suffering from psychological problems. The indeterminate and loose guidelines thus expanded from physical to include psychological suffering. It is reasonable to correlate the ever widening qualifications for euthanasia to the ever increasing numbers of lives being euthanized. Official figures show that 13 patients suffering from mental illness were euthanized in 2011; by 2013 this number had risen to 42 patients.\(^{199}\)

In a comment posted to *The Weekly Standard*, on September 13, 2004, guidelines were expanded to include incompetent people such as Alzheimer’s patients. The doctors assured the public that non-voluntary killing would be limited to patients who would have asked for it if they were competent.\(^{200}\) The arbitrariness of reasoning with loose concepts is, however, clear from the fact that the goalposts have constantly shifted in relation to the euthanasia policy. Such reasoning has actually led to the ability to justify death within an ever widening group of guidelines. Such reasoning opens the dangerous door of medical paternalism, whereby doctors decide what lives are worth living and what lives are not.

This development reflects a highly paternalistic attitude which has been developing within the medical community in the Netherlands. Such paternalism develops in part because euthanasia occurs within a self-contained medical vessel. The strangely sacrosanct value of

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doctor-patient privilege means that no one else may be privy to these discussions. Doctors are assisting in the decision-making process, the same doctors may be providing the lethal euthanasia drugs, and the same doctors may be providing the reporting. This, I suggest, is a slippery slope, clearly related to the risks implicit in new moral boundaries established on the basis of indeterminate concepts. The regulatory system is self-contained, self-regulating and self-reporting. Safe-guards appear to be deficient in providing protection to those vulnerable and ill persons who need it. In fact, patient confidentiality ensures that much of what the legalizing of euthanasia and physician-assisted suicide in the Netherlands has entailed cannot be brought out into the “light of day”. Patient confidentiality in this case creates a form of legal immunity, and shifts the medical defaults in connection with the deaths of old, ill and disabled people.\footnote{Diane Coleman, “\textit{Not Dead Yet\textquoteright}”, ed, Kathleen Foley et al. (Baltimore: The Johns Hopkins University Press, 2002), 225.}

The result of analysing indeterminate concepts with methods appropriate for analysis of determinate concepts now becomes visible. In the Netherlands, the medical guidelines limiting euthanasia to the terminally ill and competent of mind, has literally stepped down the slope to include children and babies. In the Netherlands, such reasoning is now being applied to the question of euthanizing children under the age of 12. Groningen University Hospital has decided its doctors will indeed euthanize children under the age of 12 if doctors believe their suffering is intolerable or if they have an incurable illness. Indeed, according to the \textit{Royal Dutch Medical Association}, as many as 650 babies are killed each year in the Netherlands because they are deemed to be in pain or face a life of suffering.\footnote{Sarah Zagorski. “Doctors Euthanize 650 Babies Under Assisted Suicide Law in the Netherlands”, \textit{Lifenews.com}, January 2, 2015, accessed October 17, 2015, http://www.lifenews.com/index.php?uds_ads_id=12}
The *British Medical Journal* has revealed that already in 1997, fully 8% of all infant deaths in the Netherlands were from euthanasia due to fetal anomalies. Alex Schadenberg, Euthanasia Prevention Coalition Executive Director states that “this is clearly eugenic euthanasia, and has nothing to do with having a terminal illness”.\(^{203}\) What is astonishing, not least in view of what is said in discourse concerning consent in euthanasia advocacy, is that, approximately 21% of the infant euthanasia deaths may occur without the request or consent of parents.\(^{204}\) Safeguards did not protect these children.

The numbers may be disputed, but it seems that an arbitrariness has entered into medical ethics in relation to the lives of such babies deemed to be in pain, and in the judgement calls made that have bequeathed powers of life and death authority to the Dutch doctors in question. The loose concepts applied to the first step onto the euthanasia slope in the Netherlands, have provided no rules for halting at any particular step along the slope. There is a reason for this, however, and it is that these concepts are indeterminate. As a result, the practice of euthanasia appears to have gained unstoppable momentum down the slope. Wesley J. Smith reported in the *National Review* on October 14, 2015, that in 2014 the total number of persons euthanized in the Netherlands was 5306. That is nearly 400 persons per month and an increase of 10% over 2013. This astonishing figure supports the theory that euthanasia advocacy has led to a pro-euthanasia, pro-suicide mindset. In short, as was the case in the first half of the twentieth century, the once unthinkable is becoming common place.

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Even stronger momentum is found in Belgium where euthanasia was again legalized in 2002. In fact, Belgium has become the “hastened death” capital of the world, and, as in the Netherlands, euthanasia was practiced in Belgium prior to its actual legalization in 2002. Available data for Flanders, the Dutch-speaking part of Belgium where about 60% of the population live, show that euthanasia (and physician-assisted suicide) was frequent even when illegal. Further, the evidence suggests that in some 3.1% of the cases, the terminating of life has taken place without the patient’s explicit request. According to our definition, this is involuntary euthanasia and is homicide.

Several reasons are cited for the high rate of “Life-Terminating Act Without Explicit Request” (LAWER). A substantial number of physicians state that consulting the patient would have done more harm than good. So, proceeding to end life without explicit request was best for the patient. Additional data shows that doctors with more than twenty years’ experience chose to forego consulting their competent patients three times as often as did less experienced doctors. This seems to indicate the presence of strongly paternalistic attitudes on the part of these doctors.

Prior to legalization there were other violations of careful and prudent practice in Belgium. The majority of the euthanizing occurred in patient’s homes; in more than half of these cases, nurses administered the lethal dose of drugs and it is unclear as to whether the nurses were aware of the consequences (patient death) of their actions. In only 14% of these cases was

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206 Ibid.
207 Ibid.
208 Ibid.
a physician present. Finally, pharmacological practices varied widely, in fact eleven different products were used to kill.\textsuperscript{209}

The landscape into which euthanasia was legalized in 2002 has certainly changed. The issue of LAWER continues. A new study by the \textit{New England Journal of Medicine}, published in the March 19, 2015 issue, reveals that “Belgian doctors deliberately “hasten the death” of patients without an explicit request at a rate of 1.7% of all deaths in the country”. There were 61,621 deaths in Belgium during the last year for where there is comprehensive data (2013), which means that doctors are now euthanizing more than 1,000 patients per year without their having requested it. This represents the medical paternalism previously referenced. This dangerous attitude exemplifies the arrogant assumption that the doctor knows best and can decide whose life is worth living and whose life is not.

In fact, this very issue of paternalism may be creeping into discussions around euthanasia in Canada. \textit{The National Post} reported a story under a headline containing the phrase “Medical regulators are playing God on euthanasia rules, ethicists warn”, on October 22, 2015. In this article, experts in medical ethics warn that serious moral discernment in relation to euthanasia may be slipping merely into discussion of the qualifications required to request euthanasia. The result is that doctors are overstepping their role and authority as set out by the court when doctors have a role in deciding what is in a mentally competent person’s best interests. Jocelyn Downie, a professor in the faculties of law and medicine at Dalhousie University in Halifax states “That is the role and right of the patient.”

\textsuperscript{209} Ibid, p. 71.
The slippery slope in Belgium is engaged and momentous. Voluntary euthanasia has advanced down the slope to statistically significant levels of involuntary euthanasia. The New England Journal of Medicine further reports that in the six years from 2007-13, Belgium’s euthanasia rate more than doubled, rising from 1.9% to 4.6% of all deaths. Nearly one in twenty deaths in Belgium is now deliberately caused. Reasons for the dramatic rise comprise both increases in the number of requests (from 3.5% to 6.0% of deaths) and the proportion of requests granted (from 56.3% to 76.8%) from requests made. This means, that if you were to ask to be euthanized in Belgium today, chances are 3 in 4 that your request would be granted. In fact, the 2013 Belgian Euthanasia Report indicates that the number of reported euthanasia deaths in Belgium increased by more than 26% in 2013 to 1807 reported deaths. And the same report shows that in 2012 the number of reported euthanasia deaths in Belgium increased by 25% to 1432 reported deaths.

So, who are all of these people in Belgium asking to be killed? As would be expected, the population requesting euthanasia is broad. For example, the Daily Mail Online reported on June 27, 2015 that Belgian doctors qualified a physically healthy 24 year old woman for euthanasia due to suicidal thoughts. Her request was granted because the boundaries to qualify for euthanasia have been expanded to include psychological ailments. The right to die is now being granted because of a psychological condition rather than an incurable illness.

The National Post on Friday, October 30th, 2015 reported that Dr. Marc Van Hoey, a Belgian MD, may become the first physician to face possible criminal prosecution for violating Belgium’s 13 year old euthanasia law. The National Post rightly recommended that this case be held up to Canada as an example of the dangers of legalizing physician-assisted death. Simona
De Moor, the euthanized fit 85 year old asked to have her life ended due to unbearable grief after the death of her daughter. Van Hoey is president of Belgium’s Flemish Death with Dignity Association and is one of the country’s most active practitioners. He performs between 15 and 20 acts of killing by euthanasia each year. In this particular case, however, Van Hoey did not seek the required second opinion - because of his own expertise.

This further step down the slope gives the notion of loose concepts a fresh and frightening persona. “Psychological suffering” is a term which cannot be tightly contained and yet, in Belgium, this indeterminate concept is being used to determine end of life decisions.

The *Daily Mail Newspaper* in the U.K. on Monday, January 14, 2013, reported that deaf twins who discovered they were going blind had been euthanized in a Belgium hospital. These men were not sick or dying. They chose not to live with their physical ailments of blindness and deafness, even as their family vehemently opposed their decision.

The expansion of euthanasia qualifications in the Netherlands and Belgium appears to be the logical extension of legalizing euthanasia. Once the euthanasia slope is engaged, once it is acceptable to kill one group of people in a society, then further steps become possible to ever-widen the qualifications to include more groups, as indeterminate concepts continue to expand. Now physical and psychological ailments qualify as do certain kinds of babies, as do some groups of children. The slope is engaged. The expansion of the practice of euthanasia in Belgium and the Netherlands illustrates the dangerous contagion of medicalized killing within a society.
On Wednesday, May 28, 2015, Alex Schadenberg, Executive Director and International Chair of the Euthanasia Prevention Coalition headquartered in London, Ontario reported that “In Canada, the Quebec government should be very concerned about the practice of euthanasia in Belgium since they have based euthanasia Bill 52 on the Belgian euthanasia law.” The author contacted Mr. Schadenberg requesting clarification of this statement. He stated:

As the International Chair of the Euthanasia Prevention Coalition, I compared the design and language of the Quebec law and it is nearly identical to the Belgian law.

During their deliberations, members of the Quebec legislative committee visited the Netherlands and Belgium and after their return they indicated their support for the Belgian model.

The difference between the Belgian model and the Netherlands model is that in Belgium euthanasia is defined as medical treatment whereas in the Netherlands euthanasia was legalized by creating an exception in the Criminal Code.

The danger which euthanasia has introduced into the Belgian society is elucidated by Carine Brochier, project manager of the Brussels-based European Institute for Bioethics. In The National Post’s October 20, 2015 edition, she states that, “I think it is very important to say that once you open the door and you think you are going to control euthanasia or assisted suicide, it’s an illusion. It’s an illusion to believe you can control what goes on between a doctor and a patient in a room.” She dismissed the argument that Canada would have more success controlling euthanasia because its medical culture is different from Belgium’s. “The culture can change. Here, 13 years ago, euthanasia was the exception. Now the numbers continue to increase. It is no longer controlled. People say that euthanasia is the best way to die. The media say, look he is having a glass of champagne with his children, and then the doctor arrives and kills him. It is the trivialization that is very dangerous.”
Quebec’s Bill 52 referred to above, was passed in June of 2014. Quebec is the first North American jurisdiction to legalize euthanasia. The National Post reports that Quebec’s National Assembly appeared completely replete with self-congratulation. Province of Quebec, Member of the National Assembly, Carole Poirier, is reported to have stated “Quebec is a beautiful society, and again today, Quebec has shown that we are really, really, a different society.” Another PQ MNA, Veronique Hiron, stated, “I think we have before us today, with the adoption of this law, an example of all Quebec society is capable of, of this great maturity that it is capable of showing.” This emotive language such as “beautiful”, “different” and “great maturity,” is nicely illustrative of the appeal to compassion without the application of reason. This emotive language produces a reliance on loose concepts without boundaries, which will inevitably lead, as Carine Brochier puts it, to trivialization. Such language masks the reality of euthanasia.

Bill 52 does not require that a patient be in physical pain or terminally ill, or incapable of killing him/herself. Such a person requires only, “an advanced state of irreversible decline”. But what is this? This nomenclature provides no boundaries for the qualification of euthanasia. The risk for abuse is enormous without clear and publicly recognizable boundaries. Such nomenclature is arbitrary, making it possible for practically anyone to qualify for euthanasia. This Chapter has already demonstrated the dangers of such a similar euthanasia lexicon in the Netherlands and in Belgium.

In Canada, the final report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying was published on November 30, 2015. It contains forty-three recommendations for the introduction, procurement and dispensation of physician-assisted suicide. The problematic and confusing language of this report has already been discussed in Chapter 2 of this thesis. In addition to the problematic language used in this report, there are two additional areas of grave concern which must be examined now. These concerns involve doctors who conscientiously object to the practice of euthanasia on the one hand, and the recommendation that no waiting period be applied to requests for euthanasia. Both of these are extraordinarily concerning.

4.3.1 Conscientious Objection

Both Quebec Bill 52 and the Provincial-Territorial Report recommend that conscientiously objecting doctors must refer their patients to a doctor who will hasten their death. Recommendation 33 of the Provincial-Territorial Report advocates that, “Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patients records through the system described in Recommendation 4.”

Recommendations 31 and 32 continue this theme. Recommendation 31 states that, “Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.”

Recommendation 32 states that “Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their
conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner”.

In Ontario, the London Free Press reported on Tuesday, February 2, 2016 that “Ontario regulators have directed doctors who oppose Physician-Assisted Death on religious or moral grounds to refer patients to colleagues who will help someone end their life.” So, although the Canadian Medical Association opposes forcing doctors to make referrals, the Ontario regulatory College of Physicians and Surgeons does not. Interestingly less than two years ago the Ontario College ordered doctors to prescribe birth control and refer patients for an abortion. This particular fight will soon be resolved in the Supreme Court. The Ontario College appears to be displaying a highly paternalistic attitude. Even as it faces a legal challenge for its policies on abortion and contraception, it is proceeding with guidelines for physician-assisted death. At the time of this writing, only the Ontario College of Physicians and Surgeons is proposing that doctors who object on moral grounds make referrals to those doctors who will provide their patients with the means to end their lives. Ontario would be alone in the world in forcing doctors to violate their beliefs or face discipline.

The Ontario College defends this position in this same article by stating that “it will mean that patients will not be forced to fend for themselves at this most difficult time of their lives.” It is not clear from this statement whether or not “this most difficult time of their lives” refers to end of life issues or if this statement refers to any moment of suffering in a person’s life. In any event, the Ontario College of Physicians and Surgeons is proposing that rather than providing compassionate and caring end of life care for these people, doctors must ensure that their patients can choose death. Further, this statement implies that without this legislation, patients will be
left to their own devices. This argument does not hold. Doctors have traditionally taken, as the first duties of medicine, to do no harm and not to kill.²¹⁰

By way of commentary on this proposal, furthermore, we may note that the American Geriatric Society reports that the image of an independent, capable person thoughtfully evaluating his/her options, unaffected by biased third parties or other circumstances is so far removed from the experience of dying as to be fanciful. Dying persons are often very weak, prone to strong emotions and vulnerable to the suggestions, expectations and guidance of others.²¹¹ Of course, these patients will be extremely vulnerable to the suggestion of euthanasia especially when it is suggested by their doctor.

Our doctors are responding to this assault. The London Free Press reported on Saturday, February 6, 2016, that Dr. Maria MacDonald, after toiling for twelve years as a student and medical resident to achieve the status of neurologist, is considering forfeiting her life’s work should she be forced to refer patients to a physician-assisted death. Of course such an attack on the integrity of our doctors will encourage them to leave this jurisdiction. It is reported that other doctors in addition to Dr. MacDonald are asking these same questions and some have already taken steps to leave Ontario and practice elsewhere. Some doctors have already applied for privileges in Michigan and one doctor has moved to Alberta.

The same February 2, 2016 London Free Press article has united evangelicals with Canadian Catholic bishops and other faiths, who jointly issued a statement released on Monday,

²¹⁰ Dr. Sheila Rutledge Harding and Dr. John Patrick, “Euthanasia. Principles and Observations from a Christian Perspective”. (Paper submitted to the Special Senate Committee on Euthanasia and Assisted Suicide, April 1995), 3.
February 1, 2016 by Bishop Ronald Fabbro of the Roman Catholic Diocese of London as follows:

Euthanasia and assisted suicide treat the lives of disadvantaged, ill, disabled, or dying persons as less valuable than the lives of others. It is an affront to the conscience and vocation of the health-care provider to require him or her to collaborate in the intentional putting to death of a patient, even by referring the person to a colleague.

This may be the last line of defence for some patients who do not need to die. The only form of protection for some of the vulnerable in our society may be those doctors who say no. When doctors are not allowed to say no, subtle or not so subtle coercion may be used to persuade a patient into following their doctor’s advice rather than allowing for a truly free decision.\(^\text{212}\) So impactful are doctor’s opinions considered, the overwhelming majority of surrogate decision makers base their decisions on the recommendations of their doctors.\(^\text{213}\) Such legislation promotes euthanasia as an acceptable option. It may be easier to end a life rather than engage in a difficult struggle to find a better alternative.\(^\text{214}\)

### 4.3.2 Waiting Period

The next area of concern is the extraordinary proposal relating to the removal of a waiting period in Recommendation 26 which reads, “We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual”.


\(^{214}\) Ibid.
A waiting period, however, is necessary. A waiting period provides a safeguard against impulsive suicides and suicidal ideation. Further support for a waiting period is provided by a survey of 321 psychiatrists in Oregon in the mid-1990s. This survey showed that only 6% of these psychiatrists were confident that they could in a visit or two adequately assess whether a patient’s judgement was impaired by a psychiatric disorder. The removal of a waiting period will disallow such an evaluation. As a general rule, those who commit suicide have a history of mental illness.

A waiting period offers those suffering from depression and other emotional ailments time for a “sober second thought”. Without a waiting period, impulsive emotions will unquestionably be acted upon and people will die needlessly.

This Chapter has illustrated how the slippery slope argument applies to the euthanasia regimes of Belgium and the Netherlands. We have seen how loose concepts have led to ever-expanding qualifications for euthanasia. The Belgian and Netherland guidelines, which were intended to control and provide oversight, have clearly failed and doctors have been able to thwart these guidelines mostly with impunity. Nevertheless, Canadian policy makers are proposing legislation that would effectively make Canada one of the most wide-open euthanasia regimes in the world. This is an extreme approach. And this approach is arrogant. Lethal

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216 Samuel I Greenberg, introduction to Euthanasia and Assisted Suicide, by Ralph Slovenko (Springfield: Charles C. Thomas Publisher, Ltd., 1997), xii.
procedures are being proposed without the kind of study and consideration that policy makers would afford any other clinical change.218

Alternatives to euthanasia do exist. Such an alternative is palliative care. This is a virtuous alternative aimed at the delivery of quality medical care rather than empowering doctors to kill.219 Palliative care manifests the virtues requisite for practising medicine. Virtue theory provides a view of medicine that explains the requirement of virtue. Palliative care and virtue theory are accordingly the topics of the next Chapter.

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219 Ibid, 206.
Chapter 5

The Virtuous Alternative of Palliative Care

Bioethicist Edmund Pellegrino has listed the following virtues as being especially relevant in the healthcare profession: fidelity to trust and promise, benevolence, effacement of self-interest, compassion and caring, intellectual honesty, justice and prudence.\(^\text{220}\) It would appear that the aspect of intellectual honesty is particularly important regarding end of life issues. Such honesty would incorporate a medical humility or the preparedness to see when burdensome medical interventions would be futile in such situations.

These ethical principles of care are central to palliative care, and could be said to be contained within the hospice mantra, “You matter because you are you and you matter to the last moment of your life and we will do all we can not only to help you die peacefully but to live until you die.”\(^\text{221}\) Palliative care maintains the virtues of medicine listed above and provides the compassionate care which confirms the humanity of the dying.

This Chapter will discuss how palliative care can address the complex issue of suffering from the perspective of the doctor, of the patient and of the family. The goal of palliative care is to define a system of care appropriate to the needs of the individual patient.

Our discussion will begin with an examination of the importance of virtue within the practice of medicine. The perspectives offered by virtue theory provide a fruitful approach to this question. Through this lens a deeper understanding of the motivational aspects of medicine can be reached. Conversely, through the lens of virtue theory we can also grasp something of the


potential changes to physicians, caregivers and society likely to result from the introduction of the practice of euthanasia.

5.1 Euthanasia Through the Lens of Virtue Theory

One of the claims of this thesis is that a moral theory which does not consider human motivation does not allow for the complexity of discussion demanded by the euthanasia debate. For this reason, I wish to suggest, the deontological and utilitarian approaches to medical ethics, which are typically used to frame this discussion, are insufficiently robust for the task.

The deontological approach, for its part, ignores many facts related to human nature and the ways in which an understanding of human nature must shape a correct account of morality. Deontological ethics can be defined as a normative ethical position that judges the rightness or wrongness of an action based on the action’s adherence to a rule or set of rules. It is sometimes described as “duty”, “obligation”, or “rule” based ethics. Whatever the merits of this approach, one serious limitation of deontological ethics is that it is difficult to provide agents with a motive to obey the moral law. Even if deontological ethics is as rationally self-evident as many of its proponents assume, the question still arises why it is that people do not appear to want to be ethical. To this extent, a deontological ethic does not adequately specify how to live a human life well, or why one should.

Similarly, an ethic based on utilitarianism also does not appear to succeed in being a theory of morality for humans. This theory has difficulty in convincing us why maximizing overall happiness should, after all, serve as the overarching motivation for human actions. Here

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223 Ibid, 19.
224 Ibid.
again, the decision-making process in view does not appear to account for the complexity of human desires.

Theologian and ethicist Stanley Hauerwas also critiques the relevance to medicine of such consequentialist moral theories in that they focus too exclusively on the ‘goods’ to be produced by human powers and interventions. All such interventions, he argues, meet their limit in death. He insists, as a result, that we must come to see medicine as a truly tragic profession, developing a vision within which it is possible to learn instead to focus on the care that can be offered when technological measures fail and a cure is not possible. Hence, the story of technology, of “setting nature aright”, cannot speak truthfully or meaningfully to the medical realities of human finitude and suffering. In other words, in adequate medical ethics, death is not to be considered a medical failure which euthanasia is positioned to correct. Death is instead the natural ending to a life lived, which medicine acknowledges even as it cares for the person dying.

Virtue ethics has the advantage over deontological and consequentialist theory here with its prescription that what is really at stake in ethical question is that humans should live well. Virtue ethics, one might say, exploits a natural desire on the part of humans to do so. The argument presented here will explore the extent to which an approach that is illuminated by insight from virtue ethics can guide the present discussion of euthanasia, taking into consideration the complexity of human nature and the complexity of end of life decisions. As will be seen, one particular advantage of this approach is that discussion within the framework of

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virtue theory will allow us to think more clearly about the kind of society we could become should our doctors have the power to kill.

5.1.1 Virtue Theory

Human desires form a complex pattern. Christine McKinnon states in her book *Character, Virtue Theories, and the Vices*, that “surely this is what human freedom and dignity consist in: not in fabricating our desires, but in becoming aware of our motives and learning to arbitrate them better.”

Virtue theorists like McKinnon argue that in large part, because of the way humans are “organized” (their biological, emotional and rational nature and the ways these interrelate), certain kinds of choices and certain kinds of traits will make it more likely that an agent will lead a fulfilled human life than other kinds of choices and traits. In this way, virtue ethics adds the dimension of the human agent to the examination of morality and considers the distinctive features of humans and the complexity of the kinds of lives they lead.

Put another way, the ethics of duty is concerned with the central question: What should I do? In this case, when a doctor finds herself in a morally complex situation such as an end-of-life decision, she will ask herself, what it is her duty to do. In order to reach a conclusion, she will consider what moral norms and principles which to the situation and seek to apply them. On the other hand, and I suggest on a deeper level, virtue ethics will consider the question of what sort of person this doctor should be and what sort of life they should lead. The morally salient features of an ethic of duty still apply. Virtue ethics, however, augments such moral consideration by drawing attention to the formation and expression of character through a

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229 Ibid, 10.
person’s actions. In other words, a doctor expresses and in a sense constitutes “who they are” through their actions. In effect the health-care integrity of health care professionals is developed and maintained through their actions. This is a useful way to approach the question of euthanasia, since in this way, virtue ethics can bring attention to the potential effect on doctors themselves, as well as, their patients and society, which could result from a doctor medically killing.

Virtue theories in general would thus be committed to the claim that the options, preferences and projects that are available to our doctors are functions of their human nature and that this same human nature helps to direct them towards certain sets of choices which will conduce to a flourishing human life. In short, virtue theories seek to relate the good to what it is natural for humans to care about, and to clarify why a life centred around these cares is a good life for a human.\textsuperscript{230}

5.1.2 The Language of Virtue Theory

Once again the issue of the vocabulary requires scrutiny. An ethics of duty uses “deontic” terms (from the ancient Greek term meaning “necessity”). Such terms include “right,” “wrong,” “forbidden,” or “obligatory.” These terms refer to what it is “necessary” to do, what we “must” do or what we “have to” do. These terms thus describe our obligations and duties.\textsuperscript{231} These terms are used to render a summary judgment on the moral status of an action or a type of action. Hence, an ethic of duty is most concerned with the rightness or wrongness of an action

\textsuperscript{230} Ibid, 10.
both in terms of the particular action of an agent and in terms of the general moral status of an action such as euthanasia.  

In contrast to an ethic of duty, virtue ethics utilizes “aretaic” terms (from the Greek term meaning “virtue” or “excellence”). These terms include “virtuous,” “good,” “admirable,” and, more specifically, “honest,” “courageous” or “modest.” So, in addition to rendering a judgement on actions, such terms make reference to the internal state or moral condition of the agent. 

The notion of “character” is, therefore, central to virtue ethics. Virtue ethics is more interested in the moral condition of the agent than in whether the accompanying action was right or wrong. The agent’s character is paramount and those virtues that make up this character are critical.

So, virtue ethics consider what sort of person one should be and what sort of life one should lead. According to virtue ethics, furthermore, what we do and how we do it determine what we become. Virtue ethics takes the notion that “actions speak louder than words” to a morally deeper level. Virtue ethics points to the character which determines one’s actions and which is formed by them in turn. There is a circularity and a momentum to one’s actions and one’s resultant character.

In his book *Understanding Virtue Ethics*, Stan van Hooft uses the terms “thin” and “thick” to refer to ethical concepts. The terms used in duty and utilitarian ethics are referred to as “thin” concepts. The terms used in virtue ethics are referred to as “thick” concepts. The thin concepts are primarily used to describe the rightness or wrongness of a situation. Not much is

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232 Ibid, 12.
233 Ibid.
234 Ibid.
offered in terms of a description of the agent of the action. So, when an action is described as “wrong”, all we know is that this action is morally forbidden.\textsuperscript{235} No information can be gleaned from such a statement which would tell us anything about the commission of the action or the agent committing this moral action.

The terms used in virtue ethics tend to convey a lot of meaning. When an action is described as “generous” or “courageous,” considerably more information is imparted concerning the agent than when an action is said to be “right.” Indeed, the rightness of an action might well be inconceivable apart from its being the action of a general or courageous person. Such moral concepts are “thick” concepts and impart information about the agent of the action in addition to the action itself.

The thick concepts of virtue theory direct attention to the deeper, inner core of the human agent, and to the subsequent consequences of that agent’s actions as opposed to the more superficial nuances of the rightness or wrongness of an action considered in isolation. In such a way, a virtue ethic entails that we are to live up to the standards of excellence that we set for ourselves and that our community or society hold out to us.\textsuperscript{236} Further, living a virtuous life can be deeply integrated in one’s living of life, e.g., in the sense of avoiding inner conflict between our feelings, desires, knowledge and ways of being. This kind of balance could be summarized as the flourishing of self and is among the goals of virtuous living.\textsuperscript{237}

It is on the basis of this complex inclination towards self-fulfilment and towards caring about others and about justice that the notion of virtue develops.\textsuperscript{238} In \textit{Understanding Virtue}

\textsuperscript{235} Ibid, 14.
\textsuperscript{236} Ibid, 10.
\textsuperscript{237} Ibid.
\textsuperscript{238} Ibid, 155.
Ethics, van Hooft defines virtue as a “trait of character that allows us to fulfill our own best aspirations and to do so by responding in the most appropriate way available to us, to the values and needs that are present in any practical situation that we might be in”.\(^{239}\) This definition points to the importance of particular judgement in specific situations.\(^{240}\) In the present discussion, of course, we are referring to end-of-life situations. This formulation of virtue ethics has advantages as well, as it can protect against the application of loose concepts in a one-size-fits-all way in end-of-life scenarios. Virtue ethics requires that attention always be paid to the question of character, it is true, but at the same time, each specific case has to be considered on its own merit. To this extent, virtue theory is situationalist and particularist. It speaks of particular living things. Hence, for example, virtue ethics accommodates the different commitments to action that are appropriate as we approach animals, the environment and other human beings. With human beings, differing responses are available depending on the condition of the person.\(^{241}\)

Van Hooft maintains that where decisions are required to be made in relation to medical care at the end of a human life, the virtue which is crucial must be the same as the virtue which is expressed and cultivated through the length and breadth of the practice of medicine: that of “reverence of life”.\(^ {242}\) Palliative care demonstrates such reverence of life. The compassionate caring which permits the sufferer to continue as a valued member of the human community is provided by palliative care. Euthanasia on the other hand must express and cultivate a radically

\(^{239}\) Ibid, 155.
\(^{240}\) Ibid, 21.
\(^{241}\) Ibid, 156.
\(^{242}\) Ibid, 155.
different set of values, since it confirms to the suffering that their lives are devalued and not worthy of continuation.

Unfortunately, the language used in the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying is “thin” rather than “thick” in the sense explored above, and the document accordingly provides an account that is not at all an adequate description of the proposed legislation. First of all, the recipients of euthanasia are referred to as individuals and patients. Thicker concepts which would consider the actual person whose “life is worth living” principle are absent. Thicker concepts would describe someone as a “mother,” “father,” “wife,” “husband,” or even let’s say “artist.” The whole of the person needs to be considered and this potentially means that not all individuals should be advised as to the availability of medicalized killing. The rather technical and de-humanizing language used reduces the person to simply their physical or emotional situation only. Such language objectifies the ill, the disabled and the elderly. This approach is too superficial.

Virtuous health-care would consider that the first motive of the doctor should be to comfort and relieve. Dr. Sheila Rutledge Harding and Dr. John Patrick in their paper entitled “Euthanasia. Principles and Observations from a Christian Perspective” state that, “It is extremely rare for it to be impossible to treat pain and comfort the patient. Mercy killing and assisted suicide are not the appropriate responses to painful deaths; better and more accessible palliative care is.”

The ethical qualities of our human lives, the qualities of nurture and care, can be exhibited thus through the provision of compassionate palliative care.

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243 Dr. Sheila Rutledge Harding and Dr. John Patrick, “Euthanasia. Principles and Observations from a Christian Perspective.” (paper submitted to the Special Senate Committee on Euthanasia and Assisted Suicide, April 1995), 4.
Euthanasia and physician-assisted suicide present the terrible risk of removing the consideration of the reverence for life of some people at end of life. One of the implications of virtue theory is that such actions will impact adversely upon our ability to be compassionate and caring to the dying. The human ethical quality of medicine in providing nurturing and compassionate care will be compromised. This lack of virtuous behaviour towards the ill, elderly and disabled has the potential not only to change the character of medicine and medical personnel, it also has the potential to change our society, to make us less caring and less compassionate in all walks of life. What we decide about euthanasia will affect what our society will become in the future. The risk that we run is that of compromising our ability to be humane.

5.2 Virtuous Behaviour and the Profession of Health Care

When considering the profession of a doctor, the practical orientation of virtuous behaviour in the world takes on a new level of complexity. As a doctor, one’s sense of oneself and one’s personal virtuous behaviour will also include the virtuous behaviour attached to one’s professional work in the medical profession. Euthanasia, unfortunately, will introduce a tension into the medical community, in which purely personal ethical commitments and physicians’ professional commitments stand in conflict. Euthanasia thus presents doctors with an ethical dilemma, a caring/killing paradox. It will not be possible for the medical profession to escape this paradox unscathed.

Stanley Hauerwas’ treatment of the (human) agent self and the formation of character speaks to this. The idea of character, “is to recognize that our actions are also acts of self-
determination; in them we not only reaffirm what we have been but also determine what we will be in the future”. \(^{244}\)

Particular situations are shaped through our actions and we also “form ourselves to meet future situations in a particular way”. \(^{245}\) This is clearly relevant to the euthanasia debate. The empirical evidence surveyed earlier tends to support the idea that increasing use of euthanasia is made once it is introduced into a society and normalized. As euthanasia becomes normalized in a society, in short, it seemingly becomes easier for doctors to kill.

Hauerwas defines a human person as “an autonomous center of activity and the source of one’s own determinations”. \(^{246}\) However, one’s own moral choices do not take place in a vacuum, as if one were a timeless creature who owes no debt to custom or habit. Too much of the discourse about medical ethics assumes that ethical decision-making were merely the application of rules by autonomous agents, rather than a struggle for the forging and expression of character. According to Hauerwas then, doctors can and will be shaped by their actions such as euthanasia.

The professional role of the doctor in face of end-of-life situations can only be challenging. What is the virtuous action in a given situation? How is reverence of life to be practiced in this case? As a profession, medicine assumes a commitment to the values inherent in that profession, values that are forged in the experience and education that shapes an individual physician’s ethical outlook. Medical education helps define what it is to be virtuous as a doctor whose goals, as mentioned above, are those of curing disease, repairing injuries and


\(^{245}\) Ibid, 98.

\(^{246}\) Ibid.
saving lives. Should the medical profession add to this list that of assisting the ill, elderly and disabled among us in hastening their deaths, then the goals of this profession will need revision. In fact, this debate is occurring at this time.\textsuperscript{247}

Euthanasia jeopardizes the virtuousness of our health care system. Consider the trustworthiness that is mentioned frequently in this context as a virtue necessary in the medical profession. Society needs to be able to trust its medical profession or else sick people will choose not to seek help. Indeed, perhaps this was the reason that Ron Siwicki’s mother chose to die over the course of five days on her bedroom floor instead of availing herself of medical care. Perhaps she did not understand that she had the right to deny all forms of medical care, including resuscitation. Already, the actions of Ms. Siwicki and her son do seem to point to a mistrust of the medical profession. If this is true, Ms. Siwicki in her vulnerability chose not to put herself in a situation of dependence on our health care system.

Euthanasia, however, attacks the integrity of the medical profession in a different way, and makes the question of suspicion a more serious concern. If some people cannot trust their physicians because they propose to preserve life, will they trust physicians once they are at liberty to hasten death? And who among the general public would be in a position to judge which physician can and cannot be trusted in these matters? “Integrity” comes from the same Latin root as the word “integration” and describes the unity or wholeness of a person’s virtues and ethical commitments.\textsuperscript{248} Hauerwas rightly considers integrity so critical as to be the keystone of moral life.\textsuperscript{249} Euthanasia, however, potentially places doctors in the position of

\textsuperscript{248}Ibid, 162.
finding that their professional virtues stand in conflict with their personal virtues. Certainly, for a great many physicians today, the integrity of their professional and personal ethical commitment is under assault.

This assault on the integrity of our doctors will also attack the covenantal relationship between physician and patient. The physician’s responsibility could shift from their patient to their administration. Our historical analysis has shown us the danger that lies with such a dual loyalty. As explained in Chapter 2, between 1933 and 1945, German physicians did not take the Hippocratic Oath. Rather they took an oath to the health of the German Reich which solidified their dual loyalty. Their patients were now in a secondary position behind the German Reich. The resulting shift in attitude from that of protecting and caring for life to that of determining what lives are worthy of living, in accordance with the assumed needs of the state, creates a worrying precedent. The results of placing patients in an un-protected position, secondary to and behind the state were horrific.

One of the ironies of the situation in contemporary Canada is that page 28 of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying states that the patient-physician relationship is founded on mutual trust, respect, knowledge and understanding between the patient and his or her health care provider. The previous argument, however, highlights a strategy which appears to purposefully confuse the reality of the tandem effect of these policy changes. The proposed euthanasia legislation, which includes the requirement of doctors to advise and refer regarding medicalized killing, combined with decreasing access to family doctors who know their patients, and increasing health care costs, all undermine this relationship. When the needs of the patient are secondary to that of the state, mutual trust and respect tend to be removed from the equation. Once again, the language used obfuscates.
Let us be clear. Even doctors who do not perform the killing, but just refer their patients to a doctor who will, will be implicit in the euthanizing. This can only affect the character of the physician as healer. Euthanasia is not a private act, unlike suicide. It is perplexing that personal autonomy should be one of the main arguments advanced in favour of physician-assisted-suicide. For in the case of euthanasia, for one person’s autonomy to be exercised, another’s autonomy must be affected. Evidence from the Netherlands suggests that the significance of this is not missed by doctors themselves, as permissive euthanasia legislation appears to drive from certain specialities the very doctors who otherwise are needed in those roles. This has occurred in Canada, like other jurisdictions with Obstetrics and Gynecology with permissive abortion laws. Also, as virtue theory maintains, there has to be concern about the effect on the character of the healer/doctor who will become, even if rarely and with whatever good intentions, the killer.\textsuperscript{250}

The “thin” approach of this legislation will thus inevitably have “thick” consequences regarding both our doctors and health care providers, our ill, elderly and disabled. This thin approach is far too simplistic for such a complex issue. Canadian society deserves a much deeper conversation around end-of-life issues. Euthanasia is the easy way and is a far too simplistic solution to a very complex issue.

Hauerwas states that “humane” care can flow only from our learning that the opportunity to give special care to those “particularly at the mercy of the human predicament” is an essential aspect of our humanity.\textsuperscript{251} To reject the responsibility and privilege it is to care for the dying is, for Hauerwas, to risk nothing less than dehumanization. This is the risk euthanasia presents to

\begin{footnotes}
\item[250] Dr. Sheila Rutledge Harding and Dr. John Patrick, “Euthanasia. Principles and Observations from a Christian Perspective”. (Paper submitted to the Special Senate Committee on Euthanasia and Assisted Suicide, April 1995), 6.
\end{footnotes}
humanity; the risk of losing that essential element which makes us human, the risk of losing the ability to be humane.

Virtuous alternatives to medical killing do exist. Palliative care is such a virtuous alternative. Palliative care protects society from the loss of its humaneness. For palliative care represents the mark of a humane society’s commitment to supporting its most vulnerable members, even in the most extreme adversity.\textsuperscript{252} Palliative care does not abandon the very sick, the elderly and disabled but rather provides respect and comfort for the dying and their families. Palliative care is the humane response to the inevitability of death.

5.3 The Alternative: Palliative Care

Adjusting to advances in medical technologies is difficult. Humane policies related to dying need to be designed.\textsuperscript{253} A “one size fits all euthanasia policy” is not the answer. Palliative care, where it is available, is becoming ever more sophisticated. Consequently, cases of suffering beyond adequate relief become even rarer.\textsuperscript{254} Dr. Eunice Gorman of King’s College in London reports that only about 10\% of pain is intractable, so it is a small percentage indeed who will struggle to find adequate pain relief. And, in fact, it has been reported that those patients requesting assisted-suicide almost always change their minds if their pain can be brought under control.\textsuperscript{255}

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\item \textsuperscript{252} Nigel Biggar, \textit{Aiming to Kill. The Ethics of Suicide and Euthanasia.} (Cleveland, Ohio: The Pilgrim Press, 2004), 170.
\item \textsuperscript{253} Lewis M. Cohen, \textit{No Good Deed.} (New York, USA: HarperCollins Publishers, 2010), 191.
\item \textsuperscript{254} Nigel Biggar, \textit{Aiming to Kill. The Ethics of Suicide and Euthanasia.} (Cleveland, Ohio: The Pilgrim Press, 2004), 170.
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To start with, palliative care should involve a change in the vision of the goals of health-care providers. Doctors and other health care professionals need to learn to see professional success not only in the fending off of death, but also in terms of helping patients flourish in their dying.\textsuperscript{256} Palliative care emphasizes precisely medical care rather than cure. Palliative care has proven to be a successful alternative to euthanasia, and could well be enhanced and embraced as an alternative to euthanasia in our own and in other jurisdictions.

British medical policy, for instance, does not appear to accept that euthanasia or assisting a patient to commit suicide is a professional obligation. Its attitude is that the “function of the physician is to relieve suffering, offer consolation and support, accurate diagnosis and expert treatment, so as to prolong independence as long and as comfortably as possible.”\textsuperscript{257} One of the interesting features of the British medical system is the way the Hospice Movement builds on these assumptions about the role of medicine in end of life situations. Indeed.

The Hospice Movement has achieved great acceptance in Britain. Its emphasis on quality of life amid palliative care sets high standards for care for the terminally ill. Of special interest here is the fact that, oftentimes, highly technical medical care is de-emphasized in favour of the comfort of the body and the spirit.\textsuperscript{258} Hospice care seeks to provide a holistic approach, in which the humanity of the sufferer is acknowledged and nurtured. Often, a patient’s hospice care program, overseen by a team of hospice professionals, is provided in the home. Palliative care can, of course, be overseen when appropriate by a team of highly trained palliative care

\textsuperscript{256} Nigel Biggar, \textit{Aiming to Kill. The Ethics of Suicide and Euthanasia}. (Cleveland, Ohio: The Pilgrim Press, 2004), 171.
professionals in an institution such as a hospital, stand-alone hospice care centre, extended care facility, or nursing home associated with the palliative care team.

One of the crucial things that the British experience teaches us is that it is possible to avoid futile and unnecessary care, thus answering one of the arguments commonly used to buttress the euthanasia option. Treatment of the terminally-ill can be greatly improved by better palliative care, with an avoidance of costly hospital procedures which only prolong life and suffering. The British do not consider euthanasia or assisted suicide as suitable functions for the medical profession. In fact members of the British House of Lords Select Committee on Medical Ethics visited the Netherlands to explore the change in that society’s attitude when a hastened death is available. The chairman, Lord Walton who is also a neurologist summed up their disquiet: “We concluded that it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary. We were also concerned that vulnerable people, the elderly, lonely, sick or distressed, would feel pressure, whether real or imagined, to request early death.”

Precedent for palliative care is provided for us also by Israel. Israeli law explicitly states that it is a citizen’s right to have palliative care. This means that the patient and family should not have to suffer at end of life and are entitled to have access to expert assistance for pain management. This is perhaps the first law of its kind in the world. Unfortunately, the final report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying did not

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259 Ibid.
260 Ibid, 288.
learn from the British or Israeli jurisdictions, or seek to investigate how a more successful palliative care program as an alternative to the proposed euthanasia policy might be pursued.

5.3.1 History of Palliative Care

The modern hospice movement began in England with the establishment of St. Christopher’s Hospice in London by Dr. Cicely Saunders in 1967. “You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but to live until you die.”262 This is the philosophy of hospice as summed up by Dr. Cicely Saunders.

The main motivation for Dr. Saunders and other hospice pioneers was their dismay at the poor care given to the dying. They were isolated and often neglected in nursing homes, or isolated in hospital ICU’s and treated too aggressively with sophisticated equipment.263

The aims of hospice treatment was palliative care of all symptoms so that quality of life could be maintained. The concept of pain was that of “total pain,” physical and mental. Mental pain included anxiety, depression, guilt and other problems, especially fear of abandonment. This shifted the focus of treatment from the individual patient to a wider context, generally concerning the patient as a member of the family. Family is still important, after all, even once the patient has died, and this focus is actively pursued in the hospice movement. The health and well-being of the caregivers thus receives attention as well, to ensure that they not be stressed beyond their physical and emotional limits.264

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263 Ibid.
264 Ibid.
This concept of “total pain” underlines that human condition that life is not easy. To live a life means that one will live, at times, with adversity, with many kinds of pain which are not necessarily physical. Pain is inveterate and can be social, spiritual, economic, psychosocial and psychological. Access to euthanasia and physician-assisted suicide will provide a means of escaping such realities for some people who may choose death rather than dealing with such a harsh reality. Our society will be detrimentally affected on two levels. First of all, our society will lose the strength and resilience which results in persons who deal with and overcome such adversity. The future loss of potentiality by the loss of these ill people cannot be calculated. Secondly, our society will lose part of its ability to support these people and provide compassionate care. Society risks developing a neutral or dispassionate attitude towards those suffering when euthanasia is but a request away. Here again, we risk losing our humaneness. This is why suicide cannot be presented as a rational alternative to the suffering which, at some point or another, visits upon all of us.

It is interesting to note that Drs. Sheila Harding and John Patrick in a paper submitted to the Special Senate Committee on Euthanasia and Assisted Suicide in 1995, stated that it was not physicians with long experience in palliative care who were leading the movement towards euthanasia and assisted suicide. Rather, it was the pathologists and physicians from the technological end of the medical profession. Harding and Patrick further noted that it was these physicians who are the most vulnerable to the danger of treating a person as an object.265

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265 Dr. Sheila Rutledge Harding and Dr. John Patrick, “Euthanasia. Principles and Observations from a Christian Perspective”. (Paper submitted to the Special Senate Committee on Euthanasia and Assisted Suicide, April 1995), 4.
It is known that good palliative care can relieve most suffering including providing people with assured support in their final illness. It is often the fear of being alone which is overwhelming in the face of imminent death. The benefits to family members such care for the dying too can be much better, as time for reconciliation and goodbyes is allowed. Finally, palliative care also addresses the much discussed high cost of dying. Most of that cost is, after all, attached to high technology in attempts at treatment which such palliative care avoids.

5.3.2 Contemporary Canadian Status of Palliative Care

In spite of the dignity and comfort provided by palliative care for both the dying and their loved ones, this end-of-life option does not appear to have a sufficiently important role in the Canadian health care system. To take the example of London, Ontario, a city of about 400,000 and the city in which this thesis has been written, such a thoughtful expansion of palliative care options is greatly needed. The London Free Press reported on Friday, February 12, 2016 that the London region so desperately lacks hospice beds and supports for people to die at home, that about 2,000 people per year must spend their final weeks in hospital.

This same release details that the palliative care network’s report also found that more than 1,400 people in the region who would rather die at home, and who could do so with the proper support, instead spent their last days in a hospital ward. This represents a questionable burden to the health care system in terms of resources and budgets. In 2012-2013, palliative patients spent 45,230 days in London-region hospital beds that are far more costly to operate than care provided at home or in hospice settings. Such factors are concerning, especially in

\[266\] Ibid, 7.
view of the possibility that those who cannot die at home or in a hospice might in future seek
physician-assisted-suicide.

London psychologist Marnin Heisel states in this same London Free Press report that, “If
people can’t get access to good quality palliative care, (it) may, in fact, lead to (some) turning to
an assisted suicide.” Dr. Gillian Kernaghan, the head of St. Joseph’s Health Care in London, is
also quoted as saying, “I cannot help but wonder if the call for physician-assisted death is a
reflection on the failing of our current system where there is inconsistent and inadequate access
to palliative care.”

Such sentiment seems to be supported by another London Free Press report also on
February 12, 2016, which states that “four years after London hospitals paid experts to
investigate how to improve palliative care, officials have failed to implement key
recommendations, even gone backward in one case and are refusing to disclose what progress
they’ve made overall.” The conclusion appears clear that the provision of palliative care for the
sick and dying in the London region is not considered a priority, either in itself or as an
alternative option to euthanasia, and is not a priority for policy makers.

It would, however, be a “virtuous” initiative were our policy makers to put time, effort
and expense into palliative care enhancements. As least as much time, effort and expense ought
to be devoted to such care as has been devoted to the organization and implementation of
medical killing.

The National Post reported on December 30, 2015, that Canada’s system of palliative
care is broken and has been deteriorating for decades. Therefore, terminally ill patients and their
families are forced to take up the slack as much as possible which means that some terminally ill patients are not getting the right kind of care. This report further states that this situation is causing unnecessary suffering and it is costing the health-care system resources.

Dr. Cindy Forbes, the Canadian Medical Association President is quoted in this article as stating, “Certainly in any conversations we are having now on physician-assisted dying, it is obviously essential that quality palliative care be available to patients and be seen as one of the options available to them.” And Jane Philpott, the Federal Health Minister states that “There is some evidence that only 15% of Canadians have access to high-quality palliative care when they need it.”

Such difficulties in accessing health care is also experienced elsewhere in the Canadian system. 800,000 Ontarians do not have a family doctor. The Toronto Sun reported on August 11, 2015, that Premier Kathleen Wynne’s government cut fifty medical residency positions in Ontario over the span of two years. Ontario already has the fewest doctors per capita of any Canadian province, tied with Saskatchewan in last place.

Nursing care too is being cut in our hospitals. The Toronto Sun reported on Thursday, April 9, 2015, that almost 250 nursing positions are on the chopping block at hospitals across Canada. France Gelinas, Member of Provincial Parliament for Nickel Belt, said hospitals are already seeing a change in nursing care and that in Sudbury alone, on April 9, 2015, there were 87,000 hours less of nursing care than was available on March 31, 2015. Dr. Eric Hoskins, Ontario’s Minister for Health, defended these cuts in this same article by stating that “we’re continuing to shift more resources to home and community care for example where Ontarians want to be and can, because of changes in technology.”
This reduction in health care access for Canadians combined with the lack of attention paid to palliative care recommendations in the London area may be contributing to the push for euthanasia. Health care providers and institutions face increasing pressure to decrease costs of health care. Given the high and seemingly disproportionate costs of health-care for the elderly and those in final phase of life, these “users of excessive medical resources” may be the targets of cost saving efforts such as a hastened death.\textsuperscript{267} It would appear that Canadian policy makers view euthanasia as a social remedy necessary to address these pressure points.

5.4 Euthanasia: An Immoral Act

The recommendations in the Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying presents euthanasia and physician-assisted suicide as a solution to the emerging societal issue of an increasing number of elderly and the concomitant explosion in dementia and age-related illness. Euthanasia and physician-assisted suicide, however, involve profound ethical, philosophical, theological, historical and sociological issues.\textsuperscript{268} The proposed legislation is far too utilitarian and technocratic in nature, however, and is largely devoid of these considerations. Rather, it appears to favour the most technically expeditious fashion to hasten the deaths of as large a population as possible.

The history of euthanasia has much to teach us. The historical account of euthanasia and physician-assisted-suicide in Belgium and the Netherlands show how once euthanasia is introduced into a society, the tendency to resort to it grows. The contagion of suicide is

\textsuperscript{267} Felicia Cohn and Joanne Lynn, “Vulnerable People,” in The Case Against Assisted Suicide. For the Right to End-of-Life Care, ed. Kathleen Foley et al. (Baltimore: The Johns Hopkins University Press, 2002), 239.
manifested by the ever-widening group of qualifiers for euthanasia. This evidence also makes it clear that where voluntary euthanasia is practiced, euthanasia which is not voluntary will follow. This contagion is evidenced by the ever increasing number of deaths by euthanasia which now include babies and children in these jurisdictions. This contagion is also demonstrated by the growing problem of medical paternalism as exhibited by some doctors in these jurisdictions.

The precedent in other jurisdictions highlights the danger that euthanasia and physician-assisted-suicide present to Canadian society, where people are rightly in search of a peaceful death. Unfortunately, it perpetuates and pushes to the extreme an ideology of technological control, with the goal of mastering life and death. It is interesting that it is this same ideology that created many of the problems surrounding end of life issues in modern medicine in the first place.269 Rather than altering the medicine which creates the problem of an intolerable death, allowing our doctors to kill or provide the means to take one’s own life simply perpetuates the “disease,” while offering an inadequate solution to the symptoms.270 This is the easy way. Palliative care, by contrast, offers an alternative approach that has been shown to be virtuous, compassionate and caring. Palliative care does not expose our ill, dying, elderly or disabled to the danger presented by our doctors having in their hands the power to directly and deliberately to take life by euthanasia and physician-assisted suicide. Let us recall Carine Brochier’s comment in Chapter 3; “I think it is very important to say that once you open the door and you think you’re going to control euthanasia or assisted suicide, it’s an illusion. It’s an illusion to believe you can control what goes on between a doctor and a patient in a room.” And it is

270 Ibid.
illusory to consider that the Canadian public will have access to accurate reporting of instances of euthanasia. The doctor/patient privilege will hinder this honesty and will protect doctors with impunity.

This brings us to the societal implications around the consolidation of such power in the hands of doctors. Physician-assisted suicide as social policy would appear to find support in the argument that some suffering is meaningless and unnecessary, and is something that ought to be relieved as decisively as possible. Further, the highly variable and subjective matter of what kind of suffering a given individual can endure is to be deemed to be best left to the irrevocable judgement of doctor and patient. However, the truth of the matter is that it is impossible to ensure that a given patient’s choice for physician-assisted suicide will be fully informed, rational and freely made. It is fanciful to consider that all sick and frightened patients near the end of life are truly in a position to make such a choice. Medications which interfere with clear headed thinking, depression, confusion, unrelieved physical symptoms, a sense of being a burden, conscious or unconscious pressures from family, friends, caregivers or society could all invalidate the assumption of autonomous choice. At such a time of great vulnerability, such patients instead tend to need protection, care and compassion. Once again, good palliative care can relieve most suffering. Good palliative care is able to provide people with such assured support in their final illness.

271 Ibid, 57.
272 Ibid.
Physician-assisted suicide is by definition a social act. It requires the assistance of someone else, other than the one dying. The difference between a suicide and assisted suicide is thus seismic. The legitimation of physician-assisted suicide would provide society with a tacit endorsement of this social aspect of the act. Hence, many aspects of our society will be affected beyond the immediate relief of the suffering in question. Apart from anything else, suicide will now be presented as a legitimate and reasonable way of coping with suffering. Suicide will be acceptable by law, sanctioned by medicine and delivered by doctors.

Unassisted suicide is understood to be a tragic situation. Even though it is no longer forbidden by law, suicide certainly is not understood to be an ideal outcome of a life. Physician-assisted suicide will destroy this balance too, and the new message to society will be that suicide is morally, legally, medically and socially acceptable.

The question of the impact upon human life and death of excessive use of technological means is also pressing, since the view of physician-assisted suicide that is emerging in our society is assisted by the fact that medicine tends, at times, to conflate the value of the sanctity of life and its goals with the medical technological imperative. The impact of this on the euthanasia debate is clear, as the distinction between killing and being allowed to die is blurred by such conflation. Death is increasingly seen as an event over which we have technological control and over which we should accordingly take responsibility.

275 Ibid.
276 Ibid, 52.
Such logic, however, is flawed. First of all, by the application of a doctor’s subjective judgement as to the “suffering” of a patient, physician-assisted suicide implies that medicine can relieve all problems associated with our human mortality. This is especially the case in connection with problems which turn on our end-of-life scenario, or the meaning of life, or why we have to die at all, or die in ways that seem pointless to us.277 Yes, doctors need to attend to the needs of the patient with care, comfort and compassion. The deeper existential malaise of life no longer having meaning or that suffering cannot be borne due to perceived pointlessness however, is not in the power of medicine to cure, and this is where the physician needs to draw the line. Medicine cannot solve these problems and should not attempt to solve these problems. Accordingly, euthanasia and physician-assisted suicide should not be embraced as solutions to such problems. Medicine has no competence to manage the meaning of life and death, only the physical and psychological manifestations of these problems.278

There is an inherent corruption in such legitimated private killing. This corruption has been seen in the German, the Belgium and The Netherland experiences. This corruption lies in the dearth of checks and balances in the euthanasia process. This corruption lies in the reality that when loose concepts and subjective reasoning are used to justify medical killing, when discussions of euthanasia are protected by the physician-patient privilege, when doctors must present euthanasia as a treatment option, then transparency around its use is not possible. This is why there is no logical way to long hold the line against euthanasia and to take care of those physically or emotionally unable to take care of their own lives. There is no logical way to deny euthanasia to any competent person who requests it for whatever reason, terminal illness or not.

277 Ibid, 59.
278 Ibid.
And finally, there is no logical way to deny euthanasia and physician-assisted suicide to those who suffer but are incompetent.279

I submit that the flawed logic of euthanasia occurs on two levels. Firstly, the loose concepts used in determining qualifiers for euthanasia such as “unnecessary suffering” are highly ambiguous. Only by using a vocabulary which honestly describes the situation, can honest debate occur. Whether or not this is even possible is highly questionable when everyone’s suffering is different.

Secondly, the power of the doctor to subjectively determine the quality of a patient’s life, or put another way, whether or not this life is worth living, is problematic. Medicine’s role needs to be limited to what it can appropriately do. When physicians use medical knowledge to directly cause death as a way of solving a patient’s problems with life and mortality itself, they go too far, exceeding the limits of medicine as a discipline, and with it, their own moral and professional rights.280

These flaws in the argument, once written into policy, will continue to be exposed throughout the application and experience of euthanasia. The dishonest communication in the form of loose concepts upon which the argument is based will inevitably lead to ever widening qualifications for euthanasia. The power of the doctor to determine life or death will lead inexorably to paternalism. The result of such flawed reasoning, in short, will be the increased application of euthanasia and ever-greater momentum down the slippery slope.

279 Ibid, 61.
280 Ibid, 59.
Therefore, it is argued that the decision for euthanasia is not a medical but a moral decision. The proposed Canadian legislation is superimposing a medico-technical approach over a more deeply human problem relating both to morality and to the meaning of our mortality. This is the undergirding for the deeply troubling questions raised by the euthanasia proposal. And, this is the basis for the argument of this thesis that euthanasia cannot be trusted to achieve what its proponents say it will achieve. Euthanasia and the bright line rule are mutually exclusive. Clearly defined standards or rules with regard to euthanasia are simply not possible.

In the language of virtue theory, the response of the proposed euthanasia legislation to the problem of human frailty is far too “thin.” The “thicker” concepts available from our historicity, as developed in virtue ethics in dialogue with philosophy and theology, are all but absent in the currently proposed legislation. Society, the dying, and our medical caregivers deserve better. The participation of physicians in killing people will be a corruption of the medical enterprise and the very identity of the physician.\textsuperscript{281}

Rather, let us focus on the meaningful care which it is possible for us to give to the dying. A society which has created such wonderful, life-saving medical technology as is available ought to be capable of a more humane answer to the issues raised by this very technology. It is a cruel irony indeed that the medicine which is life sustaining now wishes to expand its power to terminate these same lives that the technologies were invented to save. Of course we want to relieve suffering. This duty, however, cannot justify the introduction of new evils. The risk presented by euthanasia and physician-assisted suicide is too great, especially since the number

\textsuperscript{281} Samuel I Greenberg, introduction to \textit{Euthanasia and Assisted Suicide}, by Ralph Slovenko (Springfield: Charles C. Thomas Publisher, Ltd., 1997), ix.
of people whose pain and suffering could not be otherwise relieved would never be large. The societal impact would be no less than a sea change, the implications of which would extend far beyond those who are sick and dying, reaching into the practices of medicine and opening a veritable Pandora’s Box of socially-sanctioned killing. Euthanasia and physician-assisted suicide is the easy way of dealing with the tough cases, rather than providing relief of physical pain or decent psychological support for those who suffer emotionally. Our society deserves better.

Adjusting to advances in medical technologies is difficult. Humane policies related to dying need to be designed, but an easy euthanasia policy is not the answer. The risk euthanasia presents to the medical community is too great. The risk presented to our society is too great. We know that this type of killing is contagious and that it will go where it is wont once introduced into a society. The legislation as proposed does not look all that different from the “wild” euthanasia practiced in Germany during the Third Reich. The Americans and the British ended this practice at the end of the Second World War. Canada, however, may not be so lucky. History shows us that there will be no stopping the slide down the euthanasia slippery slope once it is introduced.

Euthanasia is not nurturing and does not protect the vulnerable in our society. The legitimization of euthanasia and assisted-suicide will create a fundamental inequity in which citizens who are most socially and economically marginalized will be least protected from their

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283 Ibid.
own and others’ deadly intentions. This is the reality as proven by history and is a long, long way from the autonomy and dignity proposed by the advocates of euthanasia. Such destruction of life is the destruction of our freedom.

Resolving a patient’s suffering should not rely on assisting that patient’s suicide. Rather, providing comfort care, especially when cure is no longer possible, is an important task for health care professionals. With a priority on palliative care, physician assistance in dying could come to mean supportive and comfort care rather than a lethal prescription.

Within the framework of virtue theory this chapter has argued that the medical and social consequences of the legalization of euthanasia presents a great risk to society. This risk is not necessary given that the hearty and valid alternative of palliative care is available. The application of such a medical and social policy is not a virtuous response to this medico-social dilemma. Palliative care is a virtuous alternative to euthanasia and a virtuous response to the social realities confronted by policy makers.

Other jurisdictions have turned their backs on euthanasia as acceptable social policy. What is the difference in the reasoning of the British parliament for example, and the reasoning of the Canadian policy makers? How can one jurisdiction reject such social policy and another embrace the same policy? This question will be the subject of the next and concluding chapter of this thesis.

Chapter 6

Conclusions

On Sunday, September 6, 2015, a joint letter from the head of Britain’s Christian, Jewish, Muslim and Sikh communities was sent to every British Member of Parliament. This letter urged that Parliament reject the Assisted Dying Bill, scheduled for debate the following Friday, September 11, 2015. This private member’s bill proposed to allow patients judged as having no more than six months to live and who had a “clear and settled intention” to end their lives, to be permitted to be prescribed a lethal dose of drugs. Two doctors and a family court judge would have to assess the patient’s diagnosis and prognosis and check that he or she was mentally competent to make a judgement free of coercion. The patient would then have to administer the lethal medication themselves with a health care professional present.286

The intervention in question was spearheaded by the Archbishop of Canterbury, Justin Welby, and contributed to the Bill being defeated in a free vote by a margin of 330 votes against and 118 in favour.287 It is interesting, in light of this thesis, that the arguments presented by this letter are not strictly theological. Additional strands of thought are garnered from the concern around the detrimental effects such a change in the current law on assisted suicide would have both on individuals and on British society. In fact, Archbishop Welby directly states in this same article “that we need to reflect on what sort of society we might become if we were to permit assisted suicide.”

Archbishop Welby is drawing attention to that feature of virtue theory by which an individual’s and, therefore, a society’s character is formed and expressed through their actions. This important question needs to be front and centre in current debates in Canadian society as well. How can Canadian society expect euthanasia and physician-assisted suicide to alter and inform their collective psyche and individual character? As human agents and as society, we will become what we practice. This will be the topic of our concluding discussion.

6.1 Euthanasia: Radical Social Policy

It is fundamental to the argument of this thesis that the legalization of euthanasia and physician-assisted suicide is radical social policy and represents a paradigm shift in society’s understanding of the role of medicine in our lives. This is the sea change referred to earlier in this thesis. The important and fundamental role of medicine in society means that conceptual shifts in medicine will lead to conceptual shifts in society.

6.1.1 Euthanasia Represents a Departure from the Healing Commitment of Health Care Professionals

The conceptual shift of medicine from that of a profession of healing to a profession which will now incorporate medicalized killing will be the first ripple in far-reaching consequences which will be felt by every single Canadian at some point in his or her life. Dr. Jeff Blackmer, the Canadian Medical Association’s director of ethics and professionalism, stated that he detects a mood of nervousness and uncertainty as the profession comes to grips with what
was once unimaginable. He states that “this is the biggest change in the medical profession in Canada, maybe in centuries.”

The medical profession is important not only for its own sake but because it is a very important value-carrying institution for society as a whole. Harm to the medical profession harms society. There is a special moral character to the medical profession and the ethical obligations that this moral character entails. The normative stance of the medical profession has been to heal and not to kill. The ruse of shifting a medicalized death from termination of life to just another treatment option is I suggest, just that, a ruse. Although some people may be tricked into considering euthanasia as healing, it is not. Euthanasia is anathema to the medical profession. The damage to our culture may not be immediately perceptible but it will be real and far-reaching.

This healing/killing paradox is genuinely concerning. If the basic Canadian norm that we must not kill each other is attacked then consequences will follow. It can be expected then that normative Canadian behaviour and attitudes will be altered. The introduction of euthanasia will enable and encourage the classification of lives into those worth living and those not worthy of life. Euthanasia will expand this ability to assess worthiness of life to every Canadian. Implicit in such an assessment is that some lives are more worthy than others. Euthanasia will also, crucially, confirm a person’s devaluation of his or her life. In situations of infirmity or mental illness instead of protecting people euthanasia will tend to threaten the most vulnerable.


6.1.2  Euthanasia Establishes a Continuum of Worthiness in Society

The ability to judge a life worth living introduces a moral relativity to the worthiness of life which has heretofore been unknown in Canada. The worthiness of every life is quite simply threatened by euthanasia because it assumes that this is no longer an absolute principle. The fundamental principle that life is worth living has been up until now applied to medicine in a most basic way and is bound up with the very healing nature of medicine. The imperative to save life has been recognized since the earliest records of medical practice.\(^\text{290}\) Euthanasia stands in conflict with this imperative. Euthanasia attacks our common morality and our mutual responsibility of concern for one another.

The new moral boundary represented by euthanasia will impose new responsibilities on Canadians who may or may not be equipped to deal with them. Life and death decisions are momentous. Mistakes are bound to happen and needless deaths will occur. It is not scaremongering to suggest that the potential for post euthanasia trauma for such decision makers is great. The emotional backlash of euthanasia could jeopardize the psychological security generally enjoyed by Canadians. Elder family members may begin to mistrust their families. The disabled in our society may become fearful of health care institutions and health care providers. Imperfect babies will certainly require the protection of their parents. The mentally ill will be particularly vulnerable. The emotional trauma introduced to our society by the presumed ability to judge who is worthy of life and who is not worthy of life will affect everyone. Euthanasia thus threatens the current and future security of the living. Psychological security is threatened by the knowledge that physicians are allowed to kill from the moment

euthanasia is legalized. Physical security is threatened when one accesses the medical system. Perhaps Canadians will begin to carry “Do Not Euthanize Me” cards as do some people in the Netherlands.

Trauma associated with euthanasia will be felt by physicians and health care providers too. In fact, trauma will be felt by these groups in ways not yet experienced. Assisted death will greatly change the moment of death in that care givers are generally accustomed to seeing a patient deteriorate over time. Assisted death will change this in that death will happen quickly. Other psychological risks include risk of burn-out and risk of increased moral distress.\textsuperscript{291} The psychological burden of the license to kill could very well be an intolerably high price to pay for physician-assisted suicide.\textsuperscript{292}

6.1.3 Euthanasia: Absolute Power Corrupts Absolutely

This ability to confer and determine worthiness of life will concentrate great power in the offices of doctors and health care providers. Once again, we can learn from history when we recall the historian and moralist Lord Acton’s famous quotation, “Power tends to corrupt and absolute power corrupts absolutely.” The prestige and esteem of physicians will now be enhanced by the ability to end life. The powerful will become more powerful and will exercise this increased authority over the less powerful and vulnerable in Canada. The current proscription of euthanasia by contrast protects doctors from the temptation to judge, on the basis of their own private prejudices and attitudes, whether or not this or that life is unworthy of


continued existence. One doctor will choose to assist a suicide against moderate or impending dementia, another against paraplegia and another against blindness or incurable incontinence or prolonged depression. The decision to euthanize or not to euthanize will necessarily be a relative judgement and will involve the doctor’s personal standards. The legalization of euthanasia will increase the risk of hastened death for the marginalized, the poor, the elderly and disabled. Inequalities in society will almost certainly be reflected in patterns of euthanasia.

This departure from the healing commitment of health care professionals will have the clear potential to damage the doctor-patient relationship. This will be especially true for those patients who have difficulty communicating their wishes and defending their interests or who lack a close relationship with a trusted personal doctor. For when doctors are capable of killing, trust will be eroded and suspicion will enter the doctor-patient relationship.

This attack on the trust between a doctor and patient will be corrosive and subtle. When doctors are licensed to euthanize suspicion will enter unavoidably into many a doctor-patient encounter, sometimes explicitly and sometimes tacitly. It is being proposed that doctors will have no choice but to make patients aware that euthanasia is a legal medical option. Of course there will be those who will wonder whether their doctor thinks they should die or if their doctor is indifferent to the value of their lives. The trust of the patient may well be replaced in some cases not only by suspicion but by doubt, stress, anger and resistance to treatment. Patients can

293 Ibid, 29.
294 Ibid, 30.
297 Ibid.
confer the virtue of trustworthiness on a physician who does not possess a license to kill. Once the taboo of physician-assisted killing is broken, legitimate fears of deadly abuse of the new license will likely be attached to each and every physician, even if they do not do the killing themselves. This will compromise their ability to heal and comfort. It will not matter that your doctor has not yet medically killed someone, the fact that the profession is legally entitled to do so will make a world of difference. The doctor’s attitude will have a profound effect on the likelihood of a person choosing suicide.

This departure from the healing commitment of health care professionals will also likely have technical consequences. There appears to be convincing evidence that legalization of euthanasia and assisted suicide undermines the care provided to patients at end of life. Studies have shown that the less physicians know about palliative care, the more they favour legalization; the more they know about palliative care, the less they favour legalization.

Physicians who know most about caring for terminally ill patients (for example, palliative care specialists, gerontologists, psychiatrists who treat patients who become suicidal in response to medical illness, hospice physicians, and oncologists) provide the strongest opposition to euthanasia. These physicians know that patients requesting euthanasia may well be making an anguished cry for help and a very ambivalent request for death. These patients desperately need relief from their suffering and when they are treated by a physician who can hear their

298 Ibid, 29.
ambivalence, understand their desperation and relieve their suffering, the wish to die usually disappears.\textsuperscript{300}

Policy recommendations regarding euthanasia made by those who are not knowledgeable about the care of dying patients are often removed from the reality faced by these patients.\textsuperscript{301} The reality of euthanasia is very far removed from the theory of euthanasia as proposed by policy makers. Patients need to trust the medical establishment that their doctors will listen to them in their end of life circumstances. This trust is broken by euthanasia.

6.1.4 The Social Price of Euthanasia

The acceptance of euthanasia or physician-assisted suicide as a normal medical practice will have unintended but significant social costs. The price of the doctor-patient relationship has already been discussed.

Euthanasia will also likely endanger the teaching process in that it can become a substitute for learning how to relieve the suffering of dying patients. By endangering the teaching process, euthanasia has consequences not only for a particular patient, but also for the quality of care in general.\textsuperscript{302} Studies in the Netherlands have demonstrated an inadequacy of physician training in palliative care. The consequence then of this lack of training combined with the availability of euthanasia means that physicians and health care providers simply do not know the right questions to ask in order to resolve the dilemmas of the dying. Euthanasia has become medicalized and is presented as a medical treatment now in the Netherlands to the

\textsuperscript{300} Ibid, 4.
\textsuperscript{301} Ibid.
\textsuperscript{302} Zbigniew Zylicz, “Palliative Care and Euthanasia in the Netherlands,” in The Case Against Assisted Suicide. For the Right to End-of-Life Care, ed. Kathleen Foley et al. (Baltimore: The Johns Hopkins University Press, 2002), 142.
detriment of palliative care. There is no reason not to suspect that this will become the narrative in Canada as well.

Not only will the doctor-patient relationship be altered. Our relationships amongst one another will also be altered. Perhaps the most important transformation would be the change in our relationships with others from a moral to a therapeutic basis. To take a neutral stance towards another human being’s suicide rather than a stance of caring is transformative. Such a relationship is cold, dispassionate, professional, administrative and neutral to the question of whether an individual lives or dies. Our humanity loses its humaneness with this so-called compassionate action, in fact the very basis of compassion and sympathy is eroded.\textsuperscript{303}

As a society, we must never be neutral towards the act of suicide. Suicide is a moral act, and even when bound up as a gift to the suffering in the form of medicalized killing, suicide remains an action which contradicts moral norms. To reduce the meaning and power of suicide to an everyday event is to reduce the meaning and value of each of our lives. To normalize the act of suicide will attack the very warp and weft of our culture. To normalize a suicide is to threaten compassion for one another, to threaten caring for one another, and to threaten the value we attach to our lives.

Euthanasia will remove our society’s ability to protect the vulnerable amongst us. Entire categories of people will be beyond our reach. It will be akin to not inhabiting the same moral universe. The value with which we hold certain members of our society will be diminished.

\textsuperscript{303} Kevin Yuill, Assisted Suicide. \textit{The Liberal, Humanist Case Against Legalization} (UK: Palgrave MacMillan, 2013), 150.
idea that the existence of some people is undesirable is misanthropic. And the threat of such misanthropy spreading is real and is manifested in the expansion of categories qualifying for assisted suicide.

Now for the elephant in the room, that conversation around the limited resources of our health care system and how the elderly use far too many of them. Policy makers have been careful to keep the economics argument out of their proposals, but the question of resources is implicit. This, in spite of the fact that there does not appear to be any evidentiary support that euthanasia saves a health care system money. Perhaps this dearth of evidence in this area is due to the fact that accurate analysis of euthanasia is not possible. Accurate reporting regarding the use of euthanasia does not appear viable within a self-reporting and self-regulating medical system. Hence, it may simply not be possible to accurately assess the cost of euthanasia as opposed to the cost of palliative care. The argument that euthanasia will save our health care system dollars is actually a dangerous assumption which is not based on demonstrated fact. Arthur Caplan, previously quoted in this thesis states that “my opposition to physician-assisted suicide comes not in the fear that money will play a role, but from a conviction that money will play the role in the decision.”

There will be financial gains to be had outside of the alleged health care dollars savings as well. Already, Valeant Pharmaceuticals has doubled the price of a drug commonly used to hasten death. The price has increased to U.S. $3,000 per 100 capsules. In 2009, those 100

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304 Ibid, 151.
305 Samuel I. Greenberg, introduction to Euthanasia and Assisted Suicide, by Ralph Slovenko (Springfield: Charles C. Thomas Publisher, Ltd., 1997), xi.
capsules cost less than U.S. $200.00. This same prescription costs U.S. $50.00 in Denmark.\textsuperscript{306}

So, it would appear that physician-assisted suicides could carry an increasing financial burden for our health care system while resulting in increased profits for the purveyors of the supplies needed to medically kill.

6.2 Euthanasia: Worth the Risk?

This thesis has presented euthanasia as a moral problem. Death is not and never can be a medical issue. Death will come to all of us. This is one fact which is our great equalizer. Each and every one of us will die.

The virtues which have been presented as especially relevant in the healthcare profession are fidelity to trust and promise, benevolence, effacement of self-interest, compassion and caring, intellectual honesty, justice, prudence and medical humility. This thesis has argued that euthanasia and these virtues are mutually exclusive. Euthanasia attacks the trust of the patient-doctor relationship. Euthanasia attacks the trust that a doctor will be acting in a benevolent fashion for their patients and not out of self-interest. The compassion and caring at death bed scenes will necessarily be replaced by a euthanasia bureaucracy of doctors, nurses and paperwork. Doctors will not be trusted to be honest with their patients when euthanasia must be presented as a treatment option. Assessment of qualifications for euthanasia will continue to be loose and subjective, not prudent. To hold the power of life and death in one’s hands is to eschew medical humility. Therefore it is concluded that euthanasia is not virtuous.

The imposing of a medico-technical solution to the morality of end of life is highly problematic. Medicine is simply not capable of addressing end of life existential issues and to offer euthanasia as a response and solution is to use a blunt instrument indeed. Doctors should not be given life and death power over their patients.

The common arguments in favour of euthanasia, compassion and autonomy, have been presented and accounted as flawed. The consideration that euthanasia once introduced into a society is not capable of being controlled or managed has been explained. The expected harmful results on our culture have been presented both in terms of the individual, society and in terms of our healthcare system has been developed. The benefits of euthanasia are difficult to glean from this data.

It has been demonstrated that what appears to be a simple legislative move which would affect very few people who are suffering, is instead fraught with perilous implications and meanings far beyond the few directly intended. The proposed Canadian legislation will redefine the Canadian societal landscape in terms of the most open euthanasia regime in the world. Human motivation has been introduced in this thesis as part of our discussion of virtue theory. This writer cannot speak to the motivation of the Canadian policy makers who wish to change our society so completely. However, it can only be theorized that the position of our policy makers appears to be an intellectual posturing which is not based on reasoned thought but more upon a post-modern cultural expectation. The verbal sleight of language used to promote euthanasia appears to pull at the compassionate and emotional heartstrings of Canadians. Reasoned thought, however, needs to be applied.
Also, there is a risk of opening the doors to those with less than a moral desire to kill. This may have been the case in the Northern Territory of Australia as it appears that this doctor certainly had a penchant for medicalized killing. Indeed, serial killers such as the once highly regarded physician Harold Shipman, have been detected killing within the environs of their medical practices. An official investigation of his Manchester, England practice revealed a murder count of at least 215 people. He was dubbed “Dr. Death” by the British press and seemed motivated by an intense desire to control the fate of his victims; that is who would live and who would die. He apparently gained perverted pleasure from playing God.\textsuperscript{307}

Additionally, female serial killers can also derive satisfaction from playing God, and those who are health practitioners hold life and death in their grasp. A 30 year old nurse by the name of Kirstin Gilbert went on a four month killing spree between December of 1995 and February of 1996. Four of her patients were successfully killed at the Veterans Administration Hospital in Northampton, Mass., U.S.A.\textsuperscript{308} These health care providers possess evil intent and a predilection for killing. Access to euthanasia removes a substantial defense from such predatory health care providers.

The British society has chosen to deliver quality medical care rather than empower doctors to kill. British society has chosen not to classify their population in terms of whose lives are worthy of living and whose are not. Rather, the ill, the elderly, the marginalized and disabled in Britain do not need, for the moment, to worry about their deaths being hastened. And those who are contemplating suicide can be supported and offered counselling rather than the

\textsuperscript{308} Ibid, 127.
immediate means to suicide. British culture show their vulnerable that they are cared for and supported even when one has given up on oneself.

When we examine the case for euthanasia, more questions than answers arise. This is partly due to the fact that the language used distorts the reality of euthanasia. It is being presented to the Canadian public under the guise of healing. It can only be assumed that such language is required due to the reality of these proposals. Perhaps if Canadians understood the true nature of euthanasia and its cultural impact, there would be more of a reaction. Our lack of outcry reflects a tacit agreement.

The truth seems to be that a consistent framework needed to answer the questions raised by the proposed euthanasia legislation is not possible or plausible. Questions such as “what is intolerable suffering” lie outside of the purview of medicine and its technologies. In particular, the issue of the worthiness of one’s life, is not an issue to be addressed solely by one’s doctor. Questions of pain and quality of life are not reconcilable with definitive answers. And definitive answers are needed in order to provide safe guards in a regime of euthanasia. Therefore, it does not appear that safe guards are possible.

The euthanasia regime being proposed in Canada is a huge gamble. Our Members of Parliament will be asked to vote into law policies which may or may not accomplish their stated goals. We do not know if the vulnerable in Canada will be protected. It has been argued that this will not be the case and that our vulnerable will be at greater risk of a hastened death. There can be no effective safeguard against this risk, let alone from the insidious pressure from family members who wish not to be ‘burdened’ by the illness, infirmity or dependence of a family member.
The euthanasia regime as proposed will alter a profound ordering principle of Canadian society. The judgement that suicide is a moral action and that those who consider suicide need compassion and support may slide from such a resolution based in a common morality into a resolution based in medical technology and the availability of hastened death. Hence, this new moral boundary represented by euthanasia will be determined by the few and applied to the many. This thesis argues that to apply euthanasia as the solution to alleged social problems is far too thin and simplistic. Additionally, euthanasia places great power in the hands of physicians and health care providers which can result in great risks for those accessing health care. Far less risky alternatives to euthanasia exist. Far greater public engagement is necessary.

This movement of suicide from the moral realm into the realm of medical technology represents a dangerous moral relativity in which the value of human lives can shift so easily. The value of our humanity will be determined to a large degree by those who hold the power of life and death in their hands. Such moral relativity promotes the dehumanizing of our humanity as technology is looked to for solutions to issues of morality.

The challenge that we face is to create a culture that identifies the care of the seriously ill and dying as a public health issue rather than a physical ailment to be treated.\(^{309}\) Death is a natural ending to living. The medicalization of death, the shifting of this concept from that of being a natural part of living to that of being an ailment to be treated, places far too much power in the hands of our medical professionals.

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It has been stated that wisdom is the practical side of moral goodness. Is this proposed legislation displaying an over-confidence by such reliance on technology? Is the risk presented by euthanasia wise? Can the risks to our culture presented by euthanasia be considered wise?

Canada risks such a sea change in our culture to achieve what exactly? We risk our current culture of caring and compassion into becoming a society where each life is no longer seen as worth protecting. Each life risks being placed in a hierarchy of whose life is of value and whose is not. Each of us is vulnerable at some point in our lives when we need the compassion and support of our health care providers. Such assurance is removed by euthanasia and is replaced by the knowledge that we now have the ability to hasten our deaths should recovery appear too difficult.

These are not sunny days. These are dark days. The proposed euthanasia laws represent a flawed and easy solution to very complex social issues. Our increasing technological ability to prolong life in the face of imminent death is resulting in these complex ethical dilemmas. Euthanasia does not solve such dilemmas. Euthanasia is a blunt instrument applied to a complex social issue which requires more compassionate and creative thinking. Surely such a society as ours, capable of such wonderful and lifesaving technologies as are available is also capable of a robust, ethical and virtuous response to end of life care. The reframing of this issue to better address the needs of this population with an increased focus on palliative care, for example, would not place our culture in such peril. The ill, aged and vulnerable of our society deserve
more from a culture which desires to consider itself civilized and humane as opposed to assistance or encouragement in the annihilation of all their rights by self-destruction.\textsuperscript{310}

It is a cruel irony indeed to consider that the social issues resulting from our advanced medical technologies are to be addressed with the application of lethal medical technologies. It could be stated at this juncture then, that humanity is serving technology. Our society risks becoming reliant on technology, even in death.

This thesis has attempted to argue against euthanasia using data available as well as principles. It has been argued that such proposals appear unworkable or hazardous to the vulnerable in our society. It has been argued that our society would be better off keeping euthanasia and physician-assisted suicide illegal and instead put our attention and efforts towards learning how to better provide reliable, good and compassionate care to those amongst us who find themselves needing such care.\textsuperscript{311} Such an approach maintains a more workable balance between individual rights versus duties and obligation or the concept of justice balanced with the common good. The ethics of our health-care system represent the moral health of Canadian society. Euthanasia attacks the ethic of equality of human life and, in Canada, once this ethic is altered and when the lives of Canadian citizens can be judged on a continuum of worthiness, then our moral health too will be altered. Euthanasia will allow a moral relativity to seep into our health-care system. It can be expected that such a moral relativity will impact the lives of every Canadian at some point in their lives.

\textsuperscript{310} Samuel I. Greenberg, introduction to \textit{Euthanasia and Assisted Suicide}, by Ralph Slovenko (Springfield: Charles C. Thomas Publisher, Ltd., 1997), xiv.

The facile application of euthanasia as a social remedy risks creating a subjective approach to the right to live, rather than the objective view inherent in the equality of human life ethic. Such moral relativity is dangerous and will place the lives of some Canadians at risk. This is the heart of the corruption which is euthanasia. Subjective notions of human worth, in the end, are about raw power and who gets to do the judging.\footnote{Wesley J. Smith, \textit{Culture of Death. The Assault on Medical Ethics in America.} (San Francisco: Encounter Books, 2000), 28.} This ability to judge, combined with such concentration of power, presents a real risk to the Canadian society of diminishing our humaneness.
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Appendix A:

Archbishop of Canterbury Justin Welby:

Letter to the British Parliament

Why I believe assisting people to die would dehumanise our society for ever
Why I believe assisting people to die would dehumanise our society for ever

Justin Welby

The archbishop of Canterbury and other faith leaders are urging MPs to oppose a change in the law as they fear it would mean crossing an ethical Rubicon

Saturday 5 September 2015 21.00 BST

With other faith leaders, I have joined in writing to members of parliament, urging them to oppose Rob Marris’s assisted dying bill.

We have written, not in an attempt to push “the religious” viewpoint on others but because we are concerned that a change in the current law on assisted suicide would have detrimental effects both on individuals and on our society.

While some individual religious voices, including that of my distinguished predecessor, Lord Carey, have called for a change in the law, the faith leaders’ letter represents the considered opinion of our communities that have analysed, discussed and debated the issue over many years. Their response springs from philosophical and theological reflections as well as from a vast range of pastoral experience and a profound sense of compassion.

I have three concerns:

First, a change in the law to permit assisted suicide would cross a fundamental legal and ethical Rubicon. This respect for the lives of others goes to the heart of both our criminal and human rights laws and ought not to be abandoned. While it is not a crime in the UK for someone to take his or her own life, we recognise that it is a tragedy and we, rightly, do all that we can to prevent suicide. The assisted dying bill requires us to turn this stance on its head, not merely legitimising suicide, but actively supporting it. We are asked to sanction doctors participating in individuals taking steps to end their lives. This is a change of monumental proportions both in the law and in the role of doctors; it is little wonder that it is opposed by the medical profession.

Currently, those who act wholly out of compassion in assisting someone they know to end their lives will not face prosecution. I feel profoundly the grief and struggle of anyone...
finding themselves in such a situation, desiring to respond with love in the face of suffering. I know what it is to sit at the bedside of someone you love enormously and yet be torn by fears and worries about their future. I agree that the law should take a considered and compassionate approach to caring relatives who are asked by those closest to them to help bring their lives to an end.

To change the law, however, to give individuals access to medically prescribed lethal drugs risks replacing the type of personal compassion that is forged in a lifetime relationship for a “process” marked by clinical and judicial detachment. As the European Court has noted, the legal understanding of the “right to life” would have to be fundamentally rewritten and for no good effect.

Second, a change in the law would place very many thousands of vulnerable people at risk. Age UK asserts that some 500,000 elderly people are abused in the UK each year. It is impossible to ensure that they and other vulnerable people would not be placed under pressure to end their lives prematurely in ways that proposed safeguards cannot hope to detect.

Make no mistake, MPs are being asked to take a huge gamble that a changed law would protect the vulnerable. There is no need to take such a risk since the current law continues to protect the vulnerable while harbouring no threat for those who act wholly out of compassion. We know from the US states of Oregon and Washington that between 40% and 60% of those who used legally prescribed lethal drugs to end their lives cited concern that they would be a burden on their families as a factor in their decision to bring their lives to a premature end.

Once a law permitting assisted suicide is in place there can be no effective safeguard against this worry, never mind the much more insidious pressure that could come from a very small minority of unsupportive relatives who wish not to be burdened.

The exhaustion of caring, sometimes combined with relationships that have been difficult for years before someone fell ill, can lead people to want and feel things that they should not. All of us who have been involved in pastoral care and bereavement care have heard the confusion people feel about how they behaved to a demanding relative. The tests in the bill do not make space, and never could, for the infinite complexity of motives and desires that human beings feel. The law at present does make that space, and yet calls us to be the best we can.

Little wonder, then, that groups such as Action on Elder Abuse, Mencap and Scope wrote to peers last year opposing proposed changes to the current law.

My third concern is that we need to reflect on what sort of society we might become if we were to permit assisted suicide. At present, we can show love, care and compassion to those who at all ages and stages of life are contemplating suicide. We can try to intervene, to support them to embrace life once more. We can do all in our power to surround those who are terminally ill with the best possible palliative care, including physical, emotional
and spiritual support. We can redouble our efforts to alleviate suffering. We can show that we love even when people have given up on caring for themselves. We can support our doctors and nurses as they act consistently in the best interests of their patients, affirming life and caring for the vulnerable.

We risk all this for what? Becoming a society where each life is no longer seen as worth protecting, worth honouring, worth fighting for? The current law and the guidelines for practice work; compassion is shown, the vulnerable are protected. In spite of individual celebrity opinions and the “findings” of snap opinion polls (that cannot hope to do justice to the intricacies of the issue) the current law is not “broken”. There is no need to fix it.

More comment

Topics
Assisted dying

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Appendix B

Canadian Nurses Association: Physician-Assisted Dying

Brief for the Special Joint committee on Physician-Assisted Dying

January, 2016
BACKGROUND

This brief was originally prepared by the Canadian Nurses Association (CNA) for consideration by the Government of Canada’s external panel, tasked with developing the federal legislative response to the 2015 Supreme Court decision in *Carter v. Canada (Attorney General)* regarding physician-assisted death (PAD). It has since been updated for submission to the special joint committee on PAD.

CNA acknowledges that PAD is an incredibly intricate and emotional topic. However, it is not up to CNA to suggest a position on an issue that the law has already made clear through a unanimous ruling by Canada’s highest court. CNA must respect the Court’s decision. As the voice for registered nurses in Canada, CNA’s priority is to support nurses on this issue and help them provide the best ethical and competent care to patients, including those either at or near the end of life, as per the CNA *Code of Ethics for Registered Nurses*. This work includes collaboration with both provincial/territorial nursing associations and/or colleges and the Canadian Nurses Protective Society (CNPS) to provide input on the implications of PAD, in connection with the code of ethics, and bring forth the nursing perspective.

CNA would like to mention that this submission is informed by comprehensive information collected through a series of in-depth, one-on-one interviews with Canadian and international thought leaders and experts in this field. These include

- international associations involved in developing national and state policies related to PAD
- direct care practitioners with expertise in palliative care and end-of-life care and research
- nurses with expertise on legal and ethical issues or those with a regulatory background who have insight from a jurisdictional perspective as to how PAD may impact nursing practice.

As the most consistent health-care providers for patients, nurses are the ones patients talk to and seek answers from most often. In fact, it is not uncommon for a nurse to be the first person a patient approaches regarding assisted death. It is our hope that the special joint committee on PAD will seriously consider our comments and make use of the insight and specialized knowledge nursing has to offer on this very important issue.
2 KEY ISSUES
2.1 FORMS OF PHYSICIAN-ASSISTED DEATH (PAD)

Current PAD models suggest two possible scenarios for patients wishing to pursue this option:

- Patients themselves may take a lethal dose of medication, which is provided by a physician (as is done in Oregon).
- A physician administers the lethal dose of medication to the patient (as in the Quebec model).

While it is not part of CNA’s mandate to comment on the merits of either process, the involvement of an interprofessional team throughout any process is essential (discussed more fully below).

It is also important to consider the language and terminology we use to ensure clarity and care when we talk about a patient receiving assistance to die. Health-care providers have always assisted their patients when dying. However, there is a difference between such a scenario and the one contemplated by the Carter case. For this reason, the term assisted death is preferable to the term assisted dying.

In addition, the term physician-assisted death rather than euthanasia or assisted suicide may help facilitate rational dialogue. Since the two latter terms can carry a stigma or negative connotation, they may leave the patient who requests assisted death with a feeling of being judged.

Lastly, the discussion on assisted death has been framed around the physician. Yet, when we talk about “physician-assisted death” we overlook the crucial role of the health-care provider team. As a key element of this team, the nursing perspective has not been part of the conversation, even though nurses have expertise to share on this issue.
2.2 ELIGIBILITY CRITERIA AND DEFINITION OF KEY TERMS

In its 2015 ruling, the Supreme Court of Canada noted that, to qualify for physician-assisted death, one needs to be “a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable” to that person (p. 85). The patient does not have to suffer from a terminal illness.

The competency requirement should apply both at the time of request for PAD and at the time the assistance is provided. Being competent throughout the entire process (as opposed to starting off competent and losing competency at some point before death) ensures a degree of safeguard, in terms of narrowing the possibility of coercion and enabling a person to feel they can change their mind at any point and back out of going through with the act.

As part of the therapeutic relationship, health-care providers have a duty to provide persons in their care with the information they need to make informed decisions, related to their health and well-being, and to ensure they have understood the information and implications and have consented to a particular treatment. This duty is most well-known in cases of surgery, but the finality of PAD makes this process much more significant. The CNA code of ethics highlights the importance of informed consent and the need for nurses and others to recognize, respect and promote a person’s right to be informed and make decisions. These criteria are crucial to the assessment and eligibility process.

While it is not within CNA’s mandate to define phrases such as “a grievous and irremediable medical condition,” it is vital to have a clear and common understanding of what these broad terms mean in relation to an illness, disease or disability in order to provide proper guidance for all involved in PAD and for public knowledge.

With respect to the psychological component of pain that can be inferred in the Supreme Court’s criteria of “enduring suffering that is intolerable,” it is important to ask how this pain is assessed in comparison to physical pain and suffering. What if a person’s request is driven by depression, loss of hope and perceived loss of value as a human being? The CNA code of ethics instructs nurses that “care [be] directed first and foremost toward the health and well-being of the person” (p. 10) while acknowledging the need to “recognize, respect and promote a person’s right to be informed and make decisions” (p. 11). Respecting a competent adult’s right to make informed decisions should not stop the physician or others involved from offering assistance, such as helping the patient connect with support or counselling resources before deciding to go forth with the request for assisted death.

A patient’s eligibility for PAD will rest on the assessment process. Here, the collective experience and expertise of an interprofessional team is key, as we explore in more detail below.
2.3 RISKS

A number of risks become possible with the allowance of PAD. Most significant are concerns about vulnerability and coercion in relation to the patient and the apprehension that, over time, society may become cavalier about the issue. Safeguards are therefore important for ensuring that PAD is dealt with carefully, competently and ethically (discussed more fully in the safeguards section below).

In addition, the legal and psychological risks for health-care providers, including physicians, nurses and others involved in caring for patients who request PAD, are crucial areas to address. Finally, it is noteworthy that increased access to palliative care would be a success and could potentially reduce the demand for PAD.
2.4 Legal risks

The Carter case provides legal protection to physicians involved in PAD, so they can practise without risk of criminal prosecution. Nurses require this protection, too.

Although nurses do not deliver physician-assisted death, they care for these patients. In a sense, PAD is another treatment option (what is needed is more clarity regarding a nurse’s role at the hour of death).\(^{313}\)

Nurses, because of their critical skills in interpretation, are vital to the assessment process of a patient requesting PAD and must be part of the patient’s decision-making process. They are also an important and reliable source of information. They can assist with exploring patients’ feeling and perspectives, discussing available options/alternatives and helping to explain the PAD process.

Accordingly, when nurses are asked a question they must feel at ease to speak with the patient. In responding, nurses must have proper protections through amendments to the Criminal Code, so they can do what they have always done (i.e., discuss, listen, educate, assess, evaluate, document, and support patients and families) without fear or risk of criminal prosecution.

Nurses (registered nurses and nurse practitioners) are independent professionals within a self-regulating profession. This standing assures the public they are receiving safe and ethical care from competent and qualified caregivers. It is the reason nursing keeps its place as one of the most trusted professions. The nurse is part of an interprofessional team and is integral to providing a comprehensive assessment of a person making a PAD request, rather than simply being a doer under the direction of the physician. Patients receive the best care when there is a lateral relationship among health-care team members, when physicians and nurses work side by side (as they currently do), no matter what the issue is. Because of this working relationship, nurses also need proper protections through amendments to the Criminal Code. The quality of patient care is at risk of decline if this protection is not given to nurses.

CNA’s colleagues from the Canadian Nurses Protective Society (CNPS) addressed this issue in more detail in their submission to the external panel. CNPS offers legal advice, risk management services, legal assistance and professional liability protection related to nursing practice for eligible registered nurses.

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\(^{313}\) “Nursing regulatory organizations in Canada have yet to adopt standards and guidelines as a result of the Carter decisions. It is expected that such guidelines will be adopted once the legislative framework is in place. Each provincial and territorial regulatory body can, within that specific legislative framework and the existing regulatory framework, adopt guidelines and standards applicable to specific circumstances that it deems most appropriate in order to satisfy the ethics of the profession, the needs of the health care system and the protection of the public” (Canadian Nurses Protective Society, 2015, p. 8).
2.5 Psychological risks

Risk of burnout: While assisted death is a new issue, it is being rolled out within a challenging context: the pressures and stresses health-care providers face today. Staffing shortages, time constraints, and being pulled in several directions at once will all have an effect on a health-care provider’s ability to deliver proper care with patients considering PAD. Such conditions, for example, can restrain a nurse’s ability to fully engage in the necessary therapeutic conversation with a patient and may leave the nurse feeling a sense of failure or distress. Thus, there is a need to provide extra care for nurses and other health-care providers within the PAD environment.

Risk of increased moral distress: Moral distress is a very significant issue in end-of-life care, generally, and assisted death only adds to this moral complexity. Thus, to avoid burnout among health-care providers, it is important to ensure they are supported, emotionally and psychologically as well as ethically, via clinical ethicists and experts. The nursing clinicians CNA interviewed drew attention to grief/burnout studies that suggest health-care providers leave the profession faster when they are not supported. One can imagine that this risk would be even greater when cases of assisted death are included.

Risk of trauma: One of the nursing experts CNA spoke with made the point that assisted death will radically transform the moment of death, changing what health-care providers are used to regarding what a good death looks like. A nurse or physician is generally accustomed to seeing a patient deteriorate over time, eventually becoming less alert, more sleepy, etc. Assisted death will change this. At one moment a patient may look well and be eating breakfast and then, after the administration of the medication, they will stop breathing, change colour, and their death will be sudden. It is a different way of dying, which health-care providers are not yet familiar with. Another possibility to consider is if something goes wrong during the procedure that results in the patient being harmed. Here, there is a risk that nurses and doctors may feel traumatized in ways not yet experienced. Thus, health-care providers need support and the necessary skills to provide care in a competent and ethical manner when requests for PAD are made.
2.6 Safeguards to address risks and procedures when assessing requests for PAD

Instituting safeguards are vital to mitigating PAD-related risks in Canada and are key to upholding the integrity of the entire process. Below is a summary of important safeguards to have in place.

**Ensuring that requests for PAD are addressed through a comprehensive assessment process by an interprofessional team**

In terms of confirming a patient’s eligibility for PAD, CNA has heard a range of experts in end-of-life care and nursing say that having an interprofessional team to undertake this very comprehensive assessment is an important safeguard. Indeed, it is not something one individual practitioner can do on his or her own. The idea of simply having a physician who checks competence, which is then verified by another physician, is a highly reductive perspective on what health care should be.

To date, the discussion about assisted death has been framed around physicians. The role of the collaborative and interprofessional health team, such as nurses, pharmacists, psychologists and social workers has been left out. Yet, the reality is that health teams are present in a variety of care settings and are integral to providing good care. While the nursing perspective has not been part of the PAD conversation, it has much to contribute to the issue.

Part of the assessment process to confirm that the patient requesting PAD is competent is ensuring that the consent to PAD is voluntary. Once a person makes a request for PAD, a critical element is having continuous and meaningful opportunities for communication with the patient. Having an interprofessional team that undertakes this very important process is essential. Nurses need to be part of this team. Their independent assessment is vital.

It is important to note that assisted death is not just an act. It is a care process. It begins right from the time the patient says they are considering such a request, and it continues until death or until the patient changes their mind. Thus, it is a relational process that occurs over time. Nurses play a crucial role in this relational process. They play an important part in verifying the authenticity of the patient’s request (i.e., that a person’s request is really a desire for assisted death and no coercion is involved) by virtue of their consistent presence with patients and families in general and, more specifically, their experience during end-of-life care and their clinical skill of interpretation.

Nurses have a great deal of experience with these requests, with putting them into context and with understanding what they really mean. Nurses are adept at understanding what brings a patient to this point, what their story is and what the dynamics of the family are. They have the expertise to see a request motivated by fear of pain, abandonment or some other concern, such as lack of financial resources or the worry of being a burden to loved ones.

This level of understanding comes through skilful questioning of the patient — for example, through the use of different words to see if one gets the same answer (while documenting this process) or going back to see if the answer is consistent and does not waver the next day(s) to ensure the patient was not in a temporary phase of wanting death. It is also important to have more than one health-care provider hear the answers and to have health-care providers across disciplines asking the questions (such as...
physicians, nurses, social workers, psychologists, psychiatrists, pastors) while using different lines of inquiry. This process serves to provide important checks and balances.

The process should also involve team members who are in frequent communication with their colleagues (e.g., asking “How does this resonate with what you heard?”). It’s a group process of engagement and collective interpretation, and it may include challenges to one other (e.g., “She said X to you, but that is not what I heard.”). This way of approaching requests for PAD allows the team to get the best sense of how to proceed.

Ensuring that nurses receive legal protection when caring for patients who have requested PAD
As noted above, the Carter case provides legal protection to physicians involved in PAD, so they can practise without risk of criminal prosecution. The role of the nurse and nurse practitioner also needs to be recognized, articulated and protected in law. This will safeguard the quality of care a patient receives.

Indeed, it is important to note that some settings are not physician-led (other healthcare providers have the primary role). In the case of nurse practitioners, careful consideration is warranted. Nurse practitioners have additional educational preparation and expertise. They carry their own caseload of patients and sometimes are the healthcare provider with the most contact with patients. Many nurse practitioners work in areas where they are the sole practitioners.

As a means of ensuring access in some communities, there may be a potential role for the nurse practitioner to prescribe medications for PAD. As CNPS noted in their submission, “Should one or more nursing regulatory body eventually determine that the nurse practitioner could, acting within her scope of practice, provide medical assistance in dying, such a nurse would also be vulnerable to criminal prosecution (p. 9).”

Ensuring health-care providers involved in PAD have the proper skills and access to information, resources and support
An important safeguard is ensuring that health-care providers who are involved in PAD practise competently and ethically. Providing the proper educational resources, information and supports are key. For example:

- Educational materials to ensure health-care providers have the information they need to understand what the law means, what the options are for a patient and what the process is for PAD. In this way, they can provide proper information to patients who ask questions. A hotline that offers health-care providers information about what the law/regulations mean would be helpful.
- Educational materials and courses that foster strong communication and interview skills, so a health-care provider can understand and verify the motives of a person who requests PAD and ascertain if there are gaps where support is needed during the assessment process.
- Education that fosters expertise in pain/symptom management so nurses and other health-care providers can assess, articulate and advocate for a patient whose symptoms are not being addressed.
Education that cultivates a strong foundation in ethical principles and moral guidance, so health-care providers have a good knowledge of issues/implications and access to guidance in specific situations. In addition, it would be important for nurses and other health-care providers to have access to ethical support, via clinical ethicists and experts, to help them navigate difficult issues.

Psychological support for health-care providers, so burnout does not occur, is key. For example, in hospice care models, psychologists sit with the nursing team and debrief with them about any experiences they found to be traumatic. This process helps to sustain them in their practice. Supports are especially needed for those working in rural and remote areas.

A process that enables health-care providers to follow their conscience is essential, should they feel PAD conflicts with their moral/religious beliefs. The CNA code of ethics (2008) emphasizes that “employers and co-workers are responsible for ensuring that nurses and other co-workers who declare a conflict of conscience receive fair treatment and do not experience discrimination” (p. 46). At the same time, health-care providers cannot abandon a patient and must arrange for alternative care, which is also in keeping with the CNA code:

the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person’s needs or desires. . . . When a moral objection is made, the nurse provides for the safety of the person receiving care until there is assurance that other sources of nursing care are available. (pp. 44-45)

We have heard that the concrete guidelines outlined in our code are highly useful to nurses and employers (see pp. 44-46, https://www.cnaaic.ca/~/media/cna/page-content/pdf-fr/code-of-ethics-for-registerednurses.pdf?la=en).

Teachings on PAD should be part of nursing and medical students’ curriculums and part of health-care providers’ ongoing professional development.

Ensuring patients who request PAD, and their families, have access to information, resources and support

Another important safeguard is ensuring that patients who request PAD, along with their families, are fully informed and supported during the process. For example:

Patients have the right to be fully informed about their health condition, to know what to expect and to have reliable and unbiased information, so they have a good understanding of the options/alternatives available to them (e.g., comfort care, palliative and hospice care, pain and symptom control) aside from PAD.

Counselling and/or spiritual support is an important additional resource that should be offered to a patient (and his/her family) contemplating such a momentous decision as PAD.

A waiting/cooling-off period is important to allow time and space for patients to think about their options and discuss them with their family. It is important that this process not be rushed. Time is also crucial to allow for modifications in treatment (e.g., for counselling or adjustments of medication to decrease pain and suffering)
that may assist with a patient’s situation and affect their perspective. In cases of terminal illness, where time is of the essence, a shorter timeline might be considered. Here, given potential system constraints, advocacy efforts are needed to ensure equity and timely access for patients requesting PAD.

- For patients that pursue PAD, it is important that they always feel they can opt out at any time. They need to be told, even during the actual process, that it is not too late to change their mind (this should also be documented).

**Ensuring a pan-Canadian approach regarding end-of-life care and PAD**

Instituting a pan-Canadian approach to end-of-life care and PAD is valuable and a critical safeguard. For example:

- A pan-Canadian approach that helps patients be clear about and have access to all the options/alternatives to PAD, while enabling them to receive consistent and accurate information about the process of PAD, would be enormously beneficial.

- A national oversight body for PAD to promote a uniform standard of care and practice and ensure consistency of data monitoring and reporting is also essential. In this way, trends (including adverse events) can be tracked and analyzed and provide a solid picture of what is happening in Canada with respect to PAD. Further, such an approach would allow PAD to be evaluated and ensure it is being provided in a safe, competent and ethical manner.

- A pan-Canadian approach that would ensure equal access to PAD for all eligible Canadians is key. Patients should be able to access PAD without having to leave their home community, since most people wish to die at or close to home. Unique implementation issues with respect to accessing PAD in certain communities will need to be thought through. Furthermore, it will be important to strengthen home care, as there is currently no standardized approach. The uneven level of services across the provinces/territories may challenge our efforts to implement PAD at home.
CONCLUSION

Nurses are intimately involved in end-of-life care processes, including decision-making, and are therefore in a favourable position to develop therapeutic relationships with patients and their families and to work collaboratively with all members of the healthcare team. Our comments reflect this specialized knowledge and experience and offer an assessment through the lens of CNA’s code of ethics. CNA’s consultation with experts in the field highlight the importance of recognizing nurses and other members of the interprofessional health-care team who are involved in PAD.

We thank the special joint committee on physician-assisted dying for the opportunity to provide input on this important issue and hope our comments will inform its work.
REFERENCES


Appendix C

Letter from the Co-Chairs

On behalf of our colleagues on the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group), we are pleased to submit this report of final key recommendations to the eleven participating provinces and territories, via the Ontario Minister of Health and Long-Term Care and Attorney General.

We have done our best, under challenging time constraints, to consult with as many stakeholder groups and individual experts as possible. Although physician-assisted dying is legal in many other jurisdictions, we believe we have come up with recommendations that will create a uniquely Canadian approach to this important issue.

The recommendations included are based on the best available evidence and the diverse expertise of the Advisory Group members.

Thank you for the opportunity to provide advice on this important issue.

Sincerely,

Dr. Jennifer Gibson         Maureen Taylor
Co-Chair                   Co-Chair
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The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying wishes to acknowledge the 11 provinces and territories that came together with a vision of creating a pan-Canadian approach to physician-assisted dying. These partners provided vital support and feedback to our secretariat throughout the process and it has been a highly collaborative and rich experience.

We would especially like to thank the secretariat provided to us by the Ontario Ministry of Health and Long Term Care (MOHLTC) and the Ministry of the Attorney General. This team of bright individuals worked long hours, evenings and weekends, to coordinate, research, strategize and keep us to deadline. It cannot be easy to follow the track changes of nine editors, but they managed this without complaint. We are grateful for their patience, their guidance and their dedication.

Finally, our work could not have been accomplished without the individuals and groups across Canada, who shared their time, expertise, and experience with us. Although we heard a diversity of views and perspectives on how physician assisted dying should be implemented, we also observed a tremendous generosity of spirit and willingness to engage, understand and bridge across differences.
20 years ago Sue Rodriguez asked “Whose body is this? Who owns my life?” Having been diagnosed with Amyotrophic Lateral Sclerosis, Rodriguez wanted the option of aid in dying when her suffering became unbearable. Her request to the Supreme Court of Canada was denied by a narrow margin in 1993, but since then polls have consistently demonstrated growing public support for the option of medically-assisted death. The highly visible efforts of Canadians such as Gloria Taylor, Kay Carter and Dr. Donald Low, to exercise control over their lives and deaths have contributed to a seismic shift – both legal and social – in our country’s approach to end-of-life decisions.

The Government of Quebec took the lead on this issue, launching extensive public consultations and non-partisan discussions which resulted in Bill 52 – An Act respecting end-of-life care. In Québec, physicians will start offering qualifying patients the option of medical aid in dying in December 2015. The rest of Canada will not be far behind.

On February 6, 2015, the Supreme Court of Canada rendered its decision in Carter v Canada (Attorney General) (“Carter”).

The Supreme Court unanimously struck down the Criminal Code prohibitions against assisted dying to the extent that they prohibited physician-assisted dying for a competent adult person who (1) clearly consents and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The Court held that the prohibition on physician-assisted dying deprived the claimants and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person. The Court further held that this prohibition was overbroad and could not be justified in a free and democratic society.

The declaration of invalidity was suspended for 12 months (until February 6, 2016) to allow federal, provincial and territorial governments to respond, should they so choose, by enacting legislation consistent with the parameters set out in the Supreme Court’s decision. Complementing any potential federal response, each province and territory must decide whether to enact legislation and/or adopt policies to clarify the rules affecting the provision of physician-assisted dying in its jurisdiction in light of the Supreme Court’s decision.

Stakeholders hold diverse opinions on physician-assisted dying. While the majority of Canadians are supportive of the Carter decision, the idea of physician-assisted dying remains ethically challenging for some. As well, important values are at stake (and potentially in conflict) with respect to various elements that comprise the proposed regulatory framework for physician-assisted dying. Acknowledgement of the differing ethical positions on physician-assisted dying in general and a careful ethical analysis of specific issues related to implementation must accompany the development of any policies, legislation and regulations.

Participating jurisdictions include: Alberta, British Columbia (as an observer), Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Saskatchewan, and Yukon.

A federal External Panel, established to provide options for a federal legislative response to *Carter*, was recently asked to deliver a report by December 15, 2015, outlining feedback received to date, but without any policy advice or legislative recommendations. With this in mind, our report includes recommendations that ask provinces and territories to advocate for certain changes to federal legislation.
4.2.2.1 Overview of Recommendations

The Advisory Group is grateful to the large number of individuals and groups from across the country who shared their time, expertise, experience and advice with us as we developed our final recommendations. Below we provide an overview of our key recommendations.

Physician-assisted dying is a critical social policy issue for our generation. We believe strongly that the introduction of physician-assisted dying should be part of a larger discussion about high quality and equitable access to end of life care in Canada. Specifically, we recommend that provincial, territorial and federal governments should work together to develop a pan-Canadian strategy for palliative and end-of-life care. This strategy would include physician-assisted dying as part of a continuum of services and supports to Canadians at the end of life.

Effective February 6, 2016, all provinces and territories must ensure access to physician-assisted dying. Provinces, territories, and the federal government, along with professional regulatory authorities, should work together toward the common goal of a harmonized, effective, and equitable regulatory framework for physician-assisted dying. This will involve an array of actions by a variety of government, regulatory, institutional and professional actors detailed in our report. A strong legislative response is essential.

Although the *Carter* decision refers only to physician-assisted dying, and we adopt this term in our report, the Advisory Group feels strongly that other health professionals – notably nurse practitioners, registered nurses and pharmacists – will need to be involved in the process of physician-assisted dying. Given increasing emphasis on interprofessional team practice as a standard of care in some settings, consideration of other health professionals will be necessary to ensure equal access and high quality of care. This is reflected in our recommendations.

Our recommendations place the patient at the centre. We have outlined a pathway for the provision of physician-assisted dying, including who should have access, how patients may request physician-assisted dying, how eligibility criteria should be assessed, and where physician-assisted dying may be provided. We recommend safeguards to protect vulnerable populations, including those who may face social factors that may impair a patient’s ability to make a truly autonomous choice. These safeguards include assessment by two physicians, reflection to ensure all eligibility criteria are met, robust assessment of competency and consent, and a witnessed patient declaration form that serves as a formal request for physician-assisted dying.

The *Carter* ruling underscored the need to reconcile the interests of patients and providers. As we explain in this report, health care providers have the freedom to object to the provision of physician-assisted dying for reasons of conscience, but they are required to provide information about all end-of-life options, including physician-assisted dying. Conscientiously objecting health care providers are also required to either provide a referral, a direct transfer of care to another health care provider, or to contact and transfer the patient’s records through a third party, agency or service which would have a duty to ensure the safe and timely transfer of care of the patient to a non-objecting provider.

Health institutions, including regional health authorities and other institutional providers (e.g., hospitals, hospices and long-term care facilities) are critical enablers of effective and equitable access to physician-assisted dying. Non-faith-based institutions should have an obligation to provide physician-assisted dying.
assisted dying and faith-based institutions should have an obligation to either provide physician-assisted dying or make arrangements for a safe and timely transfer of the patient to a non-objecting institution. Regardless of how the process unfolds, we believe that there must be continuity of care for the patient.

It is essential for a properly functioning regulatory framework that there is robust and independent oversight: to monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. We recommend two levels of oversight: a Review Committee at the provincial/territorial level and a pan-Canadian Commission on End-of-Life Care at the national level.

Finally, physician-assisted dying is new to Canada. There is a need to build and sustain effective capacity, including through research and continuing quality improvement, health professional education and training, and public education and engagement.
### 4.2.3 List of Recommendations

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<td><strong>End-of-Life and Palliative Care</strong></td>
<td>Recommendation 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.</td>
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<td><strong>Collaboration and Coordination</strong></td>
<td>Recommendation 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.</td>
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| **Access**                                  | **Critical Enablers of Access to Physician-Assisted Dying**  
Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.  
Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.  
Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying.  
Recommendation 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing.  
Recommendation 7: Provinces and territories should request that the federal government amend the *Criminal Code* to explicitly protect those health professionals who provide |
Section/Sub-Section | Recommendations
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 | supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying.

Recommendation 8: Provinces and territories should request that the federal government amend the *Criminal Code* to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying.

Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

Recommendation 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.

Pathway to Provision
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<td>Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.</td>
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<td>Recommendation 12: Provinces and territories should request that the federal government make it clear in its changes to the <em>Criminal Code</em> that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.</td>
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<td>Recommendation 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid.</td>
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<td>Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.</td>
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<td>Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.</td>
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<td>Recommendation 16: To support case review and system oversight, data should be collected from the patient’s initial request to the time of signing the death certificate and/or the completion of that patient’s request (e.g., patient withdrawal of request, physician denial of requests).</td>
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Assessment of Eligibility

Recommendation 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the *Criminal Code* that eligibility for physician-assisted dying is to be based on competence rather than age.

Recommendation 18: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

Recommendation 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural safeguards have been respected.

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<td>Recommendation 20: Physicians should use existing processes in the health care system to assess competency and consent.</td>
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<td>Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publiclyfunded health services.</td>
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### Review

**Recommendation 22:** Two physicians must assess the patient to ensure that all criteria are met.

**Recommendation 23:** Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment.

**Recommendation 24:** For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used.

**Recommendation 25:** We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.

### Provision

**Recommendation 26:** We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.

**Recommendation 27:** Physician-assisted dying should be available wherever patients live (including in hospitals, long-term care facilities and at home), except certain conscientiously objecting facilities.

**Recommendation 28:** There should be no requirement that a physician be present at a self-administered assisted death.
| Reporting | Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death. |

| Role of Conscientiously Objecting Health Care Providers | Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.

Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner. |

| Duty to Care for the Patient | Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient’s records through the system described in Recommendation 4. |

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<td>Role of Institutions</td>
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| **Duties of Institutions** | Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.  
Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.  
Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way. |
<p>| <strong>Duties of Non Faith-based Institutions</strong> | Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities. |
| <strong>Duties of Faith-based Institutions</strong> | Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory. |
| <strong>Oversight</strong> | Recommendation 39: Provincial and territorial governments should establish a Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability. |</p>
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<td>Recommendation 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-Life Care to provide system oversight and to report to the public.</td>
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<td>Research and Continuing Quality Improvement</td>
<td>Recommendation 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.</td>
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<td>Health Professional Education and Training</td>
<td>Recommendation 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.</td>
</tr>
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<td>Public Education and Engagement</td>
<td>Recommendation 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.</td>
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5.1 Advisory Group
Mandate

Our mandate is to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to physician-assisted dying. The advice is meant to assist provinces and territories in deciding what policies and procedures should be implemented within their jurisdictions in response to the Supreme Court’s decision in *Carter*.

In developing our recommendations, our starting point was the *Carter* decision and we have (to the best of our abilities) provided recommendations that are consistent with the *Criminal Code*, the Canadian *Charter of Rights and Freedoms*, provincial/territorial Human Rights Codes and other applicable laws. We reviewed key health care policy questions related to, among other issues, eligibility criteria, conscientious objection, procedural safeguards, access and oversight. As part of this review, we invited written submissions from key stakeholder groups in the fields of health care, law and ethics, and from a range of patient, professional, regulatory and health care provider perspectives. We also sought extensive additional input and advice from targeted experts and stakeholders.

We recognize that provincial and territorial governments will retain final decision-making authority over whether to accept our recommendations and how physician-assisted dying should be implemented within their respective jurisdictions. This advice is not binding on participating or non-participating jurisdictions, and each government will maintain its authority to respond to the *Carter* decision as it deems appropriate.
5.1.1 Composition

Advisory Group members hold a wide variety of positions on physician-assisted dying and bring a range of professional expertise on key clinical, legal and ethical issues (see Appendix 1 for full biographies).

Jennifer Gibson (Co-Chair) - Director of the University of Toronto Joint Centre for Bioethics and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto

Maureen Taylor (Co-Chair) - Physician Assistant in Infectious Diseases and Medical Journalist

Doug Cochrane - Patient Safety and Quality Officer for British Columbia and Chair of the BC Patient Safety and Quality Council

Jocelyn Downie - Professor in the Faculties of Law and Medicine at Dalhousie University

Ruth Goba – Human Rights Lawyer/Commissioner, Ontario Human Rights Commission

Nuala Kenny - Professor Emeritus of Bioethics at Dalhousie University and Former Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada

Arthur Schafer - Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Trevor Theman - Registrar of the College of Physicians & Surgeons of Alberta

Karima Velji - President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London
5.1.2 Process

The Advisory Group conducted its work from late August to November 2015. This included four face-to-face meetings in Toronto and numerous teleconferences. Our work was informed by background briefings on physician-assisted dying and significant stakeholder engagement.
5.1.2.1 Background Briefings

Background briefings included:

• a legal analysis of the Supreme Court decision and a review of the division of powers with respect to law and health care between Canada’s federal government and its provinces and territories;
• a comparative analysis of the implementation of physician-assisted dying internationally in Belgium, the Netherlands, Luxembourg, Switzerland, Oregon, Washington State and Vermont;
• a literature synthesis on key issues related to physician-assisted dying; and
• a review of publicly-accessible policy documents regarding physician-assisted dying from Canadian provider and other stakeholder groups.
5.1.2.2 Stakeholder Engagement

The Advisory Group engaged a broad range of stakeholder perspectives in two phases. In the first phase, we invited over 250 stakeholder groups in September 2015 to complete written submissions on a wide range of issues related to the implementation of physician-assisted dying in Canada. Invited stakeholders included: provider associations, professional regulators, faith-based groups, patient, social, and legal advocacy groups, health institutions, and academic and other groups (see Appendix 2 for a list of stakeholders consulted). Stakeholders provided input and advice on issues related to:

- eligibility criteria;
- procedural safeguards;
- the role of physicians and other health care providers;
- conscientious refusal by health care providers;
- the role of institutions;
- access issues;
- settings for the provision of physician-assisted dying; and
- case review and system oversight.

In the first phase, we also met with representatives from the Government of Québec to learn about that province’s experience with public and stakeholder consultations, crafting legislation, and working with health care professionals, facilities and others on the implementation of physician-assisted dying, and with the Governments of Nunavut, Yukon and the Northwest Territories to gain an understanding of the unique issues of the northern territories regarding the implementation of physician-assisted dying.

In November 2015, the Advisory Group conducted a second phase of consultations to clarify specific implementation issues. The Advisory Group invited panel discussions (in-person or by phone) with experts and national stakeholders over two days in Toronto. These sessions brought together stakeholders with divergent positions on the implementation of physician-assisted dying and created an opportunity for meaningful dialogue between those holding conflicting views.
5.1.2.3 Deliberations

The Advisory Group comprised a diversity of perspectives on physician-assisted dying, which we sought to reconcile through our deliberations in light of the background briefings and stakeholder input. In some cases, this involved re-considering and sometimes putting aside deeply-held personal views to find common ground in the interest of Canadian patients and the public.

These recommendations represent our best advice for implementing a comprehensive system to respond to the decriminalization of physician-assisted dying in Canada.

We acknowledge that our recommendations will have to be revisited and may need to be revised upon action taken by the federal government in the near future. We urge provinces and territories to work closely with the federal government, with each other and with health professional regulatory authorities to ensure an efficient approach to planning, communication and implementation, as well as a harmonized regulatory framework. It is the Advisory Group’s firm belief that synchronized regulation of physician-assisted dying is critical to the public interest.

We also recognize that time constraints may impede the full implementation of some recommendations by February 2016. However, we believe that it is incumbent upon provinces and territories to put in place a regulatory framework by February 2016 that best protects those who are vulnerable and ensures access for those who are eligible for physician-assisted dying.
5.2 Legal Context
5.2.1 Supreme Court Decision

Our recommendations were developed in response to the Supreme Court’s decision in *Carter*. In its decision, the Court held that “Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.” Where the above-noted criteria are met, the *Carter* ruling serves as an exception – for physician-assisted dying – to the general prohibitions in the *Criminal Code* against aiding and abetting a person to commit suicide and consenting to having death inflicted upon them.

It is notable that the Supreme Court did not limit the ruling to those unable to take their own lives, to cases of terminal illness, or to people near death. The Court’s declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness.

The Supreme Court agreed with the British Columbia Supreme Court that the risks sometimes associated with physician-assisted dying – especially the potential risks to vulnerable people – “can be limited through a carefully designed and monitored system of safeguards.” Although the Supreme Court did not outline the framework for such a system in the *Carter* decision, it expressed confidence that such a system could be implemented in Canada.

The Court noted that “nothing in its decision would compel physicians to provide assistance in dying”, but also said that “the *Charter* rights of patients and physicians will need to be reconciled.” The Court expressly left open the question of how to reconcile the rights of patients who seek physician-assisted dying with the religious or conscientious objections of physicians to participate in it. The Court was silent on the issue of whether institutions have any right to refuse to allow the provision of physician-assisted dying or otherwise participate in the provision of physician-assisted dying.

Several key terms were also left undefined in the Court’s decision, including “adult” and “grievous.” While the Court did not explicitly define “irremediable”, the Court did clarify that “irremediable… does not require the patient to undertake treatments that are not acceptable to the individual.”
5.2.2 Division of Powers

It is important to understand the federal and provincial/territorial division of powers to appreciate fully the context of our recommendations and any possible provincial/territorial action on physician-assisted dying.

In Canada, health is an area of shared federal and provincial/territorial jurisdiction. The federal Parliament may enact laws in relation to health care under its criminal law power (e.g., restricting controlled drugs, prohibiting certain practices). The provinces and territories, on the other hand, may legislate in relation to health care with their powers over health insurance, the regulation of health professions, and hospitals.

If there is no inconsistency between a valid federal law and a valid provincial/territorial law relating to health, then both laws apply. In the event of an inconsistency between a valid federal law and a valid provincial/territorial law, the federal law applies and the provincial/territorial law is inoperative to the extent of the inconsistency. “Inconsistency” in this case means either that there is a conflict in operation between the two laws (e.g., the federal law says a person must do something while the provincial/territorial law says the person must not do that thing) or that the provincial/territorial law frustrates the purpose of the federal law.

The federal Parliament may (subject to the Charter) use its criminal law power to stipulate the circumstances under which physician-assisted dying is permitted and to prohibit physician-assisted dying in other circumstances. Provinces and territories cannot enlarge or restrict the circumstances in which physician-assisted dying is permitted beyond those validly provided for by Parliament. The criminal law power allows Parliament not only to enact prohibitions, but also gives Parliament a measure of regulatory authority as well. However, because there are some health matters of exclusive provincial jurisdiction, there is a limit to how detailed or “regulatory” the federal law can be. As outlined in the Supreme Court’s reference to the Assisted Human Reproduction Act, criminal laws for the protection of health must address a “legitimate public health evil” rather than merely set uniform national standards for otherwise-beneficial medical activities. Parliament could establish physician-assisted dying rules aimed at reducing a risk of serious harm (e.g. rules ensuring that consent is unambiguous), but could not set medical standards unrelated to any risk of harm (e.g., Parliament could not regulate the referral or transfer-of-care obligations of physicians who object to physician-assisted dying on religious or conscientious grounds).

It is not possible to identify in the abstract a “bright line” past which valid federal criminal law turns into an invalid interference with provincial control over health. If the federal government sought to enact detailed regulations concerning the practice of physician-assisted dying (e.g., prescribing only certain permissible methods or drugs to be used in carrying out physician-assisted dying), it would need to be able to respond to any legal challenge to its regulatory authority by demonstrating with persuasive evidence that such regulations were aimed at addressing a legitimate public health evil. Provided that provincial/territorial laws were not inconsistent with valid federal legislation or with the Charter, provinces and territories could regulate aspects of physician-assisted dying not prohibited by federal law. For example, provinces and territories could enact legislation to regulate in relation to at least:

- eligibility (including rules regarding who may determine eligibility);
• determining competency and obtaining consent;
• safeguards to protect the vulnerable;
• settings in which physician-assisted dying is permitted;

• provider participation, including health institutions and both physicians and non-physician health professionals;
• means of delivery of physician-assisted dying;
• insurance (life and professional liability);
• certification of death; and
• reporting requirements and quality review.
5.3 Statement of Principles and Values

In developing our recommendations, we relied on a number of principles, values and existing rights, freedoms, responsibilities and obligations that exist in our health care systems. Some of these are enshrined in the *Charter of Rights and Freedoms* or provincial/territorial Human Rights Codes, while others are expressed in the Codes of Ethics of health care provider organizations. They all informed our work and form the basis for the recommendations in this report.
5.3.1 Individual and Institutional Rights and Duties

- The right to patient autonomy in end-of-life care decision-making
- The rights of freedom of conscience and religion
- The duty of health care providers to care for patients and not abandon them
- The right of Canadians to equitable access to health services
- The right to protection from discrimination as outlined in provincial Human Rights Codes
- The right to privacy
- When rights conflict, they must be reconciled
5.3.2 Pan-Canadian Principles

- Physician-assisted dying is one option in the end-of-life care continuum
- Canadians need access to high-quality palliative and end-of-life care
- Canadians need a harmonized system across the country
- Health care providers need clear guidance on rules, regulations and reporting requirements
- Transparency should be an ongoing goal whenever possible

In developing our recommendations, we also relied upon a set of beliefs with respect to regulation.

We believe that there are three critical actors in the regulatory system for physician-assisted dying: the federal government, the provincial/territorial governments, and the health professional regulatory bodies.

We believe that harmonization of regulation across jurisdictions is critical to the public interest and that an effective and efficient oversight system is essential to ensure responsible governance and trust in the regulatory system. A weak regulatory system would fail to meet the reasonable expectations of Canadians, including patients seeking physician-assisted dying and their loved ones.

We believe a strong legislative response is needed to ensure access to physician-assisted dying for all individuals who meet the eligibility criteria, to ensure that physician-assisted dying is provided only to individuals who meet the eligibility criteria, and to reconcile the sometimes competing interests of health care providers and institutions and patients (see Appendix 3 for a full list of recommendations that the Advisory Group believes should be implemented through provincial/territorial legislation). We also believe that health professional regulatory authorities will play a critical role in the implementation of physician-assisted dying and their role in implementation will help to integrate physician-assisted dying into existing end-of-life processes and mechanisms (as much as possible and consistent with the physician-assisted dying legislation).

We believe that intergovernmental and cross-jurisdictional collaboration is essential. Of significance is the willingness by the new federal government to work collaboratively, as expressly set out in the Mandate Letter of the federal Minister of Justice, which urges the Minister to “lead a process, supported by the Minister of Health, to work with provinces and territories to respond to the Supreme Court of Canada decision regarding physician-assisted death.” We strongly encourage the provinces and territories to take up this invitation. Physician-assisted dying rests at the intersection of jurisdiction between the federal and provincial/territorial governments, as well as at the intersection of jurisdiction between the provincial/territorial governments and the professional regulatory authorities. Where there is a legitimate argument to be made that jurisdiction is shared or overlapping, we take the view that regulation should happen at the level with the greatest capacity for harmonization across the country, accountability, efficiency, and capacity for effective enforcement.

We believe the following three features are at the core of our call for a pan-Canadian regulatory framework:

1. Core elements established through the Criminal Code;
2. Additional procedural safeguards and provisions to ensure access established through provincial legislation (preferably based on a single model statute); and
3. Additional guidance for health care professionals established through their regulatory authorities (preferably based on model standards and guidelines developed collaboratively by the regulatory authorities).

Finally, we believe that physician-assisted dying should be integrated into existing end-of-life processes and mechanisms as much as possible. When faced with offering a new service, it can be tempting to create new systems to accompany the service. While physician-assisted dying is unique in some ways, it is also similar in many ways to existing procedures and can and should be treated as such. Physician-assisted dying should be treated as one appropriate medical practice within a continuum of services available at the end-of-life. Where we recommend different or additional processes or mechanisms, it is because we have concluded that they are necessary to appropriately balance the competing interests and values at stake and to ensure that the regulatory framework assures the trust of Canadians.
RECOMMENDATIONS
RECOMMENDATION 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.

Canadians need better access to quality palliative and end-of-life care, and should be made more aware of the options currently available to them. These were common refrains in the written submissions we received, the face-to-face consultations we conducted, and during our own deliberations.

Many provinces and territories have long been working to improve access to quality palliative and end-of-life care within their own jurisdictions. The Advisory Group strongly recommends that this work be expedited and that provinces and territories develop and implement a pan-Canadian strategy to ensure consistent standards and adequate resources for meeting what should be a national priority.

We also heard some stakeholders suggest that a patient could not truly give free or properly informed consent to physician-assisted dying without first being aware of and having access to adequate palliative care. The Advisory Group understands that the validity of patient consent lies at the heart of the assessment of eligibility for physician-assisted dying and that lack of access to quality palliative care might, in some specific cases, threaten various elements of a valid consent. However, withholding physician-assisted dying from everyone until palliative care is available and offered to all is not the appropriate response, as it denies those who are eligible the right to die in the manner they choose. Instead, society should work tirelessly to improve access to quality palliative care and health care providers should ensure that, in each individual case, any consent to physician-assisted dying is free and informed and made by a competent individual within the constraints of the system.

Despite our recognition of the importance of a pan-Canadian strategy for palliative and end-of-life care, we do not believe the implementation of physician-assisted dying should be delayed. We believe that a better approach is to ardently promote palliative care while ensuring that health care providers are aware of the potential concerns related to patient consent (to physician-assisted dying) and are equipped to effectively address these concerns while respecting patient autonomy. Better palliative care should not be seen as a pre-condition for the development of a system that permits physician-assisted dying, but rather as a complement to improved end-of-life care.
6.2 Collaboration and Coordination

**RECOMMENDATION 2:** Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.

Many stakeholders who spoke to the Advisory Group were concerned about the uncertain impact of physician-assisted dying on the health care system and the negative consequences for patients and the public of a patchwork of approaches across the provinces and territories. The introduction of physician-assisted dying across Canada will inevitably raise issues that cannot easily be anticipated by government working alone. Early and active engagement with all impacted areas of the health care system will be required to identify and resolve these issues quickly.

The Advisory Group believes that the successful introduction of physician-assisted dying in Canada will require coordinated action by a number of organizations and institutions with various responsibilities within our health care systems. Provinces and territories should reach out to these groups immediately to ensure that all policies and planned changes within each jurisdiction are well-aligned and understood and that gaps and challenges are identified as quickly as possible. Key stakeholder groups include health care provider associations, health care facilities and institutions, insurers, the Canadian Institute for Health Information, the Vital Statistics Council of Canada, clinical specialty groups, academic institutions (e.g., faculties of medicine, nursing and pharmacy), and accreditation bodies.

We direct the attention of provincial/territorial governments to the actions around which collaboration and coordination is necessary to create a comprehensive system for physician-assisted dying (See Figure 1).
6.2.1 Figure 1. Necessary Activities of Other Organizations and Institutions

<table>
<thead>
<tr>
<th>Health Authorities</th>
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<tr>
<td>• Develop plans for enabling access (e.g., privileges, payment, managing transfers of care)</td>
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<tr>
<th>Associations of Health Care Institutions</th>
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<tr>
<td>• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law</td>
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<th>Health Institutions</th>
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<td>• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law</td>
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<tr>
<td>• If faith-based and objecting to physician-assisted dying, develop plan for transfer of patients to another institution</td>
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<th>Professional Associations</th>
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<tr>
<td>• Revise Codes of Ethics to be consistent with the law</td>
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<tr>
<th>Specialty Clinical Groups (e.g., Critical Care, Family Medicine, Palliative Care)</th>
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<tr>
<td>• Develop clinical practice guidelines for physician-assisted dying</td>
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<tr>
<th>Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, and analogous bodies for Registered Nurses (including Nurse Practitioners) and Pharmacists</th>
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<tr>
<td>• Develop physician-assisted dying competencies</td>
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<td>• Develop physician-assisted dying education programs</td>
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<th>Accreditation Bodies</th>
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<td>• Develop standards regarding physician-assisted dying for professional schools (e.g., Medicine, Nursing, Pharmacy)</td>
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<tr>
<td>• Develop standards regarding physician-assisted dying for health care institutions</td>
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<th>Professional schools (e.g., Medical, Nursing, Pharmacy, Social Work, Law, etc.)</th>
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<tr>
<td>• Develop undergraduate, postgraduate, and continuing education curricula and materials on clinical, legal, and ethical aspects of physician-assisted dying</td>
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<td>• Revise “agreed data set” for reporting to the Canadian Institute for Health Information</td>
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<td>• Develop data access plan for Review Committees and researchers</td>
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<tr>
<th>Canadian Institute for Health Information</th>
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<tr>
<td>• Design data collection and access systems to flow information from governments to researchers in consultation with Canadian researchers as well as researchers who conduct the regular studies in permissive jurisdictions</td>
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<th>Insurers (Health Professional Liability Insurers, and Life and Health Insurers)</th>
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<tr>
<td>• Develop explanatory materials regarding life insurance coverage</td>
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<td>• Develop explanatory materials regarding liability insurance coverage for health professionals</td>
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6.3 Access
6.3.1 Barriers to Access

During our stakeholder consultations, we learned that there are many reasons why patients within the same province or territory might not have equitable access to the same health services, some of which are common to many health care services and some of which may be unique to the provision of physician-assisted dying.

Representatives of territorial governments and northern/remote communities repeatedly raised the issue of geography and the uneven distribution of health care professionals. Rural communities can also suffer from inadequate health infrastructure or resources. These access issues are not unique to the provision of physician-assisted dying. Indeed, we anticipate that the challenges already associated with the delivery of adequate health care in certain areas of the country will present themselves with the introduction of physician-assisted dying as well.

The introduction of physician-assisted dying brings with it the possibility of unique barriers to access. These may include inadequate training of health professionals on its appropriate implementation, fear of legal liability among physicians and other health professionals, and issues of conscience. Some stakeholders raised the possibility that cultural factors may affect access to physician-assisted dying in some settings and fear of social stigma in small communities may dissuade health care professionals from participation in the procedure. Other impediments to access may include language barriers, concerns about professional liability insurance or life insurance policies, and the costs of physician-assisted dying services.
6.3.2 Critical Enablers of Access to Physician-Assisted Dying

In this section, we recommend a series of critical enablers of access that are specific to physician-assisted dying. However, we believe it is important to recognize that ongoing attempts to improve access to an array of health care services and supports will also help to provide effective access to physician-assisted dying.

**RECOMMENDATION 3:** All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

**RECOMMENDATION 4:** Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Physician-administered and self-administered physician-assisted dying is ultimately a communal responsibility of society, governments and health care professions. It should never rest solely on the shoulders of individual health care providers or facilities. The burden of finding a physician or institution that is willing to assess and ensure eligibility and provide access to physician-assisted dying should never fall to the patient alone, regardless of their geographic location or whether they are in a hospital, hospice, or engaging with another part of the health care system.

We recommend the creation of a publicly-funded care coordination system to link patients with an appropriate provider of physician-assisted death. This system must be given the resources and legal authority necessary to ensure that patients do not face access barriers because of geography or physician supply or objection. This system would ensure that people in rural and remote communities have equitable access to physician-assisted dying (e.g., through physician visits and/or telemedicine services) and that those without a current primary care provider or with a conscientiously objecting physician still have the opportunity to receive care from a provider who will consider their eligibility for physician-assisted dying.

We recommend that this system be modelled on successful examples used in other health care services (e.g., cancer care, organ transplantation). We envision them as “patient navigators”, people who have an understanding of the field, knowledge of health care providers who are willing to provide physician-assisted dying to individuals who meet the eligibility criteria, and the interpersonal skills, resources, and legal authority to facilitate the transfer of care between health care providers (including the transfer of medical records so as to protect the identity of the health care providers accepting the patient). While the system’s initial role would be to connect patients to physicians and manage the transfer of patients, over time they may also assist with helping patients understand the range of end-of-life options available, including palliative care.
**RECOMMENDATION 5: Provincial/territorial governments should publicly fund physician-assisted dying.**

We believe that provincial/territorial governments should take steps to ensure that access to physician-assisted dying is not dependent on a patient’s ability to pay for the service. This will require that physician-assisted dying, including all aspects from counselling about end-of-life options to assessments and provision, are included as insured services under provincial and territorial health insurance plans.

**RECOMMENDATION 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing.**

Interprovincial billing agreements exist between provinces and territories for medically necessary insured hospital inpatient and outpatient services rendered in publicly-funded hospitals. All provinces and territories with the exception of Québec also participate in reciprocal billing arrangements for the payment of insured medically necessary physician services.

These agreements cover insured hospital and physician services for Canadians who are temporarily away from their province/territory of residence but are within Canada (e.g., travelling or on an approved absence for work or educational purposes). The agreements and the supporting billing system endeavour to ensure that the province or territory providing the service directly bills the patient’s home province or territory, and that the patient is not required to pay directly for health services (provided the patient presents a valid health card). A small number of procedures have been placed on an exclusion list for interprovincial reciprocal billing. Physician-assisted dying is not analogous to the other services on the exclusion list and so should not be on this list.

While we recommend that all provinces and territories have a policy of providing access to physician-assisted dying, we recognize that in order to provide access to physician and hospital services in some rural and remote northern and border communities, there may be reliance on out-of-province/territory patient transfers and the interprovincial billing arrangements that support the related physician and hospital services. In addition, some individuals may wish to move from one province or territory to another for the last weeks or months of their lives in order to be near loved ones and caregivers. The Interprovincial Reciprocal Billing Agreement should not be allowed to create a barrier to access to physician and hospital services for them.

Our overall goal in making Recommendations 5 and 6 is to ensure that physician-assisted dying is an insured service for all eligible patients within Canada who qualify for publicly-funded health services. These recommendations would also mitigate concerns about international medical tourism within Canada, while still recognizing that some Canadian communities may not have the capacity to offer physician-assisted dying to their own residents, and that some patients may wish to move elsewhere within Canada towards the end of their lives.
RECOMMENDATION 7: Provinces and territories should request that the federal government amend the Criminal Code to explicitly protect those health professionals who provide supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying.

Our health care systems function best when teams of providers with diverse skills and scopes of practice work together to provide the best possible care for patients. The Carter decision permits physicians to provide physician-assisted dying within the circumstances of the decision, but is silent on the role of other health professionals. To ensure that all health professionals can provide quality care within their scope of practice as part of a team-based approach, we recommend that the federal government provide additional clarity in the Criminal Code. These Criminal Code changes should ensure that health professionals can provide the support services they normally would, including but not limited to a pharmacist dispensing a prescription, a nurse drawing medication into a syringe, or a personal support worker giving a patient prescribed medication.

RECOMMENDATION 8: Provinces and territories should request that the federal government amend the Criminal Code to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying.

While Recommendation 7 deals with the invaluable role other health professionals should be allowed to play in supporting the provision of physician-assisted dying, this recommendation deals specifically with the provision itself. Nurse practitioners have independent scope of practice to assess the patient and prescribe medication when appropriate. Where access to physicians or nurse practitioners is limited other regulated health professionals (registered nurses or, if applicable, physician assistants), acting under the direction of a physician, should be able to write the prescription or give the injection without exposure to criminal liability.

Given that, in the Carter decision, the Supreme Court referred only to physician-assisted dying, it will be important for any Criminal Code amendments to explicitly permit regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners, to facilitate adequate access across Canada. Without this clarity, non-physician professionals would face uncertainty about their role and would potentially be exposed to liability for providing physician-assisted dying. It will be essential that provincial/territorial scope of practice legislation does not create barriers to these health professionals providing physician-assisted dying.

Throughout this report, our recommendations refer to physicians when discussing the provision of physician-assisted dying. If the Criminal Code changes advocated for in this recommendation are adopted, these recommendations should be read to include regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners.
**RECOMMENDATION 9:** Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

We view the appropriate protection of health care providers from liability as a way to promote access to physician-assisted dying. We heard from many stakeholder groups that if health professionals feel they are exposed to liability, they will be much less likely to provide physician-assisted dying.

This recommendation has two aspects. First, provinces and territories should ensure that necessary legislative or regulatory amendments are made to codify this protection. Health professionals who provide physician-assisted dying need to know that their participation will not expose them to liability as long as they are not negligent and act in good faith within the rules set out to support the implementation of physician-assisted dying. Second, provinces and territories should ensure that health care providers’ liability insurance does not discriminate against providers based on whether or not they provide physician-assisted dying. Provinces and territories should work with the Canadian Medical Protective Association and other insurers of health professionals, and make any necessary legislative or regulatory changes to ensure that liability coverage is not affected by whether the provider participates in physician-assisted dying.

**RECOMMENDATION 10:** Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.

Life insurance payments can be critically important to beneficiaries after a patient has died. Provinces and territories should ensure that beneficiaries do not have life insurance claims rejected solely on the grounds of the benefactor receiving physician-assisted dying.
6.4 Pathway to Provision

In this section, we outline the process by which a patient may initially discuss their end-of-life options, request physician-assisted dying, go through a rigorous assessment process, and then, where the eligibility criteria are met and procedural safeguards observed, be provided with physician-assisted dying. Throughout this section, we will highlight areas where we have added additional safeguards to existing processes to protect patients and ensure that consent for such an important decision is free and informed and made by a competent individual. Graphical depictions of our proposed patient pathway are included throughout this section. A full version is included as Appendix 4. The pathway below describes the most common scenario; however, a modified approach may be required in some cases. Once we have outlined the standard patient pathway, we will examine the role of health care providers and faith-based institutions who object to physician-assisted dying for reasons of conscience.
6.4.1 Request and Documentation
The patient-physician relationship is founded on mutual trust, respect, knowledge, and understanding between the patient and his or her health care provider. Through the relationship, the physician gains a medical and psychosocial understanding of the patient and the reasons for his or her wishes with respect to health care. This relationship is the basis for assessments of competency, knowledge of the medical condition or conditions affecting the patient, and the impact and natural evolution of potential treatments. This relationship provides the patient with an understanding of his or her condition and treatment options and provides the physician with the knowledge needed to assess the patient’s competency in making a request for physician-assisted dying. This relationship may take time to develop.

In the context of the patient-physician relationship and the principles of their profession, health care providers have several duties that apply regardless of their personal position on physician-assisted dying. These duties include the duty to inform, the duty to care for patients, and the duty of nonabandonment. In practice, this means that any physician has a duty to discuss all end-of-life options with their patients, including physician-assisted dying, even if they themselves would not be willing to participate in it.

When a patient raises the issue of physician-assisted dying, his or her physician should engage in a meaningful dialogue with the patient on diagnosis, prognosis, all end-of-life options (including palliative
care and physician-assisted dying) and their potential consequences. If the patient is willing and agrees, these conversations should also involve the patient’s family and caregivers. Based on these discussions, if the provider is willing to participate in physician-assisted dying, they should move on together to the next step on the pathway. If the physician is unwilling to participate, or if in an institution that does not provide physician-assisted dying, the physician should trigger the conscientious objection process (see Recommendations 31-38 below).
6.4.1.1.1 Revocation

The patient can, at any time, rescind his or her request for, or consent to, physician-assisted dying either verbally or in writing.
6.4.1.1.2 Patient Declaration Form

RECOMMENDATION 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

The patient declaration form, developed by provinces and territories or an oversight body established by provinces and territories, must clearly state that the patient has been informed about his or her condition and all available options, understands the information and appreciates the consequences of the decision, and has requested physician-assisted dying. If the declaration is being completed before the patient is experiencing enduring intolerable suffering, it must also include a statement clearly explaining what the patient considers to constitute enduring intolerable suffering.

The patient declaration form must be signed by the patient and countersigned by an independent witness and the attending physician. Where a patient cannot physically write or sign the patient declaration form, an alternative means may be used, such as a video recording. A documented patient declaration witnessed by an independent party will serve as formal confirmation of the patient’s wishes and a means of providing assurances to the attending physician and other interested parties that the patient has clearly requested and consented to physician-assisted dying.
Timing of Completion of Declaration

**RECOMMENDATION 12:** Provinces and territories should request that the federal government make it clear in its changes to the Criminal Code that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

**RECOMMENDATION 13:** Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid.

We have carefully considered the question of when the requirement for competency must be met. We have considered four possibilities and determined that physician-assisted dying should be permitted in three of those situations.

Provinces and territories should advise the federal government to make clear in the Criminal Code that physician-assisted dying is permissible where:

a) the patient is competent at all times from the initial request to the moment of provision of assistance;

b) although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the patient declaration form, the patient lost competence between the completion of the patient declaration form and the provision of assistance; or

c) although competent and having been diagnosed with a grievous and irremediable condition, but not yet experiencing intolerable suffering, at the time of the completion of a patient declaration form, the patient lost competence between the completion of the patient declaration form and the onset of the enduring intolerable suffering.

We note that *Carter* requires that physician-assisted dying be provided to a competent adult. Scenario (a) above is clearly allowed under the Supreme Court of Canada’s decision. However, the Supreme Court’s decision is silent on scenarios (b) and (c) above.
Figure 3. Timing of the Completion of a Declaration

The first situation is the most straightforward: a patient who has a grievous and irremediable condition and is experiencing intolerable suffering and is competent until the moment of provision. This person should qualify for physician-assisted dying.

The second situation involves a patient who, although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the declaration form, loses competency between the completion of the form and the provision. In this case, we believe that the person should be eligible for physician-assisted dying.

The third situation is more complex. It may occur when a patient has been diagnosed with a condition that will remove competency, such as dementia, and has concerns about the quality of his or her end-of-life in that future. The patient is not experiencing intolerable suffering, but has been diagnosed with a grievous and irremediable medical condition. Should this patient be permitted to complete a patient declaration indicating that he or she would like to receive physician-assisted dying when certain conditions that the patient believes would constitute enduring intolerable suffering are met, even if the patient will no longer be competent when those conditions are met? Our answer is yes.

Particularly for certain degenerative diseases, we feel that to require that these patients be competent at the time physician-assisted dying is delivered would force many of them to trigger the act earlier in the course of their disease than necessary. Some people may be more comfortable with their diagnosis knowing that physician-assisted dying will be available to them after they lose competency. In such cases, physicians will need to take extra care to ensure that the patient understands and freely consents to his or her decision. The physician and patient should discuss the normal progression of the disease and how patients often respond and adapt to the disease. These conversations should continue throughout the progression of the disease (or up to the point of losing competence) to assess and confirm that the patient maintains his or her decision with respect to the future provision of physician-assisted dying.

We recognize that rules about advance directives vary across the country and, therefore, where a patient wishes to consent to physician-assisted dying in advance, the Advisory Group recommends that a standardized patient declaration form requesting physician-assisted dying be used instead of existing
mechanisms. The patient's symptoms and/or presentation at the time of the provision of the assistance will need to be assessed against the criteria for intolerable suffering set out by the patient in advance.

There is a fourth, possible situation that we considered which involves a person who has not yet been diagnosed with a grievous and irremediable medical condition, but has completed a patient declaration form. We did not come to agreement on whether such a declaration should be considered valid consent for the purposes of eligibility for physician-assisted dying. Some members of the Advisory Group believe that this is consistent with existing practice with respect to advance care directives and so should be permitted, while others believe it is not possible to give informed consent to physician-assisted dying prior to a diagnosis of a grievous and irremediable medical condition. We therefore recommend that provinces and territories work with the federal government to consult further on this issue within the coming year and update legislation if needed by February 2017.
RECOMMENDATION 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Many stakeholder groups emphasized the paramount importance of patient autonomy as justification for respecting requests for physician-assisted dying. Allowing substitute decision makers to authorize/consent to this procedure on behalf of a patient leaves open the possibility that a patient’s life could be ended in contravention, or without the explicit knowledge, of his or her wishes.
6.4.1.2.2 Patient Information Form

**RECOMMENDATION 15:** Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

Patients who request physician-assisted dying should be asked to complete a simple form that outlines demographic information and their reasons for requesting physician-assisted dying. This information will be required by provinces and territories as part of an oversight system to be outlined later in this report. The de-identified information will also be relevant to researchers who choose to study the implementation of physician-assisted dying in Canada.

**RECOMMENDATION 16:** To support case review and system oversight, data should be collected from the patient’s initial request to the time of signing the death certificate and/or the completion of that patient’s request (e.g., patient withdrawal of request, physician denial of requests).

Data should be collected from the patient’s initial request to the time of signing the death certificate. In addition to the data gathered through the declaration form and information form, data should also be collected on the number of, and grounds for, refusals of patient requests for physician-assisted dying and the number of patients permitted physician-assisted dying that chose not to proceed. Data should be gathered by the attending physician as part of the request and assessment process and provided to the Review Committee and Oversight Body, outlined below.
6.4.2 Assessment of Eligibility
The willing attending physician must ensure that the patient is eligible for physician-assisted dying based on the eligibility criteria set out in the *Carter* decision. According to the Court, a patient must be 1) an adult person 2) with a grievous and irremediable medical condition (including an illness, disease or disability) 3) that is causing enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The court also required that the adult person be competent and clearly consent to the termination of life.
6.4.2.1.1 Adult Person

**RECOMMENDATION 17:** Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based on competence rather than age.

The *Carter* decision applies to a “competent adult person,” but does not include a definition of adult. In assessing whether someone is an adult person, an arbitrary age limit such as 18 years old provides no valid safeguard. Instead, it is important that willing physicians carefully consider the context of each request to determine whether the person has the information needed, is not under coercion or undue pressure, and is competent to make such a decision.

Competence and consent to treatment laws vary among provinces and territories. In some cases, decisional competence is based on age, but in others, age is irrelevant to whether the patient has the legal authority to make decisions about his or her treatment.

An ideal regulatory framework for physician-assisted dying would have uniform eligibility rules. Indeed, many provider groups asked the Advisory Group to recommend a consistent national approach to eligibility for physician-assisted dying and patient advocacy groups also sought an easily understandable criterion for accessing the service regardless of where in the country a patient lives. The federal government could facilitate this by affirming that the definition of “adult” in the context of physician-assisted dying relates to a patient’s ability to give consent rather than a particular age cut-off. That is, to allow access to patients who are competent, regardless of age.
6.4.2.1.2 Grievous and Irremediable Medical Condition

**RECOMMENDATION 18:** “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

**RECOMMENDATION 19:** Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural safeguards have been respected.

The second aspect of eligibility requires that the physician confirm that the patient is suffering from a grievous and irremediable medical condition. The Supreme Court does not offer a definition of “grievous” in the *Carter* decision. The Canadian Oxford Dictionary defines “grievous” as “very severe or serious.” This definition should be used in any changes proposed to the *Criminal Code*, provincial/territorial legislation or regulatory authority standards related to physician-assisted dying. Consistent with the *Carter* decision, we understand that “irremediable” is used to describe a condition that cannot be alleviated by any means acceptable to the patient. The determination of whether a condition is irremediable should be a two-step process. First, the physician must determine whether any treatments exist for the condition. Second, the patient must determine whether any of the available treatments are acceptable to him or her.

We heard consistently through the stakeholder engagement process that grievous and irremediable should not be defined in terms of specific health conditions. No list of specific conditions could capture the range of illnesses, diseases and disabilities that might meet the parameters established by the Supreme Court. Instead, we recommend that regulatory authorities develop tools to assist physicians in making this determination on a case by case basis.
6.4.2.1.3 Intolerable Suffering that is Enduring

The Supreme Court states that the medical condition must cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition. This is a subjective test based on the patient’s response to his or her condition. In order to determine whether this eligibility criterion has been met, the physician must receive from the patient a very clear statement of what the patient considers or would consider to be suffering that is intolerable.
RECOMMENDATION 20: Physicians should use existing processes in the health care system to assess competency and consent.

During our consultations, we heard from some stakeholder groups who felt that a panel of doctors, a tribunal or judge, or a specially-trained professional should be required to conduct a vulnerability assessment for all persons with disabilities seeking physician-assisted dying. We also heard that a mental health assessment should be required for all persons seeking physician-assisted dying.

We share these group’s concerns about the protection of vulnerable populations and the need for safeguards to do so. However, our research and discussions lead us to believe that existing mechanisms are sufficient to ensure that patients are making an informed choice and that physicians can effectively assess patient competence. In the text that follows, we describe the current systems in place to support informed consent and competency assessment and show how these systems can be applied to the implementation of physician-assisted dying.
6.4.2.1.4.1 Informed Consent

To be valid, consent must be free and informed. To be free, the person making the choice must not be subject to coercion or undue pressure. For consent to be informed in the context of physician-assisted dying, we follow the Federation of Medical Regulatory Authorities of Canada’s advice in their June 6, 2015, guidance on physician-assisted dying:

The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, pain and symptom control and other available resources to avoid the loss of personal dignity. The physician must advise the patient of any counselling resources that are available to assist the patient. The attending physician must inform the patient of his or her right to rescind the request at any time. The attending physician has an obligation to take reasonable steps to ensure that the patient has understood the information that has been provided.
6.4.2.1.4.2 Competency

To be competent to consent to treatment, the person must be able to understand information relevant to the decision and appreciate the nature and consequences of the specific decision being made or not made. Competence can fluctuate over time and a person may be competent for one decision (e.g., simple with minor consequences) but not another (e.g., complex with very serious consequences).
6.4.2.1.4.3  Assessment

In most cases where a person requests physician-assisted dying, there will be little doubt that his or her decision is free and informed and that the patient has the competence to make the decision to choose physician-assisted dying. In other cases, competency may be in question and there may be reason to doubt whether the decision is free and/or informed. Particular concerns that have been raised include those involving persons with psychiatric conditions, minors, and persons living with severe disabilities. For example, we heard concern from some stakeholders that individuals with psychiatric conditions or minors may not be capable of appreciating the consequences of the decision because of their mental condition or lack of life experience and not-yet-fully developed executive functions. There were those who felt individuals living with severe disabilities may be particularly vulnerable to coercion or make the choice because of a lack of social supports and few other options. As a consequence, some suggested that age, psychiatric illness, and disability should be exclusion criteria for access to physician-assisted dying (or should be subject to different regulatory requirements).

Governments undoubtedly have an obligation to protect individuals who might seek physician-assisted dying while they are not capable of making an autonomous choice. However, we do not feel those who fall into these categories should automatically be denied the right to access physician-assisted dying.

Instead, we acknowledge the need for heightened scrutiny during assessments of the eligibility criteria for physician-assisted dying in the face of any signals that might indicate compromised autonomy (including, but not limited to psychiatric illness, disability, or age). Just as they already do for other endof-life decisions, where a health care provider has concerns, doubts, or uncertainty about whether an individual is competent and is making a free and informed choice, the provider should take whatever time and consult any additional experts as is necessary to reach the conclusion that the person does or does not meet the eligibility criteria. Health care providers must assess the components of a valid consent on a regular basis and often in circumstances in which the decision is complex and the consequences dire. The same skills (and time and additional expertise) that are used for assessing the elements of informed choice for other end-of-life decisions are transferable and adequate for making such assessments for the physician-assisted dying decision.

Although we do not recommend the use of age, psychiatric condition, or disability as exclusion criteria for access to physician-assisted dying (as described in Recommendation 18), we do recommend the development of better assessment tools for consent and competency (especially in relation to vulnerabilities associated with lack of social support for persons living with disabilities). We also recommend the development and implementation of educational materials designed to improve the capacity of health care providers to assess competency – particularly in the presence of potentially compromising conditions or social contexts. This approach will serve the objective of protecting individuals who might seek physician-assisted dying but are not capable of making an autonomous and informed choice. It will also have the added benefit of protecting individuals who might make other lifelimiting decisions while not capable of making an autonomous choice (e.g., refusing life-sustaining treatment in the face of a traumatic injury).
RECOMMENDATION 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

In addition to the criteria set out in the Supreme Court’s decision in Carter, we believe that only patients who are eligible for publicly-funded health services should be considered eligible for physician-assisted dying. The Carter decision does not include citizenship, residency, or status as an insured person as an eligibility criterion for access to physician-assisted dying, but almost all jurisdictions where physician-assisted dying is legal limit access to the service in this manner. Although imposing a Canadian residency requirement would prevent residents of foreign countries from visiting Canada to receive physician-assisted dying, imposing limits based on citizenship or permanent residency status could also create a barrier to access for some in Canada. As a result, we recommend that all – and only – those eligible for publicly-funded health services also qualify for physician-assisted dying.
6.4.3 Review
6.4.3.1 Second Assessment

RECOMMENDATION 22: Two physicians must assess the patient to ensure that all criteria are met.

Patients who are enduring intolerable suffering and who meet all other eligibility criteria for physician-assisted dying should not have their suffering extended or compounded by an unnecessarily burdensome administrative process to access this service. We feel, however, that the approval of an attending and reviewing physician (or nurse practitioner acting within their scope of practice) is a reasonable safeguard to help ensure that a patient has indeed met the eligibility requirements for accessing physician-assisted dying and an appropriate step to help support the attending physician.

Following the request for physician-assisted dying and assessment of eligibility and competency by the attending physician, we recommend an additional safeguard be put into place for physician-assisted dying whereby a second physician assesses the patient for eligibility and provides a report to the attending physician. For this to be justifiable hurdle, and not an unjustifiable barrier, this recommendation is conditional upon our earlier recommendation that Criminal Code changes make it possible for other regulated health care professionals – in addition to physicians – be permitted to provide assistance in dying (see Recommendation 8).

RECOMMENDATION 23: Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment.

While we recommend that two physicians should be involved in ensuring that all criteria have been met, we recognize that some communities do not have access to local physicians at all. In these cases, provinces, territories or the regional health authorities should work to provide patients with access to physicians either through telemedicine, by bringing physicians into the community or, if the patient is willing, by transporting him or her to an area where physicians are available and willing to conduct the necessary evaluations.
6.4.3.2 Appeals and Dispute Resolution

**RECOMMENDATION 24:** For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used.

Existing provincial/territorial mechanisms allow patients to appeal decisions related to competency and set out the circumstances in which a patient has a right to appeal. For example, in Ontario, if a physician has determined that a patient is not competent to consent to treatment, the patient has the right to appeal to the Consent and Capacity Board. No new system to handle competency disputes is required for physician-assisted dying.

**RECOMMENDATION 25:** We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.

We do not feel it necessary to set up an appeals process when the attending or reviewing physician concludes that the eligibility criteria (other than competency) have not been met. Instead we recommend the following:

- If the attending physician determines that the eligibility criteria (other than competency) have not been met, the attending physician shall inform the patient of the reasons for that determination. The patient should not be precluded from consulting another physician.
- If the reviewing physician determines that the criteria (other than competency) have not been met, the reviewing physician shall inform the patient and attending physician of the reasons for that determination. The attending physician or patient should not be precluded from seeking the opinion of another reviewing physician.
6.4.4 Provision
Once the reviewing physician has confirmed that the eligibility criteria have been met, the attending physician may request that the patient re-confirm his or her intention (if the patient is still competent) and the physician may provide physician-assisted dying to the patient.

**RECOMMENDATION 26:** We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.

Several stakeholder organizations have requested that governments be prescriptive in setting out a specific waiting/reflection period as part of a clearly articulated physician-assisted dying process. Others have suggested this would not respect patient autonomy and physician judgement. While a mandated waiting/reflection period has been established in some jurisdictions, such as in the U.S. states that offer physician-assisted dying, we believe that such an approach would impose an arbitrary barrier to access that would negatively impact both patient decision-making and physician judgement.

Furthermore, a specific time period serves as a poor proxy for detecting decisions that are either not fully informed, not voluntary or made when a patient is not capable of fully appreciating the consequences of the decision being made. In some cases, a set time period may be too short for the physician to make a confident assessment of the elements of a valid consent. In other cases, it may be longer than is necessary.

As such, we do not recommend a particular prescribed time period. What is essential is that the patient has sufficient time to come to an informed and voluntary decision, to understand the information, and
appreciate the consequences of his or her decision, and that the physician has had sufficient time to come to the conclusion that all of the eligibility criteria have been met. The time required to meet these conditions will vary depending on circumstances and so a set amount of time would be arbitrary. Furthermore, the passage of at least some time in every case is assured by the requirement that the attending and reviewing physicians both be confident that the consent is free and informed and made by a competent individual.

**RECOMMENDATION 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-term care facilities and at home), except certain conscientiously objecting facilities.**

Increasingly, Canadians express the desire to die in their own home and we believe both physician-assisted dying and palliative care should be delivered in the home if that is the patient’s wish. In some cases, a patient’s home may be a retirement facility, nursing home or hospice.

**RECOMMENDATION 28: There should be no requirement that a physician be present at a self-administered assisted death.**

Patients should have the right to choose who is present at their time of death. Therefore, there should be no requirement that a physician (or nurse practitioner acting within the scope of their practice) be present at a self-administered physician-assisted death. We recognize that self-administered physician-assisted dying may result in more complications than physician-administered physician-assisted dying. However, patients should be free to determine for themselves whether the benefits to them of allowing self-administration without a physician present outweigh the potential risks. Self-administration without a provider present may lead to more complications and adverse events, but research from other jurisdictions indicates that these events are extremely rare. Physicians should ensure that the potential risks are clearly explained to the patient and provide instructions on how to respond to them should they materialize.
6.4.5 Reporting
6.4.5.1 Case Review

**RECOMMENDATION 29:** Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Although we do not support case review before provision of physician-assisted dying (as outlined in Recommendation 20), we believe that a regular review of individual cases after provision is required to confirm that all procedural safeguards have been followed correctly and to identify any systemic problems as soon as possible. Within 14 days of the provision of the assistance (either through the writing of a prescription or direct provision by a health care provider), the attending physician must file a report with the Review Committee (for details on the makeup and mandate of the Review Committee, see Recommendation 39). The Review Committee should have access to all patient files including the patient declaration form, patient information form, attending and reviewing physician’s reports and additional competency assessments (if undertaken). Provinces and Territories should undertake any legislative or regulatory changes required to ensure that such health information can be shared with the Review Committee.
6.4.5.2 Vital Statistics

**RECOMMENDATION 30:** Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Listing physician-assisted dying on medical certificates of death may require legislative changes in some jurisdictions, but we believe that it is an important step for tracking and data collection purposes to ensure full transparency. Physician-assisted dying should be listed as the manner of death. The name of the medical condition that qualified the person for physician-assisted dying should be reported as the underlying cause of death. The injection or ingestion of drugs should be recorded as an antecedent cause.

Provinces and territories should direct their Vital Statistics registrars to work together to ensure a common approach is used across Canada to ensure that system oversight can be efficient and effective (See Recommendations 39-40 regarding oversight).
6.5 Role of Conscientiously Objecting Health Care Provider

We have already outlined the process for the provision of physician-assisted dying when there are no conscientious objections being raised. We have also highlighted the duties and obligations of all health care providers, whether or not they object to the provision of physician-assisted dying. These duties include the duty to provide full information about all end-of-life options, including physician-assisted dying, the duty to care for the patient in a non-discriminatory manner and the duty of nonabandonment of the patient until such a time as care has been transferred to another provider.

These duties must be fulfilled by a conscientiously objecting health care provider. While we believe that there is a communal responsibility to provide access to physician-assisted dying, individual providers are not absolved of their personal/professional responsibilities, particularly in a publicly-funded system.

We believe that the positions set out below represent a respectful reconciliation of the many competing values at stake in the context of physician-assisted dying.

We believe that this reconciliation of competing values also harmonizes the approach taken across health professions (i.e., nurses’ consciences are not given less weight than physicians’). We also believe that the burden of the risk of lack of access should not fall on patients. We believe that the burden of the risk of failure to ensure the design, implementation and maintenance of a system for arranging transfers of care from providers and institutions that object to providing physician-assisted dying should rest on those with the greatest power and voice to ensure that the government and other organizations design, implement, and maintain an effective and efficient transfer of care system (i.e., health care providers, professions, regulators and institutions rather than patients with grievous and irremediable conditions that cause enduring intolerable suffering).

Furthermore, we heard from health care provider organizations that, even without any legislation or regulation addressing the issue of conscientious objection, access to physician-assisted dying is likely not going to be a problem. We can draw a logical inference that a duty to inform and duty of nonabandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party) is, in their view, redundant.

We also heard repeatedly from groups representing individuals who want access to physician-assisted dying to be available that they believe that, without legislation establishing a duty to inform and a duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party), there may be problems with access. It is our hope that this approach will increase trust in the health care system among these individuals by setting out these duties in law. Health care providers will not be harmed by a redundant provision and members of the public who support access for physician-assisted dying will benefit. It therefore seems reasonable and prudent to enshrine the duties in legislation.

In developing the recommendations below, we have attempted to reconcile the patient’s rights and freedoms (to conscience, autonomy, life, liberty and the security of the person) with the provider’s (to conscience, religion/creed, and privacy). We have consulted extensively on these questions and have worked to create a system that ensures access without unnecessarily limiting the conscience rights of providers.
6.5.1 Duty to Inform

**RECOMMENDATION 31:** Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.

All end-of-life options (including palliative care and physician-assisted dying) should be discussed with patients in a respectful way regardless of the provider’s beliefs. Such requirements are often already included in professional codes of ethics. For example, the Canadian Medical Association’s Code of Ethics requires that physicians provide patients with the information they need to make informed decisions about their medical care.

**RECOMMENDATION 32:** Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a nondiscriminatory manner.

Conscientiously objecting providers have a duty to inform new patients and, when appropriate, current patients of their position on physician-assisted dying. This allows patients to make an informed choice with respect to enrolling with or retaining that provider. Regulatory authorities and governments should produce educational materials for physicians and patients to help navigate these discussions. We also encourage all physicians to initiate and regularly revisit conversations with patients around advance care planning, the goals of care, and the patient’s end-of-life wishes.
6.5.2 Duty to Care for the Patient

**RECOMMENDATION 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient’s records through the system described in Recommendation 4.**

To facilitate access to physician-assisted dying, conscientiously objecting health care providers must refer, transfer care or contact a third party in a timely manner and transfer records to another health care provider or third party, as required. There is no expectation that they will assess the patient’s eligibility for physician-assisted dying.

We heard from some stakeholders who believed that a referral in the context of physician-assisted dying implied that the conscientiously objecting physician had assessed the patient, found them eligible for physician-assisted dying and was transferring care for the purposes of providing the service. While this is an option available to those who object to the provision of service, we did not want to imply that assessment is an obligation, or that this was the only option available to providers.

When we discuss a direct transfer of care, we envisage a situation where a patient has requested physician-assisted dying and has already discussed end-of-life options with their health care provider. We recognize that some providers view a transfer of care as morally preferable to referral because, unlike referral, it is taken to neither explicitly nor implicitly affirm the service sought by the patient. A health care provider could transfer the patient to another health care provider for the assessment and treatment of the patient’s medical condition and, if the patient meets the eligibility criteria, provision of physician-assisted dying. The receiving health care provider must be someone who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying.

Following the transfer of care, the receiving health care provider would follow the pathway outlined earlier in this report.

For those conscientiously objecting health care providers who are not willing to provide a direct transfer of care on conscience or religious grounds, we provide the option of contacting and transferring the patient’s records through a publicly-funded system designed to ensure that patients are able to access a health care provider willing to accept them as a patient for assessment and, if the eligibility criteria are met, to provide physician-assisted dying. If this system is not in place, conscientiously objecting providers should be required to make a direct transfer of care to a health care provider who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. It is imperative that the burden of the transfer to another physician, institution or third party not fall on the patient seeking the care.

As described in Recommendation 4, we recommend a system where regional health authorities develop a publicly-funded care coordination system to help facilitate access to physician-assisted dying. One of this system’s key functions should be to receive requests from unwilling or unable health care providers and transfer patients to providers who are willing and able to receive new patients.
6.6 Role of Institutions
6.6.1 Duties of Institutions

All institutions have certain responsibilities in common, many of which align with our recommendations related to physicians.

RECOMMENDATION 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

This recommendation will ensure that patients have clarity on what is permitted within the facility. They can then make informed decisions with respect to whether to enter or remain in the facility.

RECOMMENDATION 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

RECOMMENDATION 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

Taken together, the two recommendations above limit the power of institutions to restrict the autonomy of patients who may wish to seek physician-assisted dying at a later date, and providers, who may wish to provide physician-assisted dying outside a faith-based institution that does not offer physician-assisted dying. They represent an appropriate balance between patient and physician autonomy, patient access, and institutional autonomy.
6.6.2 Duties of Non Faith-Based Institutions

RECOMMENDATION 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Governments have significantly more levers to influence the policies and practices of institutions that are funded in whole or in part by public funds. However, as a point of principle, we believe that physician-assisted dying should be available wherever people are living and dying. This includes privately-funded institutions. Recognizing that not all institutions will feel capable of providing physician-assisted dying for a variety of reasons, including size, geography and mandate, we concluded that institutions should be permitted to offer a patient transfer to another institution, as long as the receiving institution can and will provide a health care provider who is willing and able to accept the person as a patient, to assess whether the criteria for access to physician-assisted dying have been met, and provide physician-assisted dying where the criteria for access have been met.
6.6.3 Duties of Faith-Based Institutions

**RECOMMENDATION 38:** Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Faith-based institutions have a duty to care for and not abandon the patients within their institution. While they should not be required to provide access to physician-assisted dying, they must still ensure access for patients who wish to seek it.

When a patient makes a request for physician-assisted dying, faith-based institutions should be required to either allow for the assessment and provision of physician-assisted dying within the institution or make arrangements for an effective transfer of the patient to a non-objecting institution. This transfer must also include the transfer of all relevant records, and must be made to a non-objecting institution where the patient’s medical condition can be assessed and treated by a health care provider who is willing and able to assess whether the patient meets the eligibility criteria for physician-assisted dying and, if so, can provide assistance. If a safe and timely transfer to a non-objecting institution is not possible, the objecting institution must allow an outside health care provider to assess the patient and, if the eligibility criteria for physician-assisted dying are met, to provide assistance. The receiving outside health care provider would follow the pathway for physician-assisted dying as outlined previously in this report.
6.7 Oversight

It is essential for a properly functioning regulatory framework that there is robust and independent oversight to: monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. To support the implementation of physician-assisted dying, we recommend two levels of oversight: one at the provincial/territorial level and one at the pan-Canadian level.

**RECOMMENDATION 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.**

An independent review committee system should be established in each province and territory, or with agreement amongst groups of provinces and territories, to monitor compliance with the legal and regulatory framework for physician-assisted dying and to facilitate public reporting on physician-assisted dying in Canada. The Review Committees should include a physician, a legal expert, an ethicist, and a public representative who can determine whether the relevant laws and professional standards have been followed. Where issues arise, the Review Committees should report any potential violations to the appropriate authorities.

Individual cases should be reviewed after provision of assistance (see Recommendation 29). For each case of physician-assisted dying, the Review Committee will review the documentation submitted by physicians. As a starting point, we recommend that all cases be reviewed by the Review Committee. However, it may be possible for only a sample to be reviewed once the system of providing physician-assisted dying has matured in Canada. Where the Committee determines that the physician acted in compliance with the relevant laws and professional standards, the physician will be informed and the file will be closed. Where a physician is thought to have potentially violated laws or standards, the Review Committee will report this to the relevant professional regulatory authority for investigation and response under its professional self-regulatory powers. Any subsequent reporting by a regulatory authority to the police will follow the regulatory authority’s normal processes with respect to reporting suspected violations of provincial or federal legislation. Where the Review Committee determines that a health institution or any other person was non-compliant with provincial/territorial legislation, it will refer the case to the relevant regulatory authority in its jurisdiction (e.g., regional health authority, Ministry of Health).

The Review Committee will also compile de-identified population-level data on physician-assisted dying in its jurisdiction. This may include incidence of physician-assisted dying, the underlying causes of death, the settings where physician-assisted dying was provided (e.g., hospital, home), the regulated health professional who provided the service (e.g., physician, nurse practitioner), the modality of physician-assisted dying (i.e., self-administered or provider-administered), and any complications arising in the provision of physician-assisted dying. To facilitate pan-Canadian comparisons, common metrics should be developed for application across Review Committees.
The Review Committee should be required to prepare an annual report of its findings for the purpose of public reporting on physician-assisted dying at a provincial or territorial level and for submission to the pan-Canadian Commission on End-of-life Care.

**RECOMMENDATION 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-life Care to provide system oversight and to report to the public.**

A pan-Canadian Commission on End-of-Life Care should be established to report to the public on the implementation of physician-assisted dying. The Commission could be developed as part of a pan-Canadian strategy on palliative and end-of-life care, including physician-assisted dying, or it could be a separate body if a pan-Canadian strategy cannot be developed in a timely manner. It should report annually on things such as: the number of cases of physician-assisted dying; the number of requests for physician-assisted dying including those that were refused or never acted upon; and demographic data about who is requesting physician-assisted dying and why. These reports will help to ensure that the system in place is – and is seen to be – legitimate, trustworthy and non-discriminatory.

The Commission should also be given additional functions associated with a robust regulatory framework for physician-assisted dying including to:

- conduct or commission research it deems necessary in accordance with relevant federal, provincial, and territorial law and policy;
- consult with the public, health providers, and other experts on issues related to physician-assisted dying;
- inform the development and delivery of resources on moral, legal, and clinical aspects of physician-assisted dying to health care providers, legal professionals, and the public; and
- make recommendations to federal, provincial and territorial governments about potential law and policy reform with respect to physician-assisted dying in Canada.
RECOMMENDATION 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.

Physician-assisted dying is a new practice in Canada. We are entering a critical phase in which evidence-gathering should be undertaken systematically and rigorously to inform responses to these Canadian questions. Although other jurisdictions provide insight into its practice, physician-assisted dying in the Canadian context raises unique policy and practice questions. There are unanswered questions, for example, about organ donation in the context of physician-assisted dying and the role and regulation of palliative sedation. Answering these questions will require the research community and governments to work collaboratively to advance a coordinated research agenda in service of Canadians.
RECOMMENDATION 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.

A recurrent theme throughout our consultation with stakeholders was the need for education and training of health professionals with respect to physician-assisted dying, including its clinical, legal, and ethical aspects. Health professional education and training should include both undergraduate and postgraduate education, as well as continuing professional education of licensed health professionals. Health professional education should not be limited to regulated health professionals, but should also address the learning needs of other health care workers involved in patient care. Although some clinical specialties may be more likely to participate in the provision of physician-assisted dying, end-of-life conversations including about physician-assisted dying may arise in any therapeutic relationship between patients and providers. This suggests that physician-assisted dying and related end-of-life issues should be a core component of all health professional education. The curriculum should ideally include training on: how to talk with patients about physician-assisted dying; what the legal, regulatory, and ethical obligations are; the extent and limits of conscientious objection; the psychosocial aspects of illness; awareness of and sensitivity to cultural, linguistic, and other forms of diversity; and assessment of social vulnerability. Notably, this curriculum would be broadly relevant to the delivery of high quality end-of-life care and other clinical care.
Public Education and Engagement

RECOMMENDATION 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

Public education and engagement are critical to a transparent system of end-of-life care, including physician-assisted dying. There is a need for public education on what physician-assisted dying is (and what it is not), how it fits within a continuum of end-of-life services, how it can be accessed and under what conditions, and how physician-assisted dying is governed, administered, and monitored, including what safeguards are in place. Patients and families also need information about what supports and services are available for patients and their families at the end-of-life. While some of this information may be provided by physicians and other health professionals in conversation with their patients, such information should also be readily publicly available for patients and members of the public. There is also a need for patient and public engagement to inform the continuing development of high-quality end-of-life care and supportive care, and the implementation of physician-assisted dying. Current best practices in patient and public engagement should be proactively incorporated into provincial and territorial planning and the implementation of physician-assisted dying.
Appendix 1 – Member Biographies
7.1 DR. JENNIFER GIBSON (CO-CHAIR)
7.1.1 Ontario

Director of the University of Toronto Joint Centre for Bioethics

Jennifer Gibson is Sun Life Financial Chair in Bioethics and Director of the University of Toronto Joint Centre for Bioethics, and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto. She holds a PhD in philosophy (bioethics and political theory). Her research focuses on ethical governance and performance of health organizations and systems. Gibson directs the World Health Organization Collaborating Centre for Bioethics at the University of Toronto and is also a member on the Executive Committee for the Global Institute for Psychosocial, Palliative, and End-of-Life Care, University of Toronto and Princess Margaret Cancer Centre. Jennifer has served on government and health sector advisory committees on public health emergencies, critical care triage, drug funding and supply, and the Ebola response in Ontario and internationally.
7.2 MAUREEN TAYLOR (CO-CHAIR)
7.2.1 Ontario

Physician Assistant in Infectious Diseases and Medical Journalist

Maureen Taylor is a Physician Assistant (PA) in Infectious Diseases at Toronto East General Hospital, and an Associate Clinical Professor in the Department of Family Medicine at McMaster University. Prior to her studies as a PA, Maureen was a broadcast journalist for 25 years, including seven years as the National Medical/Health Reporter for the Canadian Broadcasting Corporation. Maureen is a three time winner of the Canadian Medical Association/Canadian Nurses Association awards for excellence in health reporting.

Maureen was married to microbiologist and infectious disease expert Dr. Donald Low, who was diagnosed with an inoperable brain tumour in February 2013. He died seven months later. Since then, Maureen has publicly advocated for the right of terminally ill Canadians to choose an assisted death.
7.3 DR. DOUG COCHRANE
Dr. Doug Cochrane is the Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council. He is also a Professor at the University of British Columbia in Neurosurgery.

The BC Patient Safety & Quality Council has adopted a definition of quality that spans health care. Care at the end-of-life is one sector in which the Council advocates, supporting end-of-life planning, palliation where needed and primary care and home services.

Given the nature of Dr. Cochrane’s clinical practice as a neurosurgeon, meeting and care for and with families and patients facing end-of-life are common. Arising from this experience, Dr. Cochrane recognizes the importance of how a disease process and treatments are affected by the context of the patient and family. Care is not only providing treatments of a disease process or the minimization of disability, but when applicable, allaying suffering and respecting patient family autonomy. He has written on the Groningen Protocol.
Jocelyn Downie is a Professor in the Faculties of Law and Medicine at Dalhousie University. She is a Fellow of the Pierre Elliott Trudeau Foundation as well as a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences. She received an honours BA and MA in Philosophy from Queen’s University, an MLitt in Philosophy from the University of Cambridge, an LLB from the University of Toronto, and an LLM and Doctorate in Law from the University of Michigan. After graduation from law school, she clerked for (former) Chief Justice Antonio Lamer at the Supreme Court of Canada.

Specifically in the area of assisted death, Downie has published numerous books and articles including Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada, winner of the 2005 Abbyann Lynch Medal in Bioethics from the Royal Society of Canada. Downie was also a Special Advisor to the Senate of Canada Committee on Euthanasia and Assisted Suicide, a member on the Royal Society of Canada’s Expert Panel on End-of-Life Decision Making, and a member of the pro bono legal team in Carter.
7.5.1 Ontario

Human Rights Lawyer & Commissioner, Ontario Human Rights Commission

From February to October 2015, Ruth served as the Interim Chief Commissioner of the Ontario Human Rights Commission. She was first appointed as a Commissioner by the Government of Ontario in 2006 and continues in that capacity today.

Ruth received her B.A. (Honours) from the University of Toronto (1996) and her LLB from Osgoode Hall Law School (2000). She was called to the Bar in 2002.

After graduating from law school, Ruth worked in India for an international NGO on women’s equality rights and with the United Nations Special Rapporteur on the Right to Adequate Housing. She has appeared before the UN Committee on Economic, Social and Cultural Rights in Geneva, Switzerland and has advocated at the UN Human Settlement Programme (UN HABITAT) in Nairobi, Kenya. In 2001, she completed her articles of clerkship at ARCH Disability Law Centre and then worked for the Centre for Equality Rights in Accommodation (CERA), a human rights organization that works domestically and internationally for equality in housing and for the realization of economic and social rights. From 2007 to 2009, she was the Executive Director of CERA. In private human rights law practice, Ruth’s focus was on gender, disability and racial discrimination in employment and education.

Ruth has taught Disability Studies at Ryerson University, served on the Board of the National Association of Women in the Law and on LEAF’s Legal Committee.
7.6  DR. NUALA KENNY
7.6.1 Nova Scotia

Professor Emeritus Dalhousie University Department of Bioethics

Dr. Nuala Patricia Kenny received her BA, Magna Cum Laude, from Mount Saint Vincent University in 1967, an MD from Dalhousie in 1972 and became a Fellow of the Royal College of Physician and Surgeons of Canada in Paediatrics in 1975. In 1993 she completed a Bioethics Fellowship at the Kennedy Institute of Ethics at Georgetown University.

After a distinguished career in pediatrics at the Hospital for Sick Children, Toronto and Queen’s University, Kingston, she returned to Dalhousie as Professor and Head of the Department of Pediatrics and Chief of Pediatrics at the Izaak Walton Killam Hospital in 1988. In 1995, she became the founding Chair of the Department of Bioethics of the Dalhousie Faculty of Medicine.

From February to November 1999, Dr. Kenny was seconded as Deputy Minister of Health for the Province of Nova Scotia. From 2009-2014 she served as Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada.

Past President of both the Canadian Pediatric Society and the Canadian Bioethics Society and author of over one hundred and eighty papers and three books, Dr. Kenny was appointed an Officer of the Order of Canada for her contributions to child health and medical education in 1999. She has received the Lifetime Achievement Award of the Canadian Bioethics Society, the Distinguished Service Award from the Canadian Health Association, the Catholic Health Association of Canada’s Performance Citation Award, the Canadian Medical Association’s Marsden Ethics Award and the Dalhousie University Alumni Achievement Award.

She has received six Honorary Doctorates for her work in child health, medical education and bioethics from Mount Saint Vincent University, Halifax, the Atlantic School of Theology, Halifax, Regis College, Toronto, St. Francis Xavier University Antigonish, The College of New Rochelle, New York and Saint Paul’s University, Ottawa.
7.7  PROFESSOR ARTHUR SCHAFER
7.7.1 Manitoba

Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Arthur Schafer is Director of the Centre for Professional and Applied Ethics, at the University of Manitoba. He is also a Full Professor in the Department of Philosophy and an Ethics Consultant for the Department of Paediatrics and Child Health at the Health Sciences Centre in Winnipeg. For 10 years he was Head of the Section of Bio-Medical Ethics in the Faculty of Medicine of the University of Manitoba. He has also served as Visiting Scholar at Green College, Oxford.

Schafer has received a number of awards and honours. He is a Canadian Commonwealth Scholar, Honorary Woodrow Wilson Scholar, and a Canada Council Fellow. At the University of Manitoba he has received the Stanton Teaching Excellence Award, the Campbell Award for University Outreach, and the University Teaching Service Award for Teaching Excellence. He has published widely in the fields of moral, social, and political philosophy. He is author of The Buck Stops Here: Reflections on moral responsibility, democratic accountability and military values, and co-editor of Ethics and Animal Experimentation. He has published over 90 scholarly articles and book chapters, covering a wide range of topics, with a special focus on issues in professional and bio-medical ethics, business and environmental ethics. Schafer is National Research Associate of the Canadian Centre for Policy Alternatives, which has published two of his reports. He has made several hundred conference presentations in Canada and abroad, and has written dozens of newspaper articles for The Globe and Mail, The Toronto Star, The Winnipeg Free Press, The Medical Post, and The Sunday Times (London).
Dr. Trevor Theman is the Registrar of the College of Physicians and Surgeons of Alberta (CPSA), the regulatory body of the practice of medicine in Alberta. The CPSA provides direction to members on ethics and other issues such as physician-assisted dying. Dr. Theman is the former president of the Federation of Medical Regulatory Authorities of Canada (FMRAC). FMRAC is the national voice of the medical regulatory authorities in Canada.
DR. KARIMA VELJI
Dr. Karima Velji is the 46th President of the Canadian Nurses Association. She is the integrated vice-president for mental health at London Health Sciences Centre and St. Joseph’s Health Care. Most recently, Dr. Velji was the chief operating officer and chief nursing executive at Baycrest, a global leader in innovations on aging and brain health, and was vice-president of patient care and chief nursing executive at the Toronto Rehabilitation Institute, now a program in the University Health Network.

She has led the development of patient experience projects for the Ministry of Health and Long-Term Care and Local Health Integration Networks in Ontario. She has also led external reviews of several organizations including the Sunnybrook Health Sciences Centre, Bruyère Continuing Care and Schlegel Villages. In addition, she is board vice-chair with Accreditation Canada.

Dr. Velji has been a senior leader of palliative care services within her organizational leadership roles. She has clinical background as an oncology and palliative care nurse.
7.9.2 Appendix 2 – List of Stakeholders Consulted
7.9.2.1 Written Stakeholder Submissions Received

- ARCH Disability Law Centre
- Association for Reformed Political Action Canada
- Association of Registered Nurses of Newfoundland and Labrador
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Bar Association
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Federation of Catholic Physicians’ Societies
- Canadian HIV/AIDS Legal Network
- Canadian Hospice Palliative Care Association
- Canadian Medical Association
- Canadian Medical Protective Association (CMPA)
- Canadian Nurses Association
- Canadian Partnership Against Cancer
- Canadian Society of Hospital Pharmacists
- Canadian Society of Palliative Care Physicians
- Canadian Society of Respiratory Therapists
- Canadian Unitarian Council
- Canadian Working Group on HIV and Rehabilitation
- Catholic Civil Rights League
- Catholic Health Alliance of Canada
- Catholic Health Corporation of Manitoba
- Centre for Israel and Jewish Affairs
- Centres for Addiction and Mental Health
- Christian Legal Fellowship
- Citizens with Disabilities Ontario
- College of Family Physicians Canada
- College of Pharmacists of Manitoba
- College of Physicians and Surgeons of Manitoba
- College of Physicians and Surgeons of Ontario
- College of Registered Nurses of Manitoba
- College of Registered Nurses of Nova Scotia
- Council of Canadians with Disabilities
- Covenant Health
- Doctors NS
- Dying With Dignity
- Evangelical Fellowship of Canada
- Health Quality Council of Alberta
- HIV & AIDS Legal Clinic Ontario
- Hospice Palliative Care Ontario
• Human Rights Watch
• Manitoba Multi-faith Council
• Mental Health Commission of Canada
• National Association of Pharmacy Regulatory Authorities
• Northern Health Region
• NWT Medical Association
• Ontario Hospital Association
• Ontario Medical Association
• Palliative Manitoba
• Patients Canada
• PEI College of Physicians and Surgeons
• Physicians’ Alliance against Euthanasia
• Protection of Conscience Project
• Public Prosecutions New Brunswick
• Qikiqtani Medical Association
• Saskatchewan Association of Social Workers (SASW)
• Winnipeg Regional Health Authority
7.9.2.2 In-Person/Teleconference Consultations

• Association of Faculties of Medicine of Canada
• BC Civil Liberties Association
• Canadian Association for Community Living
• Canadian Association of Retired Persons
• Canadian Cancer Society
• Canadian Civil Liberties Association
• Canadian Council of Registered Nurse Regulators
• Canadian Hospice Palliative Care Association
• Canadian Life and Health Insurance Association
• Canadian Medical Association
• Canadian Medical Protective Association
• Canadian Psychiatric Association
• Canadian Society of Palliative Care Physicians
• Council of Canadians with Disabilities
• Council of Pharmacy Registrars of Canada
• Covenant Health
• Dying With Dignity
• Ontario Hospital Association
• David Zussman, Jarislowsky Chair on Management in the Public Sector, University of Ottawa
• Dr. James Downar, palliative care physician
• Dr. Eric Wasylenko, palliative care physician
• Mr. David Wright, palliative care nurse
• Dr. Paul Henteleff, palliative care physician
• Dr. Gary Rodin, psychosocial oncology and palliative care physician
Appendix 3 – Recommendations That Should Be Implemented Through Provincial/Territorial Legislation

Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying.

Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

Recommendation 16: To support case review and system oversight, data should be collected from the patient’s initial request to the time of signing the death certificate and/or the completion of that patient’s request (e.g., patient withdrawal of request, physician denial of requests).

Recommendation 18: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met.

Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.
Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. (*See Note Below)

Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner. (*See Note Below)

Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient’s records through the system described in Recommendation 4. (*See Note Below)

Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Recommendation 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

**Note:** All members of the Advisory Group agreed with the duties set out in these recommendations, but one member believes that they should be implemented through professional regulatory authority standards rather than legislation.
7.9.4 Appendix 4 – Patient Pathway

START

Patient and attending physician discuss end-of-life decisions

Attending physician informs patient of his/her diagnosis, prognosis, all therapeutic possibilities (including palliative care and physician-assisted dying) and potential consequences

Patient opts for care that does not include physician-assisted dying

Patient makes initial oral request for physician-assisted dying

Patient initiates formal physician-assisted dying request by filling out a request declaration form. Form must be countersigned by a witness in addition to the attending physician. An alternate process may be completed if patient cannot physically write/sgt form.

First opinion from attending physician

Physical assessment eligibility criteria:

In typical cases, this would include eligibility for publicly funded health services, competency, previous and irreversible medical condition, and intolerable suffering. However, the assessment of intolerable suffering may take place at a later stage in some cases.

Patient does not meet eligibility criteria

Physician seeks re-assessment from relevant experts

Physician receives feedback from relevant experts

Second opinion from reviewing physician

Reviewing physician assesses eligibility criteria and provides a report to the attending physician.

Attending physician communicates final decision to patient

Approval requires agreement of attending physician and reviewing physician

Request is denied

Patient may seek advice from another physician

Patient verifies request by providing second signature on original request form

Different process may be needed if the patient has lost competence in the period since first request.

Patient withdraws request

Patient confirms request

Physician-assisted dying is provided

Cannabis or medication administered in a public hospital, long-term care facility or related form, hospice or palliative care home, or private residence.

Physician reports death to Review Committee

CONSENTIOUS REFUSAL PROCESS

Period of evaluation and reflection

Duration to be determined on case-by-case basis between attending physician and patient.

APPEALS PROCESS

Existing appeals process for competency assessments

PATIENT APPEAL
Curriculum Vitae

Education History

1988 Graduate of Brescia University College, HBSc, with distinction
2002 Graduate of Huron University College, MTS, with distinction
2016 Candidate, MA Program, Huron University College

Work History

2008 – Present Consultant, Schooley Mitchell Consultants

Volunteer / Church History

1990 – 1998 Board of Directors, Glen Cairn Community Resource Centre
1995 – 2010 Confirmation Instructor, Trinity Lutheran Church, London
1992 – Present Active Member of the London South Rotary Club
2010 – 2015 Youth Coordinator, St. Anne’s Anglican Church, Byron
2012 – 2013 Confirmation Instructor, St. Anne’s Anglican Church, Byron
2012 – 2014 Rector’s Warden, St. Anne’s Anglican Church, Byron