The Medical Justification of Euthanasia in Canada : A Cautionary Tale

show slide 1 : title page

-- Salutation

Thank you all for taking the time to listen to this presentation. It runs approximately 18 minutes.

A dear friend of mine was fond of saying that no matter how many mistakes we make, we may always play at least one positive role for others: as a bad example.

Unfortunately, that is the place where we find ourselves today, in Canada, as regards public euthanasia policy.

Hopefully, our example may help others to make better choices.

-- The nature of the problem

The danger that we now face is not merely about the right of people to choose to die. That is one issue, of course. But completely apart from choice, and in fact largely foreign to it, is the conception of euthanasia as medical care.

From this perspective, Medical Aid in Dying is not about the right of an individual to choose to die. It is actually about the right of society: to eliminate its less profitable members through an abusive definition of medical treatment; it is about utilitarian resource allocation; it is about money: lots and lots of money.

Above all, the footprint of euthanasia, as standard medicine, is vastly larger than that of assisted suicide by choice.

show slide two : comparison Oregon-Quebec

Oregon, for instance, decriminalized assisted suicide in 1994. Twenty-seven years later (2021), we notice 238 reported deaths.

By way of comparison, during the same year, in the Canadian province of Quebec (only *five* years after legalization) two THOUSAND *four* hundred and twenty-six people died (2,426).

Admittedly, the Oregon population is somewhat smaller than that of Quebec, however: estimates indicate that Canadian numbers will grow rapidly for some years to come. And therefore, Quebec rates are apparently set to stabilize at ten times those of Oregon: one full order of magnitude greater.

Clearly, then, in comparison with the choice-based assisted suicide of Oregon, medically justified euthanasia (as observed in Canada) represents not a difference in degree, but a difference in kind.

show slide three_a : choice versus medicine, justification, ethical status

--The difference between (objective) medicine and (subjective) choice

To make a long story short: When assisted death is justified only by subjective personal choice, its objective ethical status is simply undefined. Neither individuals, nor society itself are obliged to condone such deaths.

When euthanasia is defined as an objectively essential medical treatment, however (as blood transfusion is so defined), we are actually constrained to accept euthanasia as *categorically good* (in objectively similar circumstances) in all places and at all times!

For that is meaning of medical care defined in this way: euthanasia becomes a positive (medical) good.

show slide three_b : choice versus medicine, responsibility, obligations

Moreover, it is no longer the suicidal patient who bears the brunt of responsibility for his choice. It is always the doctor who is responsible for medical treatment prescribed. It is the doctor, then, who professionally propagates this "good thing" that is euthanasia.

Obviously, from this first definition, and from the moral responsibility derived, all sorts of professional and social obligations are logically created which do not exist with regards to a morally undefined subjective choice.

Just as doctors and institutions MUST provide blood transfusion as required. So also must they provide euthanasia. (And to the extent that other treatments are guaranteed by the State, so with euthanasia also)

Further, doctors MAY prescribe appropriate treatment as they see fit. They do not wait for a patient's request. They proactively prescribe optimal treatment, to which the patient will normally consent, deferring to expert opinion. Hence, the door is immediately

opened, as in Canada, to a volume of euthanasia whose scale depends only upon the discretion of those doctors inclined to its use.

To be clear: this result is the exact opposite of autonomous patient choice.

show slide four_a : Canadian policy (institutional)

-- Canadian policy accordingly derived

As a matter of principle, euthanasia must now be practised in all Canadian medical facilities, without exception. This includes hospitals, community clinics, long-term care facilities, home care programs, and hospices. In fact, The number of surviving exceptions, nationwide, can now be counted upon one's fingers.

show slide four_b : Canadian policy (professional)

As concerns doctors and nurses: there now exists a blanket Duty to Perform. Limited conscience exemptions apply; but no professional objections are allowed; all professional (i.e. medical and scientific) opposition to the practice of euthanasia is suppressed. Effective referrals are mandatory, and a most insidious "Duty to Inform", also, whereby previously criminal suicidal suggestion, has become part of the doctor's duty to discuss all treatment options. Euthanasia compliance has become a condition of employment, advancement, and increasingly: even of training and certification.

The same conditions apply to Nurses and other auxiliary workers, while the debilitating risks of possible PTSD are common to all.

show slide five_b : effects on stakeholders (patient)

Patients are universally subject to the abusive "Duty to Inform", and worse still, to direct institutional pressure, to consent to doctor-proposed euthanasia.

It is often affirmed, at this juncture, that all depends upon the patients "choice". But of what choice are we speaking when the non-compliant dependant patient must now live in an objectively hostile institutional environment, where his or her death is promoted, by all concerned, as the optimal clinical outcome ?

show slide six_b : evolution : extensions to the incapable

Moreover, policy in Canada is already skating around the issue of choice itself: in the very young; in those having made advance directives; in those with severe mental illness. Ultimately, if euthanasia is indeed a positive "good" (again like blood

transfusion) available to all capable individuals: it is clearly unethical to deprive the incapable of this valuable benefit. Hence, euthanasia of the incapable is logically inevitable, and perhaps, even for the "treatment" of incapacity itself.

As a final consequence, therefore, of utilizing the cover of scientific (medical) objectivity, to pursue a choice-based access to euthanasia, we have effectively laid the conceptual and legal framework 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 who are childishly easy to persuade. For to repeat the plain facts: medicine is not about choice. It is about objectively applied clinical standards.

And such, in a nutshell, are the far reaching differences between assisted death, justified by choice, and assisted death justified as medical care.

show slide 7 : And this means what to me ? (Or, Why the USA is in no way immune to the effects of this sea-change in the justification of "assisted death")

-- Future focus USA

It would, of course, be reassuring to assume that medically standardized utilitarian euthanasia might remain a problem only affecting those folks North of the snow-lined border. However, we can confidently predict that all of this will be coming, very soon, to a theatre near you. In fact, in many States, it already has.

There are already many clear signs of imported messaging and demands based on medical legitimacy. Why, for instance, is the euphemism "Medical Aid in Dying" supplanting older terms like "death with dignity" ? Why are poisonous substances referred to as "medication"? What is the meaning of new gambits such as the demand that non-compliant doctors produce "effective referrals", or that institutions either allow euthanasia or face withdrawal of public funds ?

No. These are not innocent attempts to push the envelope of choice. They are well calculated strategies for transitioning to a purely medical justification.

Nor should we be in any doubt about the force with which this transition will proceed: for this is not a question of philosophy alone. The main impetus behind medically justified euthanasia is actually provided by enormous, impersonal, economic interests.

-- The Power of Money

When it is suggested that we are witnessing the beginning of a new utilitarian medical paradigm based on euthanasia, we are not pretending that policy makers are already actively seeking that goal (beyond a very committed minority who undoubtedly are).

However, we must realize that the medical justification of euthanasia does, indeed, provide the entire theoretical basis, necessary, for the ethical implementation of just such a paradigm. We therefore now face a clear and present danger.

show slide eight_a : economics, traditional model

Without doubt, a maximal recourse to euthanasia is to the obvious bottom-line benefit of any collectively structured system of medical service delivery, be it private insurance or public healthcare.

Simply put: "He who pays the piper has the right to call the tune".

Traditionally, a typical patient, desirous of surviving as long as possible, would hire a doctor to that end. The doctor, financially dependant upon the patient, would have no reason to refuse resource-intensive treatment; and certainly no advantage in literally "killing the goose" providing him with "golden eggs".

show slide eight_b : economics, collective model

If it is a major insurance company however (managed care network, or government agency) that is actually paying the doctor and hospital, the situation is different.

In this case, faithfully responding to the interests of the collective buyer (to do as much good as possible with finite resources), it is obvious that the doctor will attempt to withhold care from expensive cases; and given an option to prescribe euthanasia: there can be no doubt that maximum recourse will result, limited only by the willingness of patients to consent.

Nor do these motives need to be explicitly stated, or even understood, in order to work their formidable effect. For economic forces have an impersonal power like that of water running down hill. To the extent that doctors juggling budgets in places like the V.A. Medicare, and Medicaid come to believe that euthanasia can be represented as an objectively desirable, and fully ethical medical treatment, they **will** increasingly employ it, with or without admission to themselves, or to others, of the pervasive economic forces influencing their acts.

In summary, then, the medical justification of euthanasia provides a conceptual and ethical framework for potentially eliminating huge numbers of economically embarrassing persons; whereas the basic economics of modern collective medical delivery systems provides the most powerful of motivations to achieve precisely that effect.

In a word, this is the proverbial Perfect Storm.

What then is to be done ?

show slide nine_a : dissallowing the medical fallacy

--The antidote

Quite simply: to stop the arrival of utilitarian medically normalized euthanasia, we must deconstruct the assumed historical connection, of medicine to death by choice.

As in the familiar cinematographic depiction of bomb neutralization, we must resolutely clip the wire that joins the fuse of choice, to the much larger explosive charge of utilitarian medicine. We must no longer permit the utilitarians to piggy-back on the force of choice. We must directly confront the claim of medical legitimacy, not as confused in the artificial MAID hybrid, but as an independent proposition.

s**how slide nine_b : the medical status of euthanasia**

Luckily, it is not difficult to demonstrate that euthanasia has no objective medical legitimacy. For in the medical world, the meaningful declaration of an objective good implies a widespread, nearly unanimous agreement (such as that attached to our blood transfusion example), to the effect that in response to defined clinical indications a given treatment *should* be employed.

But no such agreement exists concerning euthanasia (either in the general or in the particular case). In a word, people *disagree* on the use of euthanasia, in a way that they do not disagree regarding other standard medical procedures.

Clearly, this obvious lack of agreement, on the objective good of euthanasia, should (logically) have decisive policy implications.

show slide 10 : defeating proposed obligations

In particular, it is impossible to claim that society as a whole (or the medical profession, or any individual professional, or institution) should have an obligation to provide a

service upon the benefit of which there is no objective agreement. And accordingly, when euthanasia militants attempt to create such obligations, they are simply trying to reinforce an *assumed notion*, of medical legitimacy, where none in fact exists.

At root, the simple fact that medical professionals (may) have been authorized to cause the death of willing individuals (for whatever politically convenient reasons) *does not imply that such actions proceed from any objective medical justification*.

And that, is what I suggest we must most strongly affirm, at every available opportunity.

Please note that in making this point we have no need of demonstrating that euthanasia is medically wrong; but simply: that there is no medical consensus on this subject and hence no basis for objective validation.

To be clear, such a strategy would have no bearing on the volume of choice-based assisted death (as reflected in the modest numbers from the State of Oregon). It may, however, provide a path to avoiding the truly industrial volume now observed in Canada. And therefore, even if incomplete, I suggest that this is a strategy well worth pursuing.

Thank you for your attention.

-- Gordon Friesen, April 6, 2022

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http://www.euthanasiediscussion.net/ (français)

http://euthanasiadiscussion.com/ (english site in development)

http://hopeandfree.com/ (personal philosophical musings)