An Open Letter to the Honorable Senator, Chantal Peticlerc

Being a personal message from one disabled individual, to another, on the occasion of Senatorial consideration of Bill 7, modifying the eligibility criteria for access to voluntary euthanasia (medical aid in dying)

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-- A personal introduction

Please accept, Madame, in so far as that might be your wish, the expression of my most sincere admiration : for your person ; for your character ; and for your numerous accomplishments, both private and public.

I am normally governed by an intense respect for the privacy of other persons. Never, therefore, would I have considered communicating with you, were it not for the circumstance forced upon us by the presentation of Bill C-7. The public perception of this law, however, cannot fail to be strongly influenced by your words and sentiments. And I thus allow myself, appealing to your position and duty as Senator, to ask that you give your attention to this letter, which I have also taken pains to share with a larger public, hoping to the stimulate wide and fruitful debate.

I do, however, also take a personal pleasure in these facts, because there are but few people who have known certain extraordinary and intimate experiences, such as you had the generosity to share in your speech of June 3, 2016 ; a speech delivered in very similar circumstances, on the occasion of the second reading of Bill C-14. Also, as chance would have it, I too find myself among that number, having suffered a complete separation of my spinal column on the first of July 1979.

I remain particularly affected by the narration of your reality during the early phase of intensive care : the period of waiting (measured in weeks) before it was possible to undergo reparative surgery ; the fear of any manipulation of one’s battered body ; the fixation on those rare changing details within the clinical environment, such as the movement of the hands on the wall-clock – and the dreaded care routines associated with it – (and I would add to that : the movement of the piston of the ventilator in its’ clear plastic housing, and the constant fear that it might be functionally deficient) ; the pain, of course ; the surreal combination of hallucination and clarity of conscience with which one perceives these things ; the inexpressible mixture of boredom, tenderness, courage, and terror ... All of that, I am able to assure the reader, is perfectly faithful to reality. I thank you, Madame, for having given a public description.

In addition, I believe that my accident occurred at an interval of only three years relative to your own. As survivors of spinal chord injury, and as period contemporaries, then, we necessarily share common references, of generation, of events, and of personalities – such as Rick Hansen, and the (late) André Viger – which will always remain precious to us, even if these persons and these circumstances are progressively forgotten by the young. I remember very well, in fact, the last time I spoke with André Viger, at his business in Montreal, where I noticed (and brought to his notice) a framed picture on the desk : of these three -- Hansen, Viger, and Petitclerc – the grand trio of Canadian wheelchair exploit.

-- The intent behind this letter return

The utility of writing this letter arises, again, from the fact that we also share direct and personal memories from a more distant phase of the still current debate surrounding the legalization of assisted suicide and euthanasia ; memories that equip us today, I believe, with a privileged perspective – and with a special duty – for evaluating the real relation between the goals that were initially aimed for, and the results that have been obtained.

It would also be my hope, that this common experience might permit us to collaborate in elaborating an optimal vision for the future, and to correct, together, certain errors committed in the past.

-- Where I must recognize our differences ; and where I nevertheless permit myself to hope for some agreement return

It would be useless, however, to pretend that we have not arrived at this point by different paths. For while you have identified yourself, in your senatorial role, as favorably disposed towards some form of “right to die” (and that, as you tell us, from the very start), I, as a simple disabled citizen, have always embraced categorical interdiction, with an equal constancy.

Clearly, it is your faction which has prevailed. I, therefore, offer my compliments ; and congratulate you on your satisfaction in this regard.

At the same time, I would like to point out that there have always been two grounds of dispute, very much distinct, one from the other ; and while one of these questions has been largely settled, with the passage of Bill C-14 (and the probable extensions of C-7), there remains a second issue which still demands our attention.

-- The intent of the law, versus the (medical) form chosen for its practical accomplishment return

In the first place, there is the principle, itself, of some sort of right to choose the moment and the manner of one’s own death ; a right to which I now have no choice but to acquiesce, faced with the evidence of a more and more certain establishment.

Nevertheless, there still remains a question of the manner in which such a right should be exercised ; and here (to announce the principal conclusion of my reflection) : I believe I can affirm that we have taken a false turn, as concerns the (excessive) medicalization of this right to die.

For we have already discovered, therein, a whole series of most serious problems : signalled first by the disabled, who have denounced the discriminatory withdrawal of protections guaranteed (previously) by the criminal code (a withdrawal, moreover, justified solely by their medical condition) ; and signalled, also, by a large contingent of doctors, who have protested against the presumed obligation to lend their cooperation to homicidal acts (and this, again, solely due to their association with the medical profession).

Yet, ultimately, I believe, the specific complaints of these groups will be echoed, amplified, and indeed overshadowed by those that will eventually be voiced by a large majority of typical patient-taxpayers. Because this majority, for better or worse, will never consent to die in a voluntary fashion ; and that, because of irrepressible vital instincts, bequeathed to us, whether we will or no, by our biological evolutionary origins.

In the end, this majority depends upon the public healthcare system for the satisfaction of its’ needs ; and this same majority, I fear, cannot fail to realize (over time) that the clinical environment is becoming less and less apt to satisfy its expectations (which is to say : becoming less and less safe), and this, to exactly the same extent that euthanasia practice has been introduced, normalised, and even prioritized as standard care.

Or, to express these observations in the language of “choice” : it would seem that the legitimate choices of a majority among the disabled, among doctors, and indeed among the bulk of the population, are being effectively compromised, to the extent that the medical industry is being transformed to maximize the satisfaction of choices made by a minority, who wish to die. And that again (to repeat the initial thesis) : not as a consequence of the satisfaction of suicidal desires, as such, but rather, by the artificial medicalization, of the satisfaction, of those desires.

-- A call to coherent action return

It would seem -- in the complex play of judicial and legislative compromises which we have seen over the last thirty years -- that majority interests were temporarily ignored before the apparent necessity to validate minority choices, at all costs.

Now however, with the central right practically granted (assuming the imminent passage of C-7), it becomes incumbent upon us to search out – in all earnestness – the means of reducing the harm already caused (and with even greater urgency : addressing those harms announced for the future).

For even if it be true that eggs must be broken in the production of omelettes : in this instance, it is the proper functioning of our public healthcare system which is ultimately at stake : so fundamental to our social identity ; so necessary to the eventual security of each one among us. And in such a case, I would suggest : it is in our interest to break no more than the strict minimum !

-- Subject plan return

To begin with, I find myself in the embarrassing obligation to apologize, to you, for the length of the following text. For even if I have tried to simplify as much as possible, the subtlety of these questions cannot be treated in the length of a typical blog-post. (And should your curiosity require it, more detail is available at : euthanasiediscussion.net (french) and euthanasiadiscussion.com (english))

In the following pages, then, I will try to resume several unavoidable problems, created by the somewhat naive attempt to justify the subjective choice of suicide, with (supposedly) objective limits (ostensibly) drawn from medical science. I will first expose this difficulty in its' conceptual dimension, followed by the practical harms resulting, and I will finish, with concrete proposals for palliation thereof.

But first of all (with your permission) I would find it useful to place the whole in context, with a description of the first major judicial test of the "right to die", in Canada. In this way, we shall identify that which was originally requested ; we will appreciate how the disabled community combined, at that time, a profound sympathy towards the petitioner, with an extraordinary foresight concerning the pitfalls to come ; and we will benefit, finally, from the recommendations produced by this community at that time (recommendations very similar, in fact, to those which I will have the honor of presenting to you, here, a generation later)

An earlier, more equitable, proposition from the disabled community return

-- Sue Rodriguez before the Supreme Court

At the time of this famous case (1993), I had already spent 14 years in my new disabled life. My wife and I were awaiting the arrival of our first child, which I was to care for at home while my wife went back to work. But by chance, one of Mme Rodriguez main reasons for choosing a voluntary death, concerned a fear of her children seeing her in a deficient state.

I will always remember the moment when I saw her expressing this idea, in a televised interview, and I remember also, the sympathetic and even enthusiastic responses of the media personalities discussing her statements. It was from that precise time that I date my constant opposition to any medical justification of assisted death.

Let me be very clear on this point : I did not take this stance in consideration of the rights of Ms. Rodriguez. That she should be allowed to die, or no – with or without assistance – these are other issues entirely. Issues indeed, upon which sensitivity, and respect for others, might easily deprive us of the confidence required to pass judgement.

However, to the extent that Sue Rodriguez was able to convince a sympathetic public that she was objectively correct in abandoning her maternal role by reason of her disabilities, her influence would extend far beyond her personal case. For from this perspective, Sue's example would constitute a terrible threat (due to public perception) to all of those in similar circumstances, who would wish to choose otherwise.

In exactly the same manner as Ms. Rodriguez, then, my choice of policy reflected what I perceived as my own interests. Also, to Sue's great disappointment, I was not alone in this, for the Society which represents those afflicted with her disease, ALS (Amyotrophic lateral sclerosis), took the same negative stand, and for the same reason : for they feared that the effects of a positive public perception of voluntary death would make their own struggles all that more difficult.

Unfortunately then, a simple dichotomy of opinion seemed to be unavoidable (and manifestly unsatisfactory for one side or the other) : that one must either support the right of a minority of individuals, who would wish to die ; or on the contrary : protect the security of those, in the majority, who wish to live.

Your choice, to stand out as the defender of the individual, brings you great honor, and is the mark of an admirably generous soul. Personally, however, I was drawn to the interests of those who wish to live (and quite frankly to my own), in the spirit of that famous dictum "Let the dead bury the dead".

It was only some years later that I began to synthesise a non-discriminatory logic that might (in theory at least) satisfy the desires of those in the one camp, without threatening the security of those in the other. And to my great surprise, I have recently discovered that theory fully explained in a Factum which was presented to the Court, at the very time of the Rodriguez proceedings, and that, by the Coalition of Provincial Organizations of the Handicapped (COPOH) !

It was in the course of a private exchange with former Member of Parliament Svend Robinson (himself a central actor in the Rodriguez controversy) that I learned of this Factum, and of the surprising fact that the COPOH, quite to the contrary of what current opinion among the disabled might suggest, actually supported the petition of Sue Rodriguez at that time ! To be clear, this was the first, the last, and the only time, that a major organization representing the handicapped has taken such a stance, in Canada, and as such, it deserves our greatest attention.

Above all, on reading this document, it becomes very easy to understand how and why majority disabled opinion has since changed so greatly regarding questions of assisted death. And that, I would suggest, is simply because the intent and direction of political initiatives, in this area, have moved ever farther from the principles which the disabled (as represented by COPOH) defended at that time.

-- An admirably nuanced position from COPOH (Coalition of Provincial Organizations of the Handicapped) return

At that time, to be sure, there was no question of a situation like the present, where euthanasia is presented as a routine intervention, recommended with ever-increasing insistence, to a class of patients whose definition is in constant expansion. Not at all. For just as you described the case in your influential speech before the Senate, it was generally understood that the freedom requested was, above all, one of personal autonomy in unique circumstances.

As disabled advocates, COPOH (a previous version of the current “Council of Canadians with Disabilities”) was primarily concerned with the functional equality of handicapped individuals. They were, however, equally concerned with the security of those persons. And so it was, that in the Factum presented to the Court, under the signature of then president, Francine Arsenault, COPOH attempted to scrupulously distinguish these two interests, and give to each its due.

I find it most unfortunate moreover, that this penetrating analysis, emanating from those most closely concerned, did not enjoy more influence as the debate progressed. Because, I believe, our present circumstances might, in that case, have been much more favorable.

Having said that, the Factum was based on a principle which should have been evident to all : that no one can explain the suicide of another ; that it was not the disability of Sue Rodriguez which demanded her death (for if so, how would we explain the other, even more advanced sufferers of ALS who demonstrated before the Court in defense of their desire to live ?). No, the ultimate justification for the death of Ms. Rodriguez was to be found (as you so rightly note) in the sovereign faculty of the human individual, to make their own autonomous choices, in their own unique circumstances.

-- The logic presented by COPOH in their support of Sue Rodriguez’ request for assisted death return

First, Mme Arsenault recalled the legality of suicide, in Canada, beginning in 1972. And from this fact, she derived a presumption that people already shared the right to die, by suicide, without the requirement of any further justification.

Secondly, she recognized the disabled condition of Ms. Rodriguez, but only so far as to point out how this functional deficit would make it impossible for her to commit suicide, alone, without assistance.

And finally (in consequence of which), Ms. Arsenault concluded that Ms. Rodriguez should have the right to seek assistance, in suicide ; without which a situation of evident discrimination would exist to her detriment ; in reason of her disabled state.

These then, according to the Coalition of Provincial Organizations of the Handicapped were the conditions for a fair satisfaction of the claims of Sue Rodriguez (as presented in their Factum to the Supreme Court in 1993) : that it should be legal for her to seek out aid in her desire to commit suicide ; and that (assuming appropriate formalities) it should also be legal for others to assist her in the satisfaction of that desire. Period. Full stop.

All that was so wisely requested, by these representatives of the disabled, was a simple permission, without approbation ; which is to say : permission without any suggestion of obligation ; either for the suicide ; or for the assistant.

(And most pertinently, for us today : without any requirement of turning the existing medical industry upside down in the process)

On the contrary ...

-- Maintaining a strict (non-medical) equality of legal protection for disabled individuals return

By far the greater portion of this Factum, presented by the Coalition, was devoted to the same concerns about the security of ill and disabled individuals, that we have heard so much of in the present study of Bill C-7 ; concerns founded in the fear (or more correctly the certainty) that any legalisation of assisted suicide must inevitably increase pre-existing pressures, upon the ill and disabled, towards an accelerated death ; and worse yet : that euthanasia is no more than homicide by another name.

Therefore, at the same time as affirming this ultimate right of assisted death, as an exercise of souverain autonomy by the disabled (in a relation of strict equality with regards to all other persons), Francine Arsenault, President of COPOH, also laid out a list of requirements calculated to minimize, although not to eliminate (as she points out with regret), the specific dangers imposed upon ill and disabled individuals, generally ; and in particular : calculated to instill a perception, and a respect, of the equal value of all lives.

The very first of these requirements, accordingly, consisted in the complete de-medicalization of any possible recognition of the “right to die”. For at bottom (categorically and inevitably) : allowing certain persons to die (but these persons alone) by reason of their medical condition – contains the presumption (if not in the intention, then with perfect certainty in the perception) that the death of disabled and ill persons be officially recognized as a positive good.

For if not : what need had we of a special law to permit the suicide (and with euthanasia, of the homicide as well) of these persons, and of these persons only ? Why would this authorisation not be restricted to the mere accommodations required (to overcome the functional limits due to illness or handicap) ? After all : ill and disabled individuals (capable of so doing), *already* possessed the right to commit suicide (in the same degree as any one else).

Yes ! therefore (said the factum) to an assistance in suicide when required to overcome the functional limits of illness or handicap ; but, No ! to any suggestion that suicide should be considered (exceptionally) “good” in the presence of an illness or disability !

-- Detailed prescriptions contained in the COPOH Factum return

To clarify her thought, and as a guide to further legislative reflection (including that of Bill C-7, we might note), Mme Arsenault set out the following principles :

That there must not be any requirement of providing a medical justification for assisted death, because ill and disabled persons may wish to die for any number of reasons, exactly as might anybody else ;

That (absent any medical justification) there is similarly no reason to require a “natural” death that is “reasonably foreseeable” (which stipulation, I submit, would answer your earlier hesitations concerning Bill C-14) ;

That there be no need of a doctor’s participation ;

That only assisted suicide by permitted, and that the final act (howsoever minimal) must be accomplished in a voluntary and conscious manner by the suicide him- (or her-) self ;

That euthanasia should be explicitly excluded, because no homicide (of ill or disabled individuals) can ever be accepted in “civilized” society ;

That the suicidal desire, and request, must originate solely with the person concerned ;

And, that, the act of proposing, suggesting, or counselling a suicidal course shall remain a crime.

Such then is the formula, for permitting assisted death, which was put forward by a disabled person, with the goal of satisfying the divergent needs and desires of those people which she believed herself bound to represent. And if we compare this proposition with subsequent court decisions (Carter, Truchon-Gladu) and the law (as we know it today) it becomes easy, I submit, to understand the prevailing negative opinion expressed by the disabled community at the present time.

For our current regime of voluntary euthanasia ("medical aid in dying") embodies the literal antithesis of those non-discriminatory principles expressed by COPOH in 1993. And for this reason, the actual judicial and legislative result appears to represent, for so many people from this community : Not a victory of equal personal autonomy ; but an attack on their physical security.

Voluntary Euthanasia (MAID) : a hyper-medicalization in stark opposition to non-discriminatory theory return

-- a summary description of the "medicalization" of the "right to die"

In its very name, "medical aid in dying" (MAID) is presented as an exclusively medical phenomenon ; access is accorded explicitly (and uniquely) by virtue of medical condition ; the act is performed by a doctor (who thus takes professional and moral responsibility) ; the patient passively undergoes the procedure ; and the whole is defined as benign medical care. According to the legislator : there is no suicide ; the role of voluntary autonomy is reduced to a minimum ; and the discriminatory importance of the disability or illness is increased to the same extent.

It would be difficult, I submit, to imagine a final result that might more abjectly betray its origins.

-- Hierarchy of value among medical procedures : the prioritization of euthanasia return

There is, moreover, an evident desire, in present policy, to maximise this "medical connection" even within the options which are available. For decidedly, not all medical care is deemed of equal priority. Indeed, some current procedures, such as aesthetic surgery or circumcision, might more correctly be understood as mere "services" : that is legal and available options which are performed under medical supervision, but by permission only, and in no way guaranteed (or condoned) by the State.

Logically, considering its highly controversial medical (and moral) nature, one would expect euthanasia to be found (at most) in this category. And that is in fact the case, for both euthanasia, and assisted suicide, in every other nation where these practices are presently authorized.

Strangely enough, however, Quebec to begin with, followed by Canada (in tacitly adopting the premises of Québec law no. 52, 2014) have given the highest possible medical status to the practice of euthanasia, which is to say : a procedure universally guaranteed to every person who satisfies the governing criteria !

By way of comparison: only the very most necessary procedures, such as blood transfusion, share this absolute priority. And in this connection, the very same logic of imperative vital necessity has actually been advanced : that certain euthanasias must absolutely take place (as emergency procedures) to prevent death of the patient !

I am quite aware, certainly, of the odor of ridicule which must surround such an example (of patients hurriedly euthanized from fear that they might die). I must protest, however, that this absurdity is not a function of the description; it is, an absurdity, rather, palpably evident in current Canadian policy.

What difference does it make ? return

-- But if our goal is achieved ... why complain ?

The medicalization of the “right to die” was the result of political forces and compromise which are significantly at odds with the simple revindications of choice and autonomy at the origin of the entire enterprise.

It would be very interesting, indeed, to explain exactly how it is that euthanasia policy has arrived at its current state. More pressing, however, at the present time, is our interest in describing exactly what real difference all of this has made.

For why complain (some might ask) ? We have finally arrived (anticipating the expected passage of Bill C-7, and even if, perhaps, by twisted and indirect paths) at a situation where pretty much anybody will be allowed to end their lives, with the participation of a sympathetic doctor ; and that, ultimately, as a simple affirmation of autonomous will.

But is it not that very respect, of such sovereign willful choice, which has always provided the motivating energy behind this quest ? And have we not gained complete satisfaction ? Wherein, then, lies the harm ?

-- The quagmire of medicalization

return

In the simplest of terms : There previously existed (that is, prior to law C-14) a categorical interdiction of assisted suicide, from which every person might draw a strict assurance that the notion of “consent” could never draw them into any homicidal scenario, either as victim, or as perpetrator.

The medicalization of assisted death, however, withdraws this protection from two specific groups (but from them only) :

1) The ill and the disabled, first of all : for it had now become possible to kill these persons (but only these) in perfect legality

2) Doctors (and diverse other health professionals) : for assuming that any patient should make the proper request (interpreted now as a universal right, pursuant to satisfaction of relevant criteria) all doctors – collectively, and individually (but once again : they and only they) -- were now found obligated to participate (or at the very least to collaborate) in homicidal acts.

In fact, we have become so used to seeing opposition to euthanasia articulated in these terms (of discriminatory danger to the ill and disabled, and of forced participation by health professionals), that we might easily be lead to believe that the only real difficulties, with euthanasia, concern protection of the “vulnerable” and the “conscience rights” of doctors !

In what follows, however, it will be my assertion that the ill, the disabled, and those dissident health professionals are really, as it were, but so many canaries in the coal mine. They will, definitely, be the first affected ; but they will not be the only ones. For thanks to the medicalization of assisted death, our entire healthcare system now finds itself in the throws of complete transformation – both conceptual and practical – involving a new philosophy of medical “usefulness” ; a philosophy, moreover, which would seem to be frankly opposed to the satisfaction of those natural desires, expressed by the vast majority of patients, who are sorely afflicted perhaps, but in no way suicidal.

And since this public system of healthcare will typically be the ultimate survival resource for every citizen ; that it constitutes no less that 11 percent of Canadian Gross Domestic Product (and consumes two thirds of all income taxes received) : the state of this system -- and the services that it will prioritize --

will most definitely be the concern -- not of doctors and of the ill and disabled only -- but of everyone without exception.

1) Conceptual harm : the double nature of this unstable hybrid called “medical aid in dying” return

-- Subjective versus objective : the limits of Will, and of Science

At the root of all the problems, discussed in this letter, we find the contradictions inherent in this artificial and complex conceptual creature that we have named “medical aid in dying” ; where we find combined, in irrational juxtaposition : both the subjective justifications of suicide ; and the objective justifications of medical science.

Indubitably, suicide, whether assisted or otherwise, remains (objectively) a moral proposition whose status is unresolved (and incapable of resolution) ; and that, as much for the general principle as for each individual instance. For assuredly, in apparently identical circumstances, one may choose death, while another will choose to live. And since the suicide has none other than his own subjective desire to claim as justification : the suicide can not ask society to declare that he or she is (objectively) “in the right”. What we can grant, at best, is the permission to act, and the assurance that we will thus respect his (or her) personal sovereign choice.

Under these conditions, it follows that the doctor’s role (if we admit the desirability of involving medical professionals in the accomplishment of assisted deaths) would be essentially reduced to that of a brute instrument, employed by the patient in the realisation of his autonomous choice.

It is also the case, however, that medical aid in dying has been defined, equally, as medical “care”. And since medicine defines itself, not as an Art only, but as a Science, as well : medical ethics begins with a strong objective bias. For example, the proper dressing of wounds is in no way justified by an arbitrary decision, from the patient, that such is for the best in his own personal case. On the contrary, physicians have decided, collectively, that dressings are “objectively” good, everywhere, and at all times, insofar as medical indications would suggest their usage. And in addition, the evaluation of that expediency, in each case, will be made under the doctor’s responsibility, in faith of his or her professional judgement.

Furthermore (and perhaps most importantly), in keeping with the normal application of medical ethics : whereas the patient may refuse care (for any reason, or for none at all), he can never *oblige the doctor to act* against the evidence of clinical indications.

And here it is, unfortunately, that we encounter the fatal contradiction at the heart of this artificial hybrid of political provenance : for MAID cannot be, at one and the same time : both the exercise of a sovereign (subjective) right (available to every eligible citizen) ; AND, a medical procedure of which the prescription depends upon the (objective) professional judgement of the doctor.

For here we see one single phenomena -- medical aid in dying -- which would claim to have two justifications at the same time ! And justifications, moreover, which are not only different, but spring from different ethical roots (the one subjective and arbitrary ; the other objective and rigorous) ; and of which the twin applications can not fail to produce fatal conflicts, where the will of the patient, and actions clinically indicated, should fail to agree.

And thus we have to choose : either the will of the patient will take precedence over medical indications (which would violate the ethical framework of the medical profession), or else ; medical considerations might over-rule the will of the patient (which would invalidate the premise of sovereign choice which is at the core of assisted death).

Unless, of course ... there might be another more subtle interpretation -- implicit in the definitions provided by the legislator -- to the effect that the rigorous "objective" study of clinical indications could never, in any situation, disagree with the subjective desires of the patient !

-- Two possible resolutions of this enigma : one more sinister, even, than the other return

As a first possibility the legislator's intention may simply have been to validate the will of the patient, by ensuring the doctors essentially obligatory cooperation.

In this alternative, we see the implicit evocation of the now famous "death on demand" scenario. For therein, the notion of euthanasia as "medical care" has no real significance, beyond creating a bit of politically reassuring ambiguity, in order to facilitate the necessary instrumentalization of the medical profession.

Fear not, however, Madame ! It is in no way my intention to bore you with the re-opening of past rhetorical wounds. I willingly accept the evidence that you (and many others also) consider the respect of sovereign choice to be more important than the possible dangers which might accompany that liberty. I understand, also, the legislator's possible desire to "sweeten the pill". I merely wish to point out, that if such be the case : the definition of assisted death as "medical care" becomes entirely unnecessary ; and unnecessarily harmful.

But unfortunately, that is not all. For as announced previously : there still remains one final trap hidden at the bottom of this bag of conceptual tricks -- a trap from whose operation I fear infinitely more painful results.

-- The eligibility criteria for MAID : taken literally as clinical indications ; and used to justify the prescription of euthanasia return

As stated : medical care can only be given, without controversy, if the patient's wishes are aligned with the doctor's judgement based on clinical indications. But as regards medical aid in dying (QC, law 52) every patient is also guaranteed access to this procedure, insofar as he or she fulfills the eligibility requirements.

Clearly, under these conditions, the only way that the theoretical integrity of the medical ethical model can be respected, would involve an exact relation of identity (imposed by law) between the "eligibility criteria", and the supposed "clinical indications" (such that the doctor's judgement can never be contrary to the patients will in this matter, by definition !). And whereas this might seem to provide an innocent and effective stratagem for resolving the paradox exposed, the further ramifications of such an idea extend far beyond that usage.

And that is because every doctor would henceforth be required to consider euthanasia as a medically indicated procedure for any patient (from an objective point of view and without consideration of that patients opinion) from the moment that he should satisfy the other criteria stipulated by law (which are, as noted, not of medical, but of merely legal provenance) !

-- The logical implications of such an interpretation return

It might be useful at this stage, to recall that the definitions of words, and the construction of ideas, entail real consequences ; and that the linguistic fantasies of the legislator cannot escape the literal implications of those definitions, and ideas, when they are implemented in practice. And thus, beyond the enormous wound inflicted by this intrusion of the State -- upon the honor and the tradition of the medical profession -- there are extremely important practical consequences which accompany the integral application of this doctrine.

In keeping with the earlier example of wound dressing, for instance, the fact of truly accepting euthanasia as required medical care (subject to criteria-indications as described above) would impose upon all doctors the duty to euthanize all patients in this category (insofar as they are able to obtain the required consent).

And what is more, each doctor would also have a strict duty to do everything possible to bring the patient to accept this objective medical benefit ! For in all ethical coherence : only the positive refusal of the patient might obstruct the delivery of a procedure of this priority ; and nothing could be allowed to interfere with the benevolent pressure applied in order to solicit and obtain an eventual cooperation. Because, once again, without artifice : these are the logical consequences of literally proclaiming euthanasia to be a high priority medical procedure, as current law so clearly does.

-- A few illustrative examples return

When the clinical application of relevant information indicates that certain persons should be vaccinated, it is normal that the recalcitrant should suffer the criticism, and perhaps even the coercion of their fellow citizens. And why should it be any different with euthanasia ?

Or again (in case that example might appear extreme), let us confine ourselves uniquely to the force of perception, in circumstances entirely free of constraint : imagine, rather, a patient suffering from diabetes who refuses to correct his behavior, or to properly follow prescribed treatment. Would they not be well within their rights (doctors, nurses, family members, friends, and even accidental acquaintances) in remonstrating with him ? Would they not be doing the right thing, all of these persons, in pushing the patient, as firmly as possible, towards the therapeutically appropriate solutions ? And why should it be any different with euthanasia ?

In fact, let us agree that the average patient, most of the time, simply allows himself to be cared for, within the “rules of the art”, by professionals in whom be believes he ought to repose his entire confidence. And why should it be any different with euthanasia ?

Oh yes ! I agree that such descriptions might appear “absurd”, or “impossible”, or even “unimaginable” ... at first sight. But there is perhaps a certain warning (I might suggest), in the fact that we have so often heard these words already (and many others of the same flavor), without the trajectory of this invasive phenomenon, of medically administered death, deviating by one iota from the most pessimistic projections.

For lucidly understood : any conceptual machine, faithfully implemented, cannot fail to function according to the nature of its design.

-- A logic which tends towards the general establishment of marginal choices return

Generally speaking, the judicial principle of “fairness” would suggest that a right of “choice” once granted for some can not easily be denied to others. So be it.

As we know, euthanasia was originally decriminalised to satisfy the desires of a few isolated individuals ; and subsequently, admissibility criteria were greatly widened through the use of “fairness” arguments (n Truchon-Gladu, and Bill C-7).

The notion of medical “care”, however, leads us far beyond even this judicial pattern ; for voluntary euthanasia (normalized as high priority medical care) presents also as a clinically advantageous solution for any person in the eligible category. It follows, therefore, that each widening of eligibility criteria also widens the basin of patients for whom it is presumed that euthanasia is a “medically indicated”, a “desirable” or (in common speech) simply a “good” choice. And from this fact, a proportionally greater number of people would also be exposed to the institutional dangers resulting.

And so it is, that we are eventually invited to credit this most bizarre of propositions : that the litigious expression of purely personal desires, emanating from statistically marginal individuals (in the way that Sue Rodriguez, herself, was objectively part of a small minority among ALS sufferers), should actually determine what is to be considered medically “good” ; henceforth normalized, for everyone, everywhere and at all times !

-- The physical security of “incapable” patients : also threatened by the “fair” application of those political indication/eligibility-criteria, which now define medical “good” return

As we must frequently remind ourselves : all public acceptance of “assisted” death depended (originally) upon a respect for autonomous choice. In the Carter case, for instance, one of the judges actually insisted on stipulating that the term “medical aid in dying” (as then presented) was identical to the more familiar expression “voluntary euthanasia”. But as shown above : the legal definition of MAID as medical “care” changed everything in this calculation. And whereas the “capable” patient (who also has a sufficient force of character) may always avoid the treatments that are “indicated” for him (through his ultimate right to “refuse care”), *this is not so for incapable patients* (those not mentally apt to make the required decisions).

For if euthanasia really is a medically indicated procedure, in such and such clinical circumstances (pursuant to the artificial criteria definitions imposed), then it also becomes our most sacred duty to provide that medical benefit to those “incapable” persons for whom we assume the care and responsibility. It therefore, follows, in a most perfectly rigorous fashion : that any incapable (and otherwise eligible) patient should be euthanized (assuming the eventual rendering of judicial decisions favorable to this interpretation) ; and finally, that incapacity itself, received as a “grievous and irremediable” condition (as per Bill C-14), should ultimately serve as the pretext for evacuating this entire class of persons.

However, even this, unfortunately is not all, because we can also reasonable predict that the more or less voluntary “good” choice of euthanasia, made by certain “capable” patients, and the normalization of euthanasia among the “incapable” population, should eventually conspire to create a near unsustainable pressure (to consent to euthanasia), brought to bear upon those eligible individuals who are “capable” ... but recalcitrant.

Is it possible that I have advanced overfar in these speculations ? Certainly, I must admit that the future remains opaque. However, we already possess several years experience in this matter. And in the end, we cannot do otherwise than to “judge the tree by its fruit”.

So of what nature, exactly, are those fruits ?

2) Practical harm : Institutional implementation, and transformation of the professional corps return

-- Institutional implementation

From the “Law concerning end of life care” (Quebec, June 10, 2014) :

Any person whose condition shall require it, will have the right to receive end of life care (alinea 4) including, by definition : voluntary euthanasia or “medical aid in dying” (alinea 3.3)

And

Every “establishment” shall offer “end of life care” (alinea 7) where the definition of “establishmemt” includes : local community service centers (CLSC), hospitals, and long-term care facilities (CSHLD), etc. etc. (alinea 3.1)

Or, to translate the basic intent : the State guarantees access to voluntary euthanasia in all establishments under its control (subject only to satisfaction of eligibility criteria) ; and because health-care service delivery (in Canada) is a virtual public monopoly, this signifies in practical terms : that euthanasia is practiced everywhere.

Moreover, since voluntary euthanasia is now defined as benign medical care (and even essential medical care) it follows in perfectly rigorous fashion ; that every doctor, in meeting with any eligible patient, should inform him (or her) that euthanasia presents as a medically appropriate treatment (in their case) and that they possess the strict right to request (and receive) it.

And thus it is, that the typical patient (possibly confused, and certainly overwhelmed by a most serious diagnosis) not only finds himself in a place where patients in his category are routinely euthanized, but right off the bat – possibly in the very first encounter with a responsible professional – euthanasia is presented to him personally as a medically indicated procedure !

Yet most unhappily (I must assure you, Madame), these are not, this time, idle speculations about some mythical “slippery slope” whose operations may, or may not, manifest themselves in some hypothetical future. Not at all. This, to the contrary, is a literal description of present conditions, as I write these lines : in Quebec, in Ontario and in British Columbia (to specifically mention these three provinces containing, together, over 70 percent of the Canadian population), and elsewhere also, according to a common formula.

(And if, perchance, the patient should receive a style of care which is other than that described, this will not be the fault of the law (nor of the new “best practice” guides furnished by provincial reglementary authorities). On the contrary ! Such an occurrence would stem, only, from the still considerable (and influential) presence of those doctors and nurses who continue to refuse to be so governed.)

And so it is (to site the somewhat facetious commentary of one particularly lucid critic) : that it is now very easy for the typical consumer to access a smoke-free hotel room (or an exclusively vegetarian restaurant) *but it is essentially impossible* for the typical patient to benefit from a clinical environment free of euthanasia, and of its influence ; and this even, with almost trivial exceptions (most of which are currently the subject of litigation) : within pre-existing centres of Palliative Care ; which were, nonetheless, created in a spirit of care which is entirely antithetical to the practice of euthanasia (and whose practitioners -- at the time of legalization -- were virtually unanimous in refusing their collaboration).

-- Instrumentalization of the professional corps return

It would be useful to repeat here this fact : that the legalization of euthanasia did not result from an evolution in the ideal mission of medicine as conceived by consensus among its practitioners. Not at all. The practice of euthanasia was imposed by apparently irresistible forces of a political nature.

And this, to be clear, is the greatest practical harm caused by the medicalization of “assisted” death (with the sole exception of that mortal danger which now hovers above the typical patient) : being the subordination of medical science to the pursuit of political goals ; the loss by this professional corps of its millenary tradition of self-definition and self-regulation ; and finally, the instrumentalization of its practitioners.

-- An imprudently general delegation of homicidal authority return

To begin with, the political definition of voluntary euthanasia, as medical “care”, entails the involvement of all health professionals, collectively and individually, as required.

But what an astonishing circumstance ! Homicide, practiced under any conditions, whatsoever, remains an act of extreme gravity, for which we would assume the authorisation to be limited, and supervised, with the greatest acuity.

And yet ...

Bestowing the euthanasia mandate, generally, upon all doctors and their support teams (as well as certain other independent professionals), signifies, in practice, an authorization to accomplish homicidal acts (of a highly discretionary nature), accorded to no less than 500,000 Canadian individuals (counting only doctors and nurses), without either individual choice, selection, certification, or monitoring !

Apparently then (within this most complex set of contrary emotions which the larger public feels toward doctors), in this one and unique particular, which is euthanasia : we have decided to embrace – without reserve – an attitude of incredible confidence, to the effect that the individual characters, motivations, and acts of these professionals should be considered – automatically and without discussion – quite above reproach ; and that we may, therefore, accord to them unheard of powers, of life and death, without any further formality ; without fear ; without regret.

(And yet, such an excessive confidence would never be acceptable in any other realm of human endeavor. And that fact alone, I submit, should fully suffice to expose the irrationality.).

-- The loss of a properly medical judgement of euthanasia return

Secondly, this definition of euthanasia as medical “care” (or rather, this decree from the State) eliminates the possibility of any *other* definition -- or even discussion -- which might be properly medical. For the political definition has *closed* discussion.

And so it is, according to official interpretation : that no doctor may object to the practice of euthanasia (wherever it is deemed legal) for reasons of professional judgement which are founded in his *medical* understanding !

-- Attrition among those doctors who continue to support a medial mission that is unconditionally oriented towards the preservation of life return

For this reason, the large majority of doctors (70 percent), who state they would not personally wish to practice euthanasia – and even more pertinently the substantial minority (30 percent), who continue to categorically dispute the legitimacy of this practice – find themselves accidentally, and involuntarily (but no less significantly), in disaccord with the new realities of their profession.

And yet, quite simply, the existence of an environment capable of supporting those typical patients whose desire to live will predictably push them beyond the bounds off that which might appear rationally “useful”, depends, above all, upon the presence of such professionals, now, and in the future.

Now without judging in favor of this group (and even while admitting the pragmatic necessity of allowing certain other doctors to practice differently) : it would still seem evident that the normalization of euthanasia practice, under artificial constraint, must inexorably play towards the marginalisation of these professionals, the obstruction of their professional development, the prevention of their replacement, and the reduction of their numbers to the same extent.

First, among more senior physicians : because Palliative Care and euthanasia are now practised in the same spaces (and because these strategies are pursued by clinical teams which complete and overlap one another), positions of higher authority must naturally become the exclusive domain of those doctors who claim to be comfortable with both (a pattern which we can be expected to proliferate, throughout the medical landscape, subsequent to enlarged admissibility criteria contained in Bill C-7)

Secondly, among doctors and nurses in development, for whom the normal expectation, for hiring, for certification, and even for admission to study, will depend, henceforth, upon a presumed willingness to participate in euthanasia as required.

Inevitably, with this new requirement of participation in homicidal acts, the tone and the spirit of the medical profession will change profoundly. And this change will be marked, quite certainly, by a corresponding change in the character-types displayed by those persons who will be attracted – or repelled – by its practice.

-- A complete transformation of the industry, towards a new medical mission return

From all of these facts, we see the emerging portrait of a medical industry which is reinventing and reconfiguring itself entirely.

Obviously, these arrangements go far beyond the needs of a simple accommodation to permit the accomplishment of personal choices expressed by a suicidal minority. And more precisely : these arrangements go far beyond any logic of compromise between patients (desirous of benefitting from one service or another), or among doctors (desirous of providing such services). For clearly, the pragmatic accommodation of competing viewpoints could never engender a result so heavily slanted towards one side alone.

With all of the respect and delicacy, then, required by the discussion of such a subject : it would appear impossible to honestly continue this enquiry without considering, also, those interests which are specific to the State ; acting at once, as both the provider and purchaser of health care services (and as a virtually monopolistic actor in both instances).

-- The darker side of State financial interest   return

It is quite evidently the most fundamental interest of the State (in its role as purchaser), to reduce to an absolute minimum the cost of services purchased.

And since the greatest part of medical costs are incurred for the benefit of a small number of persons, and for the rest, that most of the outlays involved occur in a short period, at the "end of life" : the elimination of those people – and of those final years – would result in very significant savings. These are, moreover, indisputable facts (although a common understanding of the actual extent of such savings will remain the object of competing arguments and methodologies for some time to come) ; also, as taxpayers we are all beneficiaries.

There should be nothing strange, or shocking, then, in the knowledge that there does indeed exist a vision of medicine – or more correctly a vision of public health – as influential as it tends to be discreet : where the sufferers of "grievous and irremediable" illness and disability "should" more "rationally" be directed towards and an accelerated death, rather than towards difficult and expensive supports.

Indeed, were it a question of automobile repair, or the support of profitable livestock such as dray horses, or milk cows, it is obvious that such economic rationality would be appropriate.

(And if only we were able to convince ourselves that our instinctive hesitation to perceive human life in these terms, is nothing more, in the end, than the result of prescientific prejudice and superstition : then, certainly, we would immediately be capable of enjoying, without scruple, the benefits of savings thus expected.)

-- A more generous interpretation   return

It is not my wish, in this place, to judge the intentions of our leaders. (And if I might have shocked your sensitivities with a tone of possibly inappropriate levity, I sincerely apologize). I simply wish to point out that the potential financial benefits of a new paradigm of "Death Medicine" are simply too large to be ignored. And as such, we can not avoid these questions with a simple refusal to listen, or the usual joking rejoinders.

Above all, we must admit that the "system" does indeed have its own specific interests ; and that the pursuit of those interests continues always, tirelessly, in a manner that is both automatic, and largely unconscious ; in spite of what we say ; and in spite of what we do.

In the end, the only argument that might convince the partisans of this model to moderate their enthusiasm, resides in a respect for clearly expressed democratic will. However, in this case, it is precisely that will which appears to be in dispute. For not only do we seem to be in the presence of an irresistible support for legislation which is more and more permissive with regards to the "right to die" : we also see charismatic ill and disabled individuals, before the Courts, loudly demanding the gift of a merciful death !

How then might we think of condemning our jurists, our legislators, or our administrators, should they declare themselves -- perhaps a little hastily -- in favor of a movement which they believe to be visibly in expansion ? If they proceed, even, as quickly as they may, to certain structural adjustments ; acting in the spirit of that famous exhortation : "Build it , and they will come !"

I do not condemn. I merely council a healthy prudence, and an equal respect for diverse choices. For in the same way that we have shown ourselves open to honoring choices that are suicidal, we must, also, with an equal passion, support the choices of survivors, of their families (and of their doctors also) : the first in their desire to live, and the others in their choice to support those vital desires.

3) Harm suffered by those who would wish to live return

-- The need for specialization in service delivery

A strange presumption exists, to the effect that the normalization of euthanasia changes nothing in the experience of those patients who refuse this option.

That, however would presuppose that the same doctors and the same nurses (faced with patients in essentially identical circumstances) should be able to believe, with an equal fervor, that they must move heaven and earth to save the life of one, yet deliberately end that of the other. But how could that be possible ?

Intuitively, I would say, without hesitation : that passivity in professional opinion could never extend so far ; that at a first glance, different professionals would form very different ideas on the pertinence of euthanizing this or that patient. And (a most important detail), these differences would be the reflection of past experience, and the acquired preferences of a particular team.

And that, clearly exposed, is the principal difficulty in our present system : the simplistic notion that there really can exist one single type of doctor (or one single clinical environment) which can be infinitely polyvalent and truly “all things to all people”. But there cannot. For there really are different sorts of patients (and different sorts of doctors).

Rationally, the respect of these opposed choices would require a strategy of specialization, in service delivery, which would respond to the inherent forces of the distinct markets of which they are the expression : not only, to be sure, that of the minority who wish to access euthanasia services ; be even more pertinently, that of the majority who do not.

How could we imagine (to be blunt) that the clients of one might be accommodated with those of the other ? Indiscriminately packed together in the same institutions ? In the same departments ? In the same rooms ? How could we imagine a patient, in no way suicidal and wishing to live positively in his last moments, obliged to listen to – actually incapable of not hearing – the family of his neighbor (or perhaps even his own) discussing the advantages, the rectitude – the desirable nature – of precocious death ? And that, in conference with the same nurses, and the same doctors, in whom he must repose his ultimate confidence ? Upon whom he depends, in the final instance, for his own survival ?

Permit me to suggest, with respect, that this simply cannot be ; that the only promise of safety, for the non-suicidal patient, lies in the care of professionals whose personal convictions would similarly exclude any recourse to deliberately accelerated death

-- Responding rationally to real demand : a quantitative examination return

Clearly, the main fault in our present and developing model lies in this fact : that the different choices expressed are not received with comparable respect, or equal effect. For these new organizational principles respond perfectly to the choices of the patient who wishes to die ; but they respond only very imperfectly to those of the patient who insists on living. It is to be desired, therefore, that future policies will be designed with an intent to correct this imbalance.

In addition, while accepting this framework of fundamental fairness, we must also take account of relative proportions among the choices expressed. For only in this way can we make a rational division of available resources, and afford to each the care that is appropriate.

And in this regard, the number of patients who wish to live is incomparably greater than the number would wish to die ; and this, not only in the aggregate, but in each subcategory, also, without exception.

For example : we periodically see the reappearance of a literary and cinematographic fashion portraying the idea that the victims of spinal chord injuries are naturally drawn towards suicidal choice (See : « Whose Life Is It Anyway », John Badham, Richard Dreyfus, MGM, 1981). However, the real number of paraplegics and quadriplegics who actually commit suicide (above the number expected among the general population) is only one percent.

Contrary to the dramatic depiction of pathos and tears : among one hundred persons injured in the same manner as you or I – including, also, those who have lost the functionality of their arms – only one (supplementary) individual will actually take his own life ; while ninety-nine will show themselves no more disposed to die than is any other person.

The same phenomenon was illustrated, moreover, among aids sufferers in the worst years of the recent epidemic. To recall these facts : in response to the ravages of that atrocious illness, a fashion of voluntary death emerged -- transformed to a veritable celebration of community – which gained (at the beginning of the nineteen-nineties) a virtually unanimous sympathy, and validation, regarding the essential premise : that better far is an early and voluntary death, than the suffering of inescapable degeneration (see : « It's My Party » Eric Roberts, Randal Kleiser, United Artists, 1996).

However, these facts not withstanding (and exactly like the situation among catastrophic injuries) : during this entire period, up until the arrival of efficient antiretroviral therapy. circa 1996 (not in one year, that is, but in the entire epidemic) : no more than two percent of persons so affected (above the norm) actually committed suicide.

Similarly, with regards to euthanasia today, even among the category of patients who are the most likely to request that practice (which is to say those faced with the truly terrifying diagnosis of terminal cancer), no less than ninety-percent refuse to die in that manner, and this, in the Netherlands and Belgium – where euthanasia has now been legal and generally available for nearly twenty years.

Clearly, we can gather from these facts (as I must respectfully emphasize) : that the prioritization of euthanasia practice (and thus the restructuration of the clinical environment -- with a goal of prioritizing the needs of this minority of atypical patients -- is seriously at odds with both the fundamental notion of fairness in the distribution of collective resources ; and with the very first rule of applied economics : that any offer of services shall be proportional to the corresponding demand.

-- A nostalgic look towards the past return

At the time of my own post-trauma healing and rehabilitation, forty years ago, I was aware that certain members of the care team considered my survival as impossible, and not worth the effort in any event. But these were voices, most happily, that were isolated, contradicted, and criticized by the majority. And although some did tell me that they, personally, would rather die than be in my place, no one actually suggested such a course.

(There appears, also, a very significant realization in these facts : that professionals, equipped as they are with a greater experience of outcomes, are also less easily overwhelmed in the face of present crisis. And whereas friends and family members often have a need to see proofs of a positive will on the part of the injured individual (in order to believe in future possibilities), seasoned professionals tend to begin with a confident assurance (or at least with the appearance of such an assurance) : that the patient will ultimately succeed in a positive rehabilitation.

Above all, such professionals frequently succeed in communicating this attitude to the patient himself, in a very influential manner. And as we have seen : not only does this strategy maximize the chances of a positive outcome in particular cases, it also agrees with statistically observed fact.)

And so it was, that I was able to profit from a highly positive environment in which I had the opportunity to heal. And I can affirm now, with great gratitude, that the doctors and nurses which I have had the privilege of interacting with (with a few inevitable exceptions) did everything possible to foster that environment. And not these professionals alone, but everyone on site, including, even and in some cases especially), auxiliary staff such as housekeeping and cafeteria workers.

-- A positive predisposition that was once taken for granted return

Such was the assumed expectation, even in those literary scenarios of the “right to die” which were referenced above : that the fictional medical teams – in a true reflection of reality – would show themselves ready to try, by all means, to encourage the vital instinct in the suicidal patient ; that the hero would be obliged, in order to achieve his end, to overcome this opposing will of support – perhaps awkward and inopportune – offered with such insistence and sincerity, by all around him (a little bit, I would suggest, like the child who insists upon impetuously braving life’s dangers, and who violently throws off all proposed protection, but for whom, nonetheless, we always keep an open door).

Such was, I submit, the only professional standard that was considered acceptable in such a case : that the entourage should categorically resist this atypical loss (statistically inevitable in one or two percent of cases) ; that the caregivers should never abandon either faith or hope ; and if suicide there must be, after all : that it be the suicide himself who should impose that separation ... to the regret of all.

Such was, to recall these circumstances from the past, the care which I myself received, in the first years of my injuries, where still floated the giant shadow and influence of Terry Fox (1958 – 1981) ; that most extraordinary symbol of unconditional perseverance.

And such is the care, also, that I would wish to bequeath to future generations.

-- To the detriment of the typical patient’s interests : ambivalence ; ambiguity ; and doubt return

Unfortunately, however, we presently observe the normalization of a very different model : where we expect that the caregiver will maintain an ambivalent attitude toward the life-urge of the patient ; where he (or she) will abstain from “moralizing”, from exhorting a struggle for life (and if unable to instill a faith in the future, at least to encourage perseverance, now, in the present) ; where on the contrary meritorious sympathy is now claimed to consist in assuring the damaged individual that we “understand” his despair, and even in signalling to him our proactively favorable readiness : to support him in any eventual choice of voluntary death.

But why so ? Is it in order to validate the choices made in cases involving one percent of catastrophic injuries (or ten percent of terminal cancers) ? This would seem, to me, to be an exceedingly thin justification for failing, to such a degree, in our duty towards the ninety (or ninety-nine) percent, who remain.

Is it the hidden influence, morally blind, of budgetary interests ? I sincerely believe, to the contrary, that the best, and well-considered interest, of the typical patient/taxpayer, lies rather in the quality of care that he will personally receive in his specific hour of need, he and his family.

And for that reason : in the simple defense of the interests of all (survivors) – and even while permitting the legal accomplishment of firm choices made by a particular minority – I would ardently wish to arrest this progress, already so significantly engaged, towards the institutional normalization of a maximum recourse to euthanasia.

What we might do to improve these circumstances

-- Depth of the crisis and possibilities for improvement return

At the beginning of this letter, I described a request for access to assisted suicide -- supported by important groups representing the handicapped – which was founded in a principle of simple equality ; where the disabled persons might choose to seek assistance in performing the suicidal actions which they were unable to accomplish alone ; where doctors (or others) might choose, in their turn, to provide this assistance ; where negative perceptions regarding disability would not be exacerbated by the presumption of medical reasons for suicide ; where it was admitted ,on the contrary, that disabled persons might wish to die for a multitude of reason, just as might anybody else ; where the fragility of dependant persons (and especially that of dependant persons incapable of making such highly significant decisions), should be scrupulously protected by the stipulation : that only clearly voluntary *suicides* would be permitted, sealed at the last by a final, sovereign, autonomous gesture (however minimal) ; and in no case would passive homicides be permitted, which is to say : euthanasia.

And yet that which has been provided in response, thirty years later (assuming passage of Bill C-7) is a legal framework where assisted death has become not only the business of doctors (thanks to unavoidable historical connections), but of medicine itself (by virtue of defining euthanasia as universally available medical “care” guaranteed by the State).

Indeed, faced with the scale of this redirection of intent, it might seem difficult to even seek for a remedy.

Especially, when the recognition of these difficulties has barely begun to appear in the collective conscience. On the contrary ! There remains a wide satisfaction in the first victories of “right to die” and a corresponding appetite to enlarge their influence.

However, that being said : the essential requirement (following the resent analysis) resides in a clear distinction between the actual “right to die” (apparently supported by an unshakeable political “consensus”), and the medicalization of that right (which has shown itself to be the source of so many difficulties).

And although we are now obliged to act under the constraint of important limitations, there still remains a possibility of restraining the institutional influence of euthanasia, insofar as we clearly understand what we wish to accomplish. And further, although we are not able, collectively, to agree upon the wisdom of allowing euthanasia (in absolute terns) : it seems to me that a pragmatic majority might still emerge to condemn, unequivocally, any tendency towards using the “euthanasia question” as a pretext for implementing a new “utilitarian” medical vision.

Most happily, in fact, there are practical initiatives (of great effect) which we might immediately employ to ensure this result.

-- 1) Most important : a return to first principles : to be embedded in existing law return

The first (and simplest) initiative that the legislative authority might enact in pursuit of this goal, is to be found in a new declaration of intent : designed to evoke the distinction identified above ; which will reaffirm the desire to validate personal choices ; but will repudiate the supposedly “objective” justifications derived from medical science.

Accordingly, without abandoning the current legal framework (which would seem quite impossible for the time being) it would still be possible (and highly advantageous, I suggest, using the opportunity presented to us by the revision of Bill C-7) to add some text similar to the following :

That decriminalization of assisted death aims, in the first instance, at the validation of autonomous personal choice.

That in spite of the exclusive granting of this privilege to medical professionals alone ; and in spite of the use of medical criteria in an attempt to define its limits : the privilege accorded contains no more than the permission to act, and not an official approval of the act ;

And for greater certainty :

That no inference must be drawn considering the pertinence (which is to say : the ethical nature) of either assisted death in general, or its utilisation in any particular case ; and,

That the mere satisfaction of judicial-legislative eligibility criteria in no way signifies that assisted death (legally accomplished) should be considered “objectively indicated”, whether this be in the medical, or any other, sense of those terms.

-- 2) Definitely close the path towards euthanasia of the “incapable” return

Secondly, it has unfortunately become necessary to explicitly reinforce the “capability” requirement, by using the “notwithstanding” clause (article 32 of the Canadian Charter of Rights and Privileges), for otherwise, we must understand that the security of these “incapable” persons will very certainly be threatened by way of judicial appeals to the principle of “fairness” in the provision of a medical procedure freely available to others.

-- 3) Further recommendations return

It is the present opinion, that these two initiatives alone (to state an intention of permission without approbation, and to establish an impassable barrier against euthanasia of the “incapable”), would immediately save us from great social pain to come. There are, however, several other current amendment propositions which I support, and in particular :

3-a) Interdiction of euthanasia proposal return

That it shall be forbidden for doctors (or any other actors : professional or volunteer) to proactively propose euthanasia to any patient : for the euthanasia request must always come from the patient ; while unsolicited suicidal suggestion remains an ethical (and criminal) misdeed of the gravest nature (whether this be done directly, or under cover of a so-called “duty to inform”)

3-b) Elective Certification Requirement (ECR) for euthanasia practitioners return

Prudence demands that the basin of persons authorized to practice euthanasia (assessment and/or provision) be subject to regulation.

Logically, this regulation would entail : a voluntary request for certification ; psychological selection ; comprehensive education ; active monitoring ; support resources as required.

An Elective Certification Requirement would provide protection for both patients (desirous of understanding their doctors' philosophical and professional positions), and doctors (by preventing crises of conscience, inflicted by operation of the involuntary universal mandate)

The expectation of such a distinction would favor the recruitment of a most inclusive professional corps.

3-c) A personal note on waiting periods return

I, personally, suffered from a moderately severe bout of depression three years after my accident, which combined in its causes : both persistent frustrations concerning my disabilities ; and a serious failure in business.

I would, no doubt, have been eligible for euthanasia at that time (following proposed criteria in Bill C-7) ; and this, quite possibly : to assuage the pain of financial loss !

We see here, of course, a very clear example of the discriminatory nature of selectively removing the protection previously promised to all persons.

Also as concerns waiting periods specifically :

The literature concerning catastrophic injury shows a rate of suicide that is extremely high in the first year, moderately elevated thereafter, and essentially normal after five years. A strict reading of this data would suggest that there is no reason to accord (or impose) a specific euthanasia exception for these people, because: it would be irresponsible to facilitate suicide during the first five years ; and statistically unjustifiable afterwards.

However, once again, I would hesitate to reopen this fundamental question concerning the basic right to access assisted death. I would simply like to remark that the satisfaction of this right, artificially normalized as benign medical "care", operates in a discriminatory fashion ; and also : that any non-discriminatory provision of such an option would logically include an exclusionary exception for the protection of catastrophic injury victims, through (at least) the first five years.

For decidedly : to mandate a waiting period of ninety days, only (as proposed in the current Bill), would seem akin to a malicious joke.

-- A flexible look towards interpreting the diverse laws, and professional "norms", which exist at this moment return

The accommodation of euthanasia practice will inevitably entail major changes in the medical industry, and in all of society. It would be frankly impossible to foresee the future evolution of this accommodation, just as it would have been impossible to foresee our present posture at the time of legalization, five years ago. And for this reason, it would be unproductive to attempt to plan, now, in excessive detail. Better far, I believe, would be to encourage an environment of dynamic evolution under the guidance of prudent directing principles.

That being said, our federal system provides a perfect framework for the operation of such dynamics, because "Health" remains a provincial jurisdiction, and therefore : we will benefit from as many independent development laboratories as we have provinces.

For the moment, the hyper-medicalization of "right to die" is not frankly established in federal law, for there it is presented as decriminalization only, and not a positive declaration of euthanasia as benign medical "care". As a result, the provinces (for the most part) possess a great deal of latitude in interpreting the federal intent. And thus it will be, for each one, following their own best judgement, to find some formula that might accommodate the suicidal minority, while ensuring, for the majority, a clinical environment respectful of their needs.

It would be beneficial, in this spirit, to see provinces legislating independently (and as quickly as might be) on the central issues now in play, such as the guaranteed right of professional conscience (in keeping with what has already been done in the province of Manitoba), and also, concerning the right of typical (non-suicidal) patients to enjoy access, above all, to establishments and professionals that are free of euthanasia, and of its influence.

Over time, the natural sharing of experience and "best practice" will be of benefit to all.

Finally, Quebec, unique to date among the provinces (and indeed among all the nations of the world) has gone so far as to furnish a political definition of euthanasia as medical "care" (universally available moreover and with access guaranteed by the State). And yet,, even this definition only refers (specifically) to "end of life care".

Logically, therefore, this definition should become inoperative (or at least subject to comprehensive review) due to the widening of eligibility criteria which we expect from the passage of Bill C-7. And the opportunity will exist, under these conditions, to reclassify euthanasia, not as essential priority medical "care", but rather : as a simple service offered under medical supervision.

Conclusion return

In closing, Madame Senator, I would like to thank you, once again and most sincerely, for your personal and influential contribution, which has so markedly contributed to the enhancement, and to the deepening, of this debate.

In particular, you were one of those, at the very passage of the present law, Bill C-14, who reminded us that the popular appetite for real personal autonomy concerning one's own death, could never be satisfied with some sort of regimen governing "end of life care". It is more than possible, moreover, that a greater attention to your words – demanding a more lucid understanding, at the outset, of the liberty truly requested -- might have spared us many of the problems with which we have so uselessly burdened ourselves, thanks to the unhappy strategy of medicalization (apparently expected to provide a limiting influence).

For in the end, none of these medical definitions (optimistically referred to as "safeguards") have succeeded in showing themselves to be effective : "suffering" takes whatever meaning the sufferer claims for it ; and "grievous and irremediable" condition, likewise. Quite certainly, what is practically at issue, now, is a simple right, whose exercise is conditional only upon the willingness of sympathetic doctors.

Moreover, by an appeal to the power of ostensibly objective "indication-criteria" drawn from medical science : even the presumably insurmountable bar of "willful capacity" can no longer be logically expected to halt the "fair" expansion of euthanasia as a clinical benefit.

Clearly, then, we have in no way limited effective access to voluntary death, but we have, in revenge. saddled ourselves with a whole range of secondary wrongs.

Above all, we are very, very, far, at this point, from the usual descriptions concerning “protection of the most vulnerable” or the respect of (religious) “conscience” (among professionals). For in reality, at issue now, is the integrity of our entire Canadian public system of healthcare ; a perception of insecurity among typical patients ; a potentially catastrophic doubt : that this system should be prioritizing the utilitarian interests, of the State, at the expense of personal interests among a majority of patient/citizen/taxpayers.

-- A final wish

return

Most probably, the solution to our present problems (if in indeed solution there may be) will be found in a clear distinction between the “right to die” and the medical fig leaf with which we sought to disguise its establishment.

I do not, therefore, believe that I have any right to condemn the suicidal acts of any of my fellows (although I do reserve, always, my privilege of regret). All I wish, is to deplore the novel assumption that death should be a *medically indicated solution for the relief of suffering*.

What I recommend, in the end, is simply to minimise this fortuitous and contextual link between medical practice and the right to die : not radically, first, but in the intent ; not categorically, of course, but within the limits of that which is pragmatically possible ; not passively, either, but with decision, and with purposeful energy. For only in this way, I believe, might we be liberated, together, from the fetters of past dispute.

Above all, Madame, it would be my ardent hope, to see you (and other disabled individuals who share your parting principles) engaged in this new and necessary task with all of the powers that are uniquely your own : as a private individual, personally concerned, and intimately informed ; as a public personality, object of a wide and affectionate popularity ; and as a Senator, no longer neophyte, but of considerable influence.

And with these sentiments, I consign this letter to your distinguished attention,

Gordon Friesen, Montréal,

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(The author is a resident of Montreal, disabled, father, investor, artist, and athlete)