table eleven: proactive legislative inoculation against any medical justification

A proposed model for future legislation

In order to proactively limit the scope of future euthanasia-enabling legislation (by excluding medical justification), I suggest "tagging" all proposed bills with language such as the following:

"Because assisted suicide (and euthanasia) are purportedly justified, above all, by personal choice; because (in the general case) there is no agreement on the medical legitimacy of assisted suicide, or euthanasia; because (in the particular case) there is no agreement on the objective conditions which would indicate the use of assisted suicide, or euthanasia (not as a right of choice, but as a true, objectively justified medical treatment); because, therefore, the term "medical assistance in dying" signifies only a "death facilitated or caused by medical professionals", but not a "death facilitated or caused as an objectively indicated medical procedure"; and because of the public and personal interest in limiting the propagation of suicidal suggestion: be it resolved that,

1. Assisted suicide (and or euthanasia) be allowed (if allowed at all) by permission only, creating no obligation of any kind to provide (or to assist in the provision of) these services, whether such obligation be portrayed as public, private, or institutional. And in particular:
    a) i) the public powers of government, and administration, shall have no obligation, and no mandate (express or implied) to provide or to insure access to assisted suicide, or to euthanasia.
        ii) no public resources shall be directed towards the provision of such services, or of information facilitating same
    b) no institution, whether public or private, shall have any obligation to provide assisted suicide (or euthanasia), nor obligation to permit such practices in premises under their administration.
    c) no individual, whether doctor, medical professional, or other, shall have any obligation to provide assisted suicide, or euthanasia; nor to provide information pertaining thereto; nor to provide any referral for the provision of such service, or of such information.

2. Regardless of any permission for medical professionals to provide assisted suicide, or euthanasia, pursuant to a properly expressed patient choice: it shall remain a criminally culpable act for such professionals (or any other individual) to proactively prescribe assisted suicide (or euthanasia); to proactively counsel a recourse to assisted suicide (or euthanasia); or to proactively provide any information, whatsoever, concerning assisted suicide (or euthanasia).

********** table one : title page **********

The Medical Justification of Euthanasia in Canada : A Cautionary Tale

(being a friendly warning to our Southern Neighbors)

or,

why (and how) to

deconstruct the medical "narrative"

-- Gordon Friesen, Montreal, April 6, 2022

grf1967@yahoo.com

******Table two : Comparison of choice in Oregon vs medicine in Quebec*******

Comparing the footprint of choice-based assisted suicide with that of euthanasia as medical care

****

Oregon		Quebec
assisted suicide	justification	**euthanasia**
1994	year legalized	2016
28	total years	6
238	deaths / year (2021)	**2,426**

****

****Table three_a: theoretical consequences :justification and ethical status****

Choice vs Medical Treatment

****

As to the Justification of Euthanasia

Subjective preference **vs** **Objective clinical indication**

****

As to Moral and Ethical Status

Objectively undefined **vs** **Objectively declared as a positive good**

N. B. absurdly normalizing the choice of one (who will consent to die) rather than of nine (who will not)

****

****Table three_b : theoretical consequences : responsibility and obligations created****

As to Moral and Ethical Responsibility

Patient, and doctor, bear complete personal responsibility for their respective actions.		**Responsibility is borne almost entirely by the doctor, who is assumed to have prescribed that which is (objectively) the best treatment for his patient.**
	vs	
(However, it is also assumed that the final responsibility lies with the patient).		**It is further assumed that the patient will (normally) concur.**

****

As to any Obligation to Provide

		Doctor: A Clear duty to provide
None	**vs**	
		Society: An Obligation equal to that affecting other indicated treatments.

****

table four_a: practical consequences of declaring euthanasia as (essential) medical care

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Canadian Policy: Based on the Assumption of a Social Obligation to Provide Euthanasia as Medical Care

****

Institutional Policy

As a matter of principle, euthanasia must be practised in all Canadian medical facilities, without exception. This includes hospitals, community clinics, long-term care facilities, home care programs, and hospices.

(Note: as of March 2022, The number of surviving exceptions nationwide can be counted upon one's fingers)

*table four_b : professional conduct ***

Canadian Policy Regarding Professional Conduct

1) Duty to Perform :	**--All medical professionals (nurses, doctors, etc.) are expected to perform euthanasia as required: for employment; for qualification** **--Conscientious objections are permitted, but NOT professional objections** **--even objecting doctors MUST collaborate to the extent of providing "effective" referrals**
2) Duty to Inform :	**--Doctors MUST inform all eligible patients of their "right" to euthanasia**
3) Permission to Prescribe :	**--Doctors (and other professionals) are not required to wait for patients to request euthanasia** **--Doctors MAY proactively propose (prescribe) euthanasia as the objectively indicated (best available) treatment**

****

**********table five_ a : practical effects of theory and policy : doctors and nurses**********

Practical Effects for Stakeholders in Canadian Healthcare

****

For Doctors:

-- Suppression of professional (ie., medical and scientific) opposition to euthanasia
-- Marginalization of non-participating professionals (particularly in relevant specialties such as oncology, geriatrics, long-term and palliative care, emergency medicine etc.).
-- Expectation of euthanasia compliance in candidates to medical school
-- Introduction of euthanasia practice as a required component of medical training and certification

For Nurses

(including other Auxiliary Workers and Professionals):

-- Expectation of euthanasia compliance as a condition of employment
-- Expectation of euthanasia compliance as a condition (and component) of professional certification and training
-- The debilitating effects of predictable ptsd

********table five_b : effects : patient and family; larger society

For Patients and Families:	**-- Systematic propagation of suicidal suggestion through the "duty to inform" all eligible patients of their "right" to euthanasia**
	-- Direct institutional pressure to consent based on the assumed validity of doctor prescribed (that is proactively proposed) treatment.
	-- Institutional life (for the non-compliant patient) in a hostile environment where his or her death is officially viewed as the optimal clinical outcome
For Larger Society:	**-- The unforeseeable effect of authorizing 500,000 people (doctors and nurses) --from a total population of only 35,000,000-- to accomplish homicidal acts, by professional mandate, under merely administrative supervision**

**********table six_a : future contingencies non-terminal patients**********

The Evolution of Euthanasia Policy in Canada

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Recent expansion of Euthanasia Eligibility to Non-terminal Patients

achieved via choice-based arguments of autonomy and fairness

Quebec Superior Court (Truchon-Gladu, 2019) Canada Bill C-7 (2021)

disastrous corollary effects

Because of the inherent confusion, of medicine and choice (in the hybrid concept "medical aid in dying"), extension of choice has brought about the fallacious extension of medical obligations and prerogatives also. In particular:

Perfectly viable patients must now compose not only with the psychological aggression of the insidious "Duty to inform", but also, with the direct danger of euthanasia proactively proposed (i.e. prescribed) by attending physicians.

****

**********table six_b : evolution of policy: future expansion to the incapable**********

Projected extension of euthanasia to the incapable: The final absurdity of confusing medicine with choice

If euthanasia really were an essential medical treatment (similar to blood transfusion) it would obviously be unethical to neglect its provision to the incapable. Moreover, the original designation as "end of life care" clearly implies a context where capacity is nebulous at best. We can therefore confidently anticipate extension of euthanasia eligibility to the incapable

As a final and absurd, tragic consequence, therefore, of having utilized the false cover of scientific (medical) objectivity, in pursuing a choice-based access to euthanasia (originally intended for fully voluntary individuals in the most extreme circumstances *at the very end of life*), we have effectively laid the conceptual and legal framework, in Canada, for the utilitarian evacuation of an entire class of perfectly viable dependent persons: who are in no risk of dying, and who are either incapable of consent, or childishly easy to persuade.

*********table seven : an American concern**********

And This Means What to me ?

(Or: Why the USA is in no way immune to the effects of this sea-change)

"Grooming" for the Arrival of Objectively Justified Euthanasia

Intrusion of medically suggestive vocabulary :

-- "Medical Aid in Dying|" to replace "Dying with Dignity"

-- "medication" to refer to poisonous substances

Strategic introduction of legal clauses which would logically require a medical justification (but where none in fact exists)

-- Professional duty to perform or to refer

-- Institutional obligation to allow (or to lose public funding)

****

********** table eight_a : economics : traditional model**********

The Economics of Collectively Funded Utilitarian Medicine

"He who pays the piper has the right to call the tune"

****

The traditional economic relation of patient and doctor

client/payer	client motivation	service provider	service provider mandate (expressed or implied)
patient	typically: to stay alive	doctor hospital	keep patient alive as long as possible and in the best condition possible

traditional treatment of complex and expensive patients :

maximum creativity in life-sustaining strategies, as desired and funded by patient and family. No deliberate termination of lives.

****

********** table eight_b : economics : utilitarian model**********

The modern economic relation of "beneficiary", doctor, and collectively funded service structures

client/payer	client motivation	service provider	service provider mandate (expressed or implied)
private insurance company or government agency	(as per Helen Keller, circa 1917): "... to maintain the bodies and minds of the people in a state of soundness and efficiency"	doctor hospital	To achieve the greatest total utilitarian benefit while working within the budgets provided; to decide, in this light, when to treat, and how

modern treatment of expensive patients (aka "beneficiaries") :

carefully steer resource-intensive "beneficiaries" away from expensive treatment options; implement triage protocols; obtain patient consent for euthanasia

table nine_a : rejecting the illusion of medical legitimacy : canadian model, why no need to assume medical jusification

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Refusing to Credit the Medical Fallacy

(Or How Canadian Mistakes May Be Avoided in the USA)

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The Canadian Model: A Dangerous Anomaly

The Canadian experience represents a grossly dangerous aberration, in that the definition of euthanasia as (essential) medical care resulted from no organic development within the medical community, itself, but was simply established by political decree. It is a bizarre and globally unique precedent, to be avoided at all costs.

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Why American Euthanasia Policy May Assume an Absence of Medical Legitimacy

A true justification for euthanasia as medical care would necessarily require that doctors agree upon objective clinical indications such that a given patient SHOULD be euthanized (regardless of that patient's opinion, and subject only to passive consent). *But there is no such agreement.*

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**table nine_b medical status of euthanasia

The "Medical" Status of "Medical Aid in Dying"

Objective Clinical Indications	Required Treatment
Medical treatment which doctors and hospitals MUST provide	
bleeding wound	apply pressure; surgical repair
simple fracture	align and immobilize limb
?	Euthanize Patient
Consumer services legally provided by medical personnel	
competent patient choice	aesthetic surgery
?	Euthanasia

To which group does euthanasia logically belong ?

table 10 : defeating proposed obligations

Defeating Proposed Euthanasia Obligations That are Predicated upon Assumed Medical Justification

The Propositions	The Antidote
--Duty of professionals to perform or to refer	**Because these obligations can not be sustained under a justification of subjective choice; And,**
--Duty of institutions to allow	**Because there is no collective recognition of euthanasia, as an objective medical benefit (in either the general or the particular case):**
--Duty of society to provide (ie., to fund)	**There is no basis to affirm any of these obligations**

table eleven_a: proactive legislative inoculation against any medical justification

A proposed model for future legislation

In order to proactively limit the scope of future euthanasia-enabling legislation (by excluding medical justification), I suggest "tagging" all proposed bills with language such as the following:

preamble rejecting any medical justification

"Because assisted suicide (and euthanasia) are purportedly justified, above all, by personal choice; because (in the general case) there is no agreement on the medical legitimacy of assisted suicide, or euthanasia; because (in the particular case) there is no agreement on the objective conditions which would indicate the use of assisted suicide, or euthanasia (not as a right of choice, but as a true, objectively justified medical treatment); because, therefore, the term "medical assistance in dying" signifies only a "death facilitated or caused by medical professionals", but not a "death facilitated or caused as an objectively indicated medical procedure"; and because of the public and personal interest in limiting the propagation of suicidal suggestion: be it resolved that,

table eleven_b: proactive legislative inoculation against any medical justification

absence of medical obligation to provide

1. Assisted suicide (and or euthanasia) be allowed (if allowed at all) by permission only, creating no obligation of any kind to provide (or to assist in the provision of) these services, whether such obligation be portrayed as public, private, or institutional. And in particular:

a) i) the public powers of government, and administration, shall have no obligation, and no mandate (express or implied) to provide or to insure access to assisted suicide, or to euthanasia.

ii) no public resources shall be directed towards the provision of such services, or of information facilitating same

b) no institution, whether public or private, shall have any obligation to provide assisted suicide (or euthanasia), nor obligation to permit such practices in premises under their administration.

c) no individual, whether doctor, medical professional, or other, shall have any obligation to provide assisted suicide, or euthanasia; nor to provide information pertaining thereto; nor to provide any referral for the provision of such service, or of such information.

table eleven_c : absence of medical privilege to prescribe

absence of medical privilege in prescription or suggestion

2. Regardless of any permission for medical professionals to provide assisted suicide, or euthanasia, pursuant to a properly expressed patient choice: it shall remain a criminally culpable act for such professionals (or any other individual) to proactively prescribe assisted suicide (or euthanasia); to proactively counsel a recourse to assisted suicide (or euthanasia); or to proactively provide any information, whatsoever, concerning assisted suicide (or euthanasia).