Lessons from the Canadian Euthanasia Debacle:

-- Utilitarian Death-Medicine Piggy-Backing on the Power of Choice --

why (and how) to deconstruct the medical "narrative"

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August 4, 2022

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Part I A) The Nature of the Beast

1. A cautionary tale

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

Unfortunately, much has been said about appalling euthanasia-related events in Canada.

In this little booklet, I wish to speak about why this is happening; why it matters to others; and what can be done to prevent similar catastrophe elsewhere.

Defining Death as Medical Care

2. Death defined as Medical Care

That which sets Canada apart from the rest of the world, is that our country (and our country alone) has explicitly defined euthanasia as medical care, and indeed, as essential medical care. (note 1)

That is the crucial point.

The danger that we now face is no longer merely about the right of people to choose death.

That most thorny issue remains, of course, but completely apart from choice (and in fact largely foreign to it) is this much more devastating concept of euthanasia as objectively indicated medical care.

For when euthanasia is defined in this way, it becomes possible for doctors to treat death like any other tool in their medical kit. And that, in turn, enables utilitarians to promote euthanasia, systematically, in what amounts to a vast collective cost reduction scheme, practiced at the expense of individual patients; and indeed, at the expense of patient-centered medicine itself.

Therefore, much as I would like to confess to the abuse of hyperbolic language, the phrase "utilitarian death-medicine" would seem to be no more than a plain literal statement of fact.

The **Footprint** of

Choice-based assisted suicide

Compared with that of

Euthanasia as medical care

Oregon	**Quebec**
(assisted suicide)	(euthanasia)
28 legal years (since 1994)	7 legal years (since 2014)
238	**2,426**

Deaths per Year (2021)

3. A quantitative comparison: Oregon versus Quebec

A first indication of the radical difference between assisted-suicide (justified by choice) and euthanasia (justified as medical care) appears in the relative size of their respective footprints.

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 Canadian numbers continue to rise rapidly.

It would appear therefore, that Quebec rates are set to stabilize at *ten times* those of Oregon: one full order of magnitude greater.

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

What then can explain these facts ?

An enormous moral difference

Assisted suicide

justified only by subjective choice

Objective moral status:

undefined

Euthanasia

justified by objective clinical indications

Objective moral status:

positive good

All further difficulties arise from this

4. Medicine versus Choice: a crucial distinction

There is an enormous philosophical difference between the objective justification of medicine, and the subjective justification of personal choice

To make a long story short: When assisted death is justified only by choice, its *objective* moral status is simply undefined. Neither individuals, nor society itself are obliged to approve or facilitate such deaths. They are permitted merely.

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

Moreover, it is no longer the suicidal patient who bears chief moral responsibility under these circumstances. For it is *always* the doctor who is responsible for medical treatment prescribed. While the patient's "choice", is clinically replaced with the much more ambiguous term "consent".

Medical Obligations Created

When Assisted Death is conceived as...

A Choice

The **Patient** is responsible

Others bear **NO** obligation

Medical Care

The **Doctor** is responsible

Doctors ***MUST*** inform;
Doctors ***MUST*** provide;
Society ***MUST*** facilitate

5. Professional and social obligations thus created

From this first definition of euthanasia as medical care (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.*

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

Medical Permissions Accorded

When Assisted Death is conceived as...

A Choice	Medical Care
The Patient must begin discussion NO suicidal suggestion is allowed	The Doctor may proactively promote, suggest, and prescribe euthanasia Subject only to eligibility criteria

6. Professional permissions granted

Further, while rebellious doctors come under pressure to provide euthanasia, those physicians who willingly embrace the practice are free to professionally propagate this new "treatment" as they please.

For doctors MAY suggest and prescribe appropriate care as they see fit. They do not wait for a patient's request. They are ethically required to proactively prescribe optimal treatment, to which the patient will normally consent, deferring to expert opinion.

In fact consent itself is no longer a firm boundary in this area, for it would clearly be unethical to deprive incapable persons of a positive benefit available to others.

Hence, the door is immediately opened, as in Canada, to a volume of euthanasia whose scale depends only upon eligibility requirements and the discretion of those doctors inclined to its use.

Canadian Policy Accordingly Derived

* **Require** euthanasia practice in all institutions

* **Enforce** euthanasia compliance from all health professionals

* **Systemize** euthanasia suggestion for targeted patient groups

Whether by accident or by design:
a utilitarian promotion of early death

7. Resulting Canadian policy

As a matter of principle, euthanasia must now be practiced in all Canadian medical facilities.

This includes hospitals, community clinics, long-term care facilities, home care programs, and hospices. In fact, The number of surviving exceptions, nationwide, can be pretty well counted upon one's fingers.

As concerns doctors and nurses: there exists a blanket "Duty to Perform". Limited conscience exemptions apply, but no professional objections are possible; all professional (that is, medical and scientific) opposition to the practice of euthanasia in Canada is now officially disallowed.

Effective referrals are mandatory, and a most insidious "Duty to Inform", whereby previously criminal suicidal suggestion has become part of the doctor's normal duty to discuss treatment options.

Practically speaking, euthanasia compliance has become a condition of employment, advancement, and increasingly: even of training and certification.

As for patients: they are universally subject to the abusive "Duty to Inform" (as, for instance, at admission to long-term care); and thus to direct institutional steering towards doctor-proposed euthanasia, even before other treatment has been envisaged.

It would be impossible, I submit, to design a system better adapted to maximize the practice of euthanasia.

Choice-based eligibility: The fatal alchemy of MAID

Objective clinical indications are drawn from

Arbitrary criteria of eligibility

8. Eligibility for MAID: politics and compromise

Who, then, will ultimately be eligible for (or rather subject to) this new practice of medical homicide?

Considering the serious consequences of defining euthanasia as medical care, we would expect an equally serious definition of exactly what clinical indications demand its use. However, there is no such rigorous medical foundation for euthanasia.

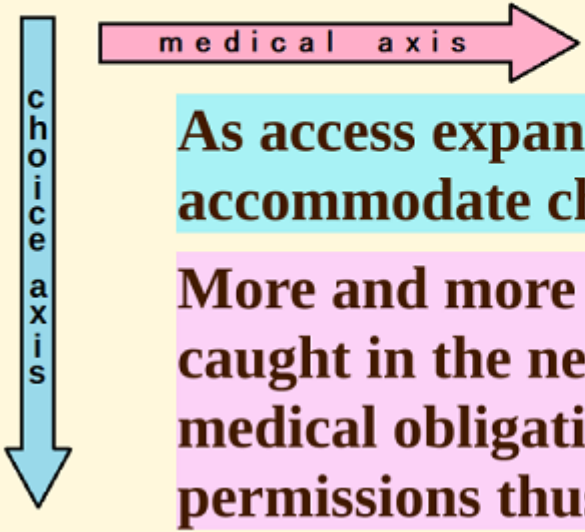
That is the Naked Emperor at the heart of MAID:

It remains an essentially political exercise, driven by ideal notions of personal choice. And the limits of choice are not definite, but subject to litigation and compromise.

In MAID, however, choice and medicine are joined at the hip.

&

Choice-Driven Expansion of Medically Justified Euthanasia



As access expands to accommodate choice:

More and more people are caught in the net of medical obligations and permissions thus created

9. Choice-driven expansion of medical eligibility

As eligibility proceeds upon the choice axis (as in Canada with passage of Bill C-7, 2021) from intolerable suffering at the end of life --to viable patients of all kinds-- it is not the limits of choice alone which are altered.

For If *all* legal euthanasia is deemed to be medically justified (which it is by definition), then the limits of what is considered a clinically indicated death must be adjusted accordingly.

Hence, the non-suicidal majority, within this ever-increasing pool of eligible patients, becomes automatically subject to all of the institutional assumptions, and pressures, which are inseparable from a corresponding inclusion along the *medical* axis, whether that inclusion be desired, or no.

Incredibly, therefore, it is the most marginal suicidal wishes, legally admissible, which ultimately determine standard clinical indications for the practice of medical homicide*;* and this objectively, not for request only, but for prescription as well.

But What About Choice ?

10. Spurious claims of autonomous choice

Ironically, even at this late date, it is glibly affirmed, that all depends upon patient "choice".

But of what choice are we speaking, when the non-compliant dependent patient must now live in an objectively hostile institutional environment; where his or her death is openly promoted as the most desirable clinical outcome?

Moreover, as earlier intimated: all of the above noted enlargements, obligations and permissions are also logically transported to the incapable zone also, through the most rigorous application of medical ethics.

Nor is this a speculative warning of some hypothetical "slippery slope". Canada is already skating around the consent requirement, *even for viable patients*: in the very young; in those with mental illness; in those having made advance requests.

In fact, all that now remains to enable a full application of euthanasia to the incapable (and perhaps, even for the treatment of incapacity itself), is to authorize the standard protocols of shared and substituted consent, which are already applied in other life-critical decision-making; in other words: nothing but a small and logically inevitable formality.

The final irony:

***incapable* choice**

11. Incapable "choice" ?

Apparently then, the ultimate destination of a regime ostensibly founded upon unconditional respect of patient autonomy may well be the evacuation of an entire class of dependent persons possessing no autonomous capacity at all.

Admittedly, these conclusions may seem absurd, but they are also perfectly real.

And that, dear friends, is what is meant by "utilitarian death-medicine piggy-backing on the power of choice".

And This Means What to me ?

(Why other jurisdictions are not immune)

"Grooming" for the Arrival of Objectively Justified Euthanasia

medically suggestive vocabulary	-- "Medical Aid in Dying" -- "medication"
demands suggesting medical legitimacy	-- Professional duty to perform (or to refer) -- Institutional obligation to allow (or lose public funding)

(Suggest, Assume; Bluff, and Ignore)

12. And this means what to me ? (why none are immune)

It would, of course, be reassuring to assume that medically justified euthanasia might remain a problem only affecting those strange folks North of the snow-lined border.

However, we can confidently predict that all of this will be coming, very soon, to a jurisdiction near you.

In fact, in many States, it already has.

There are 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 obligations such as the demand that non-compliant doctors produce "effective referrals", or that institutions either allow euthanasia or face withdrawal of public funds ?

The Economic Cause

System Self-Interest

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

13. Enormous, impersonal, interests

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 Change from Patient to "Beneficiary":

a transfer of consumer power

Previously...

Patients paid doctors directly; and doctor interest was to satisfy their patients

Today...

Doctors are paid by collective entities having interests of their own

Part I B) The economic cause

14. A shift of consumer power from patient to system

Until very recently, individuals were entirely responsible for their own personal medical expenses, while collective action was limited to public health only.

With modern ideals of group responsibility, however, these categories have become increasingly blurred: first with private insurance, but ultimately, with public medical systems of which the monopoly in Canada presents a supreme example.

As a result, the evolution of modern healthcare financing has been characterized by a shift of consumer power from the individual to the collective sphere; while the former patient/client/payer has been increasingly demoted to a lessor status of mere "beneficiary".

For to put it simply: "He who pays the piper has the right to call the tune".

Unfortunately, this change has also been characterized by the emergence of inherent conflicts between the interests of individual patients and those of the system in its entirety.

Patients and Systems:

an inherent conflict of interest

Patients...

wish to survive as long as they can

Systems...

wish to create surplus and lower cost

Euthanasia...

is to the obvious benefit of systems

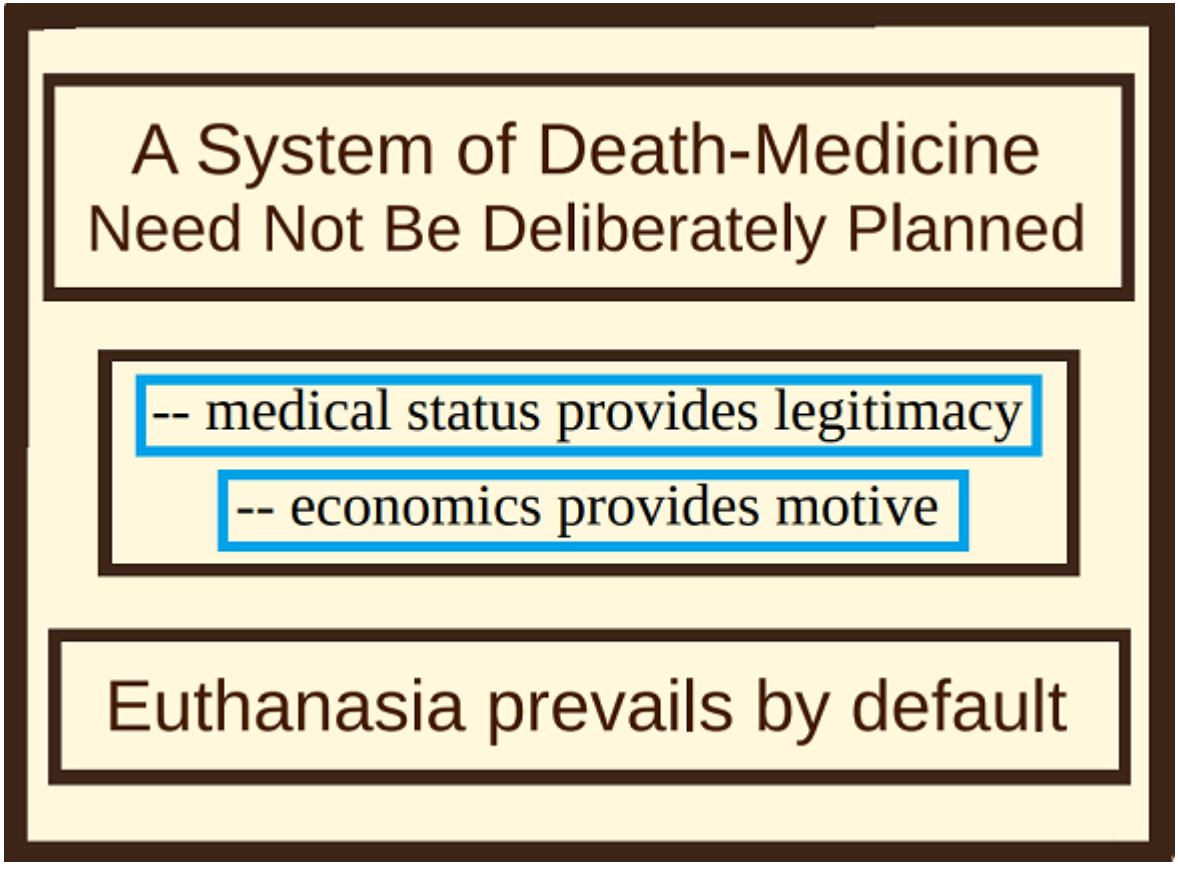
15. Conflicting patient and system interest

Traditionally, a typical patient, desirous of surviving as long as possible, would hire a doctor to that end.

The doctor, financially dependent 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".

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

In that case, faithfully responding to the interests of the collective buyer (ostensibly to do the most good with limited resources), it is obvious that doctors will attempt to strategically withhold care from expensive cases; and given an option to prescribe euthanasia: there can be no doubt that maximum recourse will result.

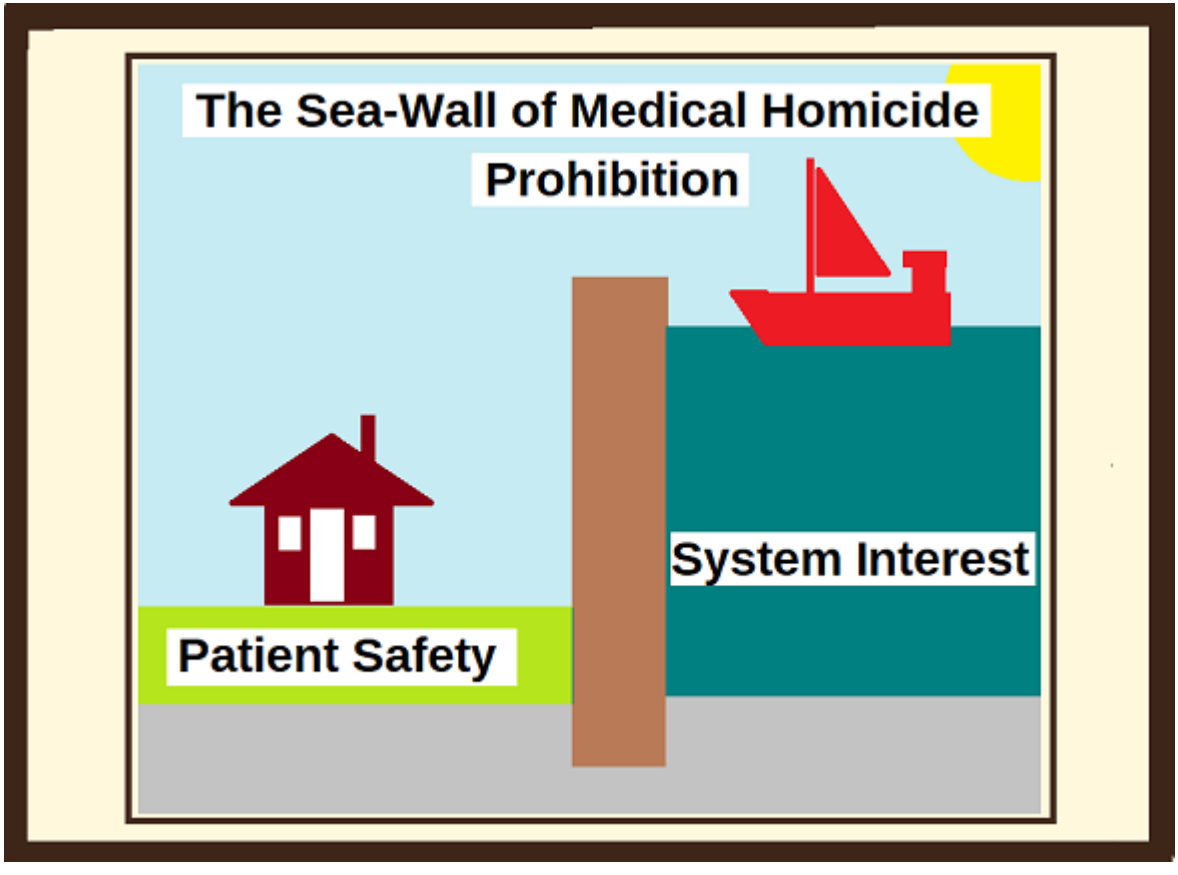

A System of Death-Medicine
Need Not Be Deliberately Planned
-- medical status provides legitimacy
-- economics provides motive
Euthanasia prevails by default

16. Death medicine does not require a deliberate plan

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.


The Sea-Wall of Medical Homicide
Prohibition
System Interest
Patient Safety

17. The dam of moral certitude removed

In past days, these dangers were commonly recognized and the equivalent of moral sea-walls were maintained to restrain them.

The invasive effect of utilitarian motives was at least partially offset by powerful traditional assumptions, of which the most important, without doubt, was the assumption that doctors would never be allowed to actually kill their patients.

But that, of course, is exactly the prohibition which has now been removed (in so many jurisdictions).

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 ?

The Antidote

Conceptual

Legislative and Judicial

Economic and Commercial

Part II: The Antidote

18. What then is to be done ?

Thus far, I have been describing a very dark situation as it exists in Canada and I have unfortunately been obliged to predict similar results wherever the medical interpretation of assisted death is adopted.

In the second part of this text, however, it will thankfully be possible to discuss a more positive vision, as we consider our own (very substantial) resources.

Deconstructing MAID

(Separation of medicine from choice)

Marginal choice

should not create

objective clinical standards

Part II A) Conceptual antidote

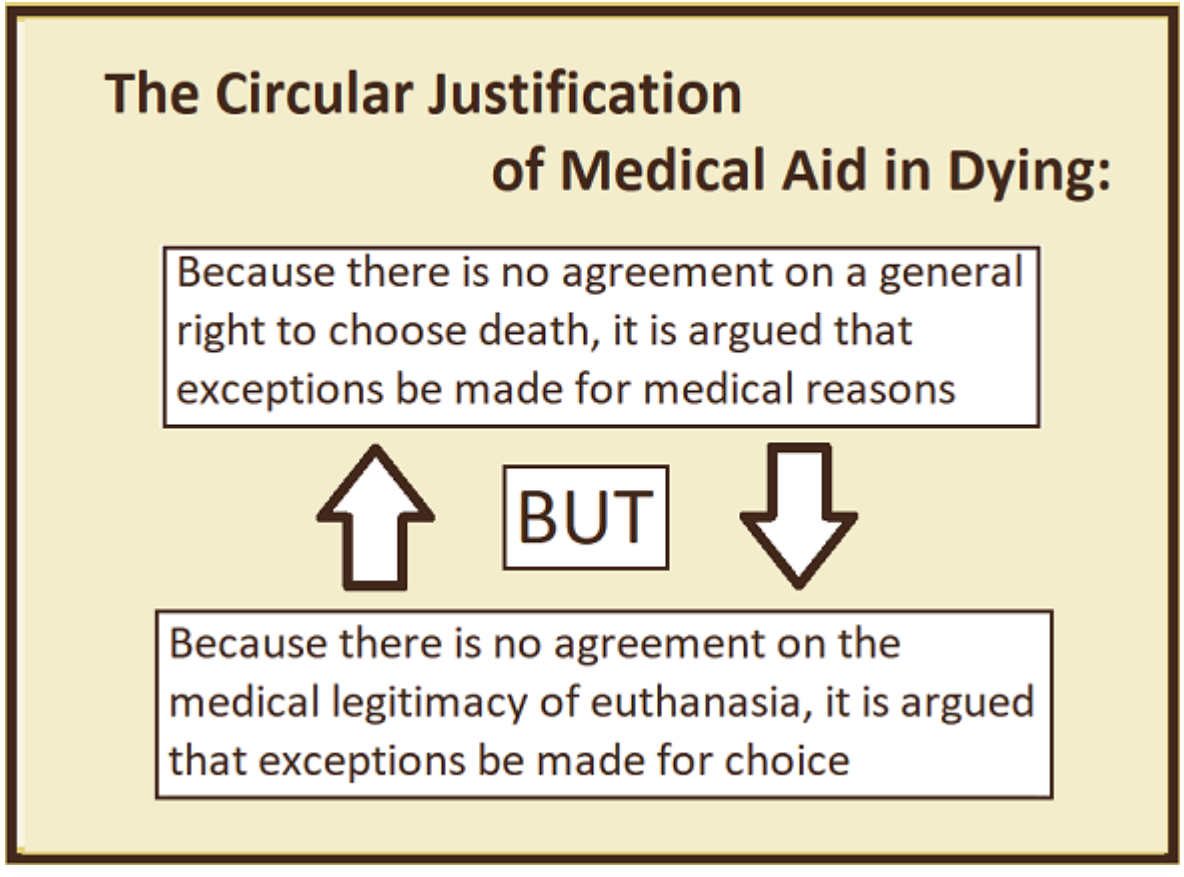
19. Deconstructing MAID

Ideas, as they say, have consequences. Defining objective medicine to conform with extreme and arbitrary choice has terrible consequences.

Our first task therefore, is to deconstruct the illogical conceptual hybrid that is Medical Aid in Dying.

We must strip out the medical component, and defeat that component separately.

The Circular Justification of Medical Aid in Dying:



20. The circular justification of medicine and choice

As typically presented, the dual justification of MAID involves a circular succession of two claims, neither of which is convincing on its own own, but where the alleged truth of each is nonetheless used to excuse the weakness of the other.

First, because there is no agreement on a general voluntary right to die, it is argued that exceptions be made for medical condition.

But,

Because there is no agreement on the *medical* legitimacy of euthanasia, it is argued that exceptions be made for choice.

(And so on, and on so forth)

It is blithely forgotten in this that the will to die is a subjective choice so marginal (regardless of medical or other circumstances) that it can only be defended through a complete repudiation of any objective judgment whatsoever, including that of traditional medical ethics.

To point, therefore, to the objective authority of medicine in this circumstance, is plainly nonsensical!

And yet we have no need to carry such a subtle point.

Defeat the medical claim separately

There is no professional consensus

Therefore...

There is no basis for granting essential status

21. Defeating the medical claim separately

To stop the operation of this logical merry-go-round we need only insist on confronting the claim of medical legitimacy as an independent proposition.

For in the medical world, the meaningful declaration of an objective good requires a widespread, nearly unanimous agreement (such as that attached to our earlier blood transfusion example), to the effect, that in response to clearly defined clinical indications, a given treatment *should* be employed.

But no such agreement exists concerning euthanasia. In a word: people *disagree* on euthanasia, in a way that they do not disagree, regarding accepted standard procedures.

Medical Opinion on Assisted Suicide and Euthanasia

(In jurisdictions where euthanasia and/or euthanasia are legal)

World Medical Association

"**firmly opposed** to euthanasia and physician-assisted suicide"

Royal Dutch Medical Association

* **not a basic right** of patients
* not included in basic care packages
* physicians under **no obligation**

American Medical Association:

fundamentally incompatible with the physician's role as healer... difficult or **impossible to control**... pose(s) **serious societal risks**.

Swiss Academy of Medical Science:

* **not a medical action** to which patients could claim entitlement

Canadian Medical Association (before decriminalization)

"physicians, by **a large majority**, were **not in favor** of legalizing these activities"

--Jeff Blackmer
Vice President Medical Professionalism
Canadian Medical Association

22. A preponderance of medical opinion

Please note, once again, that we do not actually need to prove that euthanasia is wrong. In medical terms, the mere existence of significant disagreement is sufficient to discard claims of essential status.

However, in this circumstance, we actually benefit from a preponderance of medical opinion:

for in no case has this lethal mandate ever been sought in response to organic internal demand amongst medical professionals.

Quite the contrary: where decriminalization has occurred, it has always been imposed from without, by judicial fiat and legislative decree.

What conceptual status for "MAID" ?

1) A Medical Treatment ?

-- **Objectively justified** from clinical indications

-- Hospitals and doctors **WILL provide**

2) A Discretionary Service ?

-- **Subjectively justified** from patient desire

-- Authorized third persons **MAY provide**

Grave consequences attend this choice

23. What conceptual status for Maid ? Essential medical care ? Discretionary service ?

Quite obviously: mere legality does not imply positive ethical status.

Many disputed procedures are now legally performed. But that does not make them essential care. Nor does the desire of any one patient; nor does the opinion of any one doctor.

Challenging Linguistic Assumptions

Killing is not "Care"

Poisons are not "Medication"

Assisted Death
is **NOT**
"Medical Treatment"

24. Legislative strategy and linguistic assumption

Building. now, upon this crucial understanding of *ambiguous* medical status, a proactive legislative and judicial strategy should seek to delegitimize all notions of medical normality, beginning with the linguistic assumptions at their base.

Every use of the words "medicine", "medical", "medication", "care", "treatment" etc. should be challenged and qualified.

The term MAID itself should be constantly qualified as a merely tangential service incidentally provided, perhaps, by some medical professionals.

Proactive Legislation for "Safe" States

Be it resolved:

That even if legal; In whatever form; By whatever name; And *even if legal for doctors only*:

Assisted Death is not a Medical Act

Be it further resolved:

Unsolicited Suggestion shall remain a Criminal Offense

25. Proactive legislation in "safe" States

Secondly, it is important that this contest be sustained across all fifty States, and indeed, across international borders.

In particular, jurisdictions not yet threatened should be immediately encouraged to present declarative initiatives, explicitly rejecting any *future* medical justification of assisted death.

In doing so, they will greatly assist in shaping policy elsewhere; and proactively prepare their own defense.

Amend adversarial Law to remove obligations and permissions

If... There is no recognition of essential medical status

Then... There can be no obligation to provide, refer, or inform

And... There can be no permission to (proactively) propose

26. Refuse obligations and permissions

Finally, even where decriminalization or expansion bills are successful, opposing lawmakers must do everything possible to attach positive language excluding any medical obligation or mandate.

For as implied earlier: when euthanasia enthusiasts attempt to create such obligations, they are simply trying to reinforce an assumed notion of medical authority, where none in fact exists.

economic and commercial antidote

A proactive appeal to the direct democracy of consumer choice

27. The economic antidote: democracy of the pocket book

Naturally, our adversaries will not easily cede the point of medical legitimacy. And they will always seek to hide this weakness behind the argument of choice.

Ironically, however, we need not be fearful of engaging them frankly on that terrain either. For there is an entirely amoral choice-based logic available *to us*, through the mathematical reasoning of pure economics; of consumer and provider; of supply and demand.

Moreover, *this* is an area where we are not entirely dependent upon convincing others, of petitioning government, of pleading before judges. It is an *arena* where individuals can act directly with real effect.

Indeed no social power is greater than that of consumer demand. And no consumer demand is greater than that for personal survival.

Collective & Personal Security:
Health vs Defence (fraction of GDP)

	Health	Defence
Canada	13%	1%
USA	18%	4%

The scalpel more powerful than the sword !

28. The extraordinary importance of personal healthcare

Two statistics will suffice to illustrate this point:

First, over 23% of combined government spending, in Canada, is directed to healthcare, or 13% of GDP.

And second, in the USA (where healthcare is largely private), the figure is even greater, at nearly 18% GDP (pre-covid 2019).

(By way of comparison, defense represents only 1% and 4%, respectively.)

As a quantitatively verifiable proposition, therefore: the economic importance of consumer healthcare spending is without rival; a literally unstoppable force.

The burning question therefore arises: What do people really want to buy with all of that money?

And as it turns out: this question of consumer preference was largely solved 2400 years ago, by Hippocrates of Cos.

The Patient as Consumer: Doctors we can Trust

I don't think a doctor like that could even make a living !

Well, I might not hire him for you. But I certainly would for me...

The Hippocratic Promise

* **No selling of secrets**
* **No useless treatments**
* **No killing**

29. Hippocrates and consumer choice

At a time when many doctors mercilessly exploited the hopes of their clients (and frequently catered to darker motives still): Hippocrates explored the boundaries of a true healing profession, developing a doctrine later expressed as Primum non Nocere, meaning First do no Harm.

As we are well aware, the ethical standard of Hippocrates has been severely attacked in recent years, in the same manner as any purportedly universal system: first on the grounds of circumstantial relativity; but ultimately, on that of pure subjective privilege.

What is less generally understood, however, is that questioning the moral authority of Primum non Nocere does nothing to diminish its phenomenal *commercial* importance.

For patients as consumers, following their own natural interest, immediately embraced these Hippocratic doctors; and cemented their professional supremacy, not only in Christian Europe, but also in the more permissive moral antiquity of Greece and Rome.

In other words: it is a historically proven fact that --when free to do so-- patients, as consumers, will overwhelmingly choose to trust doctors who have promised not to kill.

Who Really Wants to Die ?

observed consensual deaths among targeted patient groups

Terminal Cancer	(Belgium and the Netherlands)	Euthanasia	10%
Catastrophic Injury	Paralysis, Amputation	Suicide (beyond normal)	1%
Degenerative Incurable Illness	Amyotrophic Lateral Sclerosis (ALS) AIDS pre-therapy (pre-1996)	Suicide (beyond normal)	1%

Maximum euthanasia clientele : 1 - 10%

There is no commercial logic for prioritizing euthanasia

30. What of those who wish to die ?

There does exist, of course, a small group which would wish to follow a different path. It is extremely important, however, for us to bring a true proportional context to this phenomenon. For contrary to common perception (and regardless of medical circumstance): very few people, indeed, will ever consent to die.

Among victims of catastrophic injury, for instance (such as para- and quadriplegics), only one percent actually commit suicide above normal expectation.

And so also for degenerative disease (like A.L.S., or AIDS before the arrival of effective therapy in the mid-nineties).

Even among terminal cancer patients where euthanasia is legally and widely practiced: only one in ten will consent to die in that manner.

Categorically then, from the dispassionate perspective of commercial market share: potential *customers* for euthanasia are never more than one to ten percent.

And quite evidently: one does not rationally design any industry to prioritize the satisfaction of a one to ten percent market share.

Market Specialization vs Forced Inclusion of Assisted Death

Just as patrons may now choose meatless restaurants or smokeless lodgings :

Non-suicidal patients must be free to enjoy the care of **life-affirming professionals** in **euthanasia-free clinical spaces**

31. Specialization versus inclusion: rational market share

With regards to the *reasonable* division of these competing market segments, there exists a most pernicious assumption that assisted-death can simply be added to standard medical practice without depriving typical patients of the service that *they* seek.

However, the entire notion of euthanasia inclusion flies in the face of elementary economic experience, where detailed market *specialization* has always provided the royal road to optimal consumer satisfaction.

Euthanasia and traditional medicine cannot properly share the same clinical space.

For the non-suicidal majority of patients today, just as in ages past, simply cannot place their trust in doctors who are known to kill.

Plainly stated in economic terms: standard medical practice should be structured, by default, to cater *exclusively* to majority life-affirming care.

But...

Will patients be allowed to wield true consumer power ?

32. Who will wield consumer power ?

How must we react then, to the previously noted fact: that consumer power has been increasingly transferred from the individual patient to the system itself (and thus to satisfaction not of patient, but of system interest)?

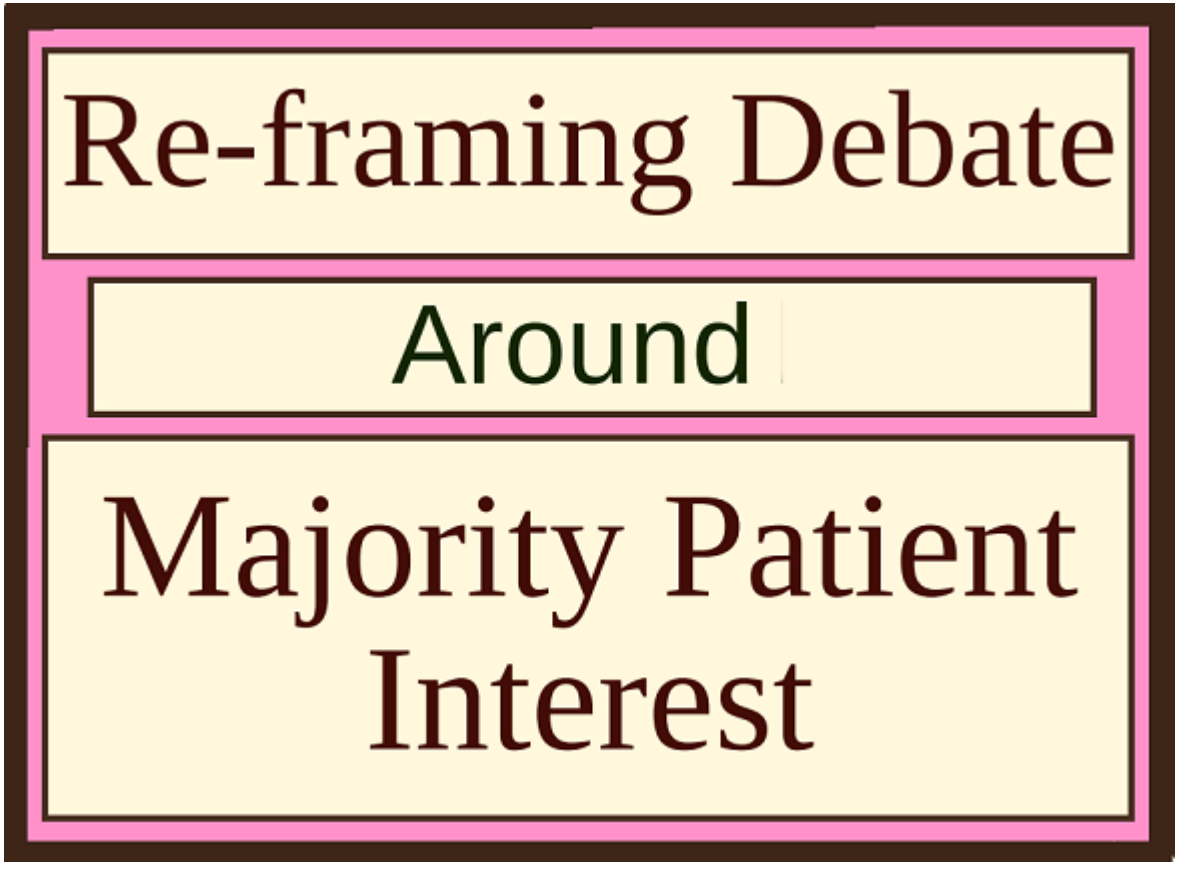
It is indeed most distressing to witness the theft of that immense power by a utilitarian delivery system apparently run amok like a rogue Artificial Intelligence: pursuing its own cost-efficiency imperative to the point of killing its patients under the cloak of medical "care"!

However, I would suggest that the intense exasperation we might feel, actually signals a golden opportunity to re-frame debate.

For we are no longer talking merely about a minority right to choose. At issue now is whether patients of the non-suicidal majority will *ever* receive the care which *they* expect, and for which they have so handsomely paid.

For the category "patient" ultimately includes everyone without exception, while substituting death for care is to steal untold yearly contributions paid in premiums and in taxes.

Presented in this way, I submit, the entire complexion of the assisted death question can be changed.


Re-framing Debate
Around
Majority Patient Interest

33. Majority interest and the soul of medicine

Happily, the natural power of the citizen/patient/consumer, although compromised, has not been entirely destroyed.

For even under the extreme Canadian monopoly there are avenues of redress through the political process; while in mixed systems, like that of the USA, a direct commercial advantage can still be invoked.

As well it must be! For this is nothing less than a struggle for the soul of medicine, and (as many have suggested) perhaps for that of humanitarian society itself.

More immediately, however: it is also about whether this lavishly funded, gargantuan medical industry, will actually respond to the wishes of those who are paying for it.

This then, is a moment of historic decision, in which we must raise our standard, and stand our ground.


Raising the Standard
of life-affirming care
We Want Doctors
Who Do Not Kill !

34. Raising the standard of life-affirming care

Our first task is simply to inform the citizen/consumer (and doctor/provider) of the existential struggle now raging between competing industrial models, just as they have been laid out here:

On the one hand, a life-affirming patient-centered medicine in the traditional mode; on the other, a utilitarian variant, where death-as-treatment is normalized to reduce cost.

We must proceed in this matter, not by debate alone, but by direct competition. The consumer/patient must be presented with a clear and significant choice.

All persons seeking medical services must learn to question providers' understanding on this issue, and to choose accordingly.

Similarly, all life-affirming providers must clearly identify themselves: to patients, on websites and in other promotional materials.

Nor need this be an entirely thankless display of principled sacrifice.

For as stated: in opposing utilitarian death-medicine we have the advantage of harnessing proven majority demand.

An extraordinary

commercial

opportunity

thus created !

35. An extraordinary commercial opportunity created

Unusual as it may seem, then, to do something good while profiting at the same time --or to invest (with no moral reservations) in a literally "sure thing"-- it would appear that both of these opportunities are now freely available to health professionals, organizations, and investors, who are willing to commit to life-affirming care.

And indeed, the same logic applies to entire jurisdictions, particularly in the competitive growth areas of medical tourism and retirement re-location.

The visible participation of service providers and consumers in seemingly "safe" States is especially important. First, because the mere existence of life-centered medicine, in one place, naturally stimulates demand elsewhere. And second, because the adamant affirmation of one's principles, now, provides the strongest possible defense against their suppression, later.

Restoring Medicine at its Core

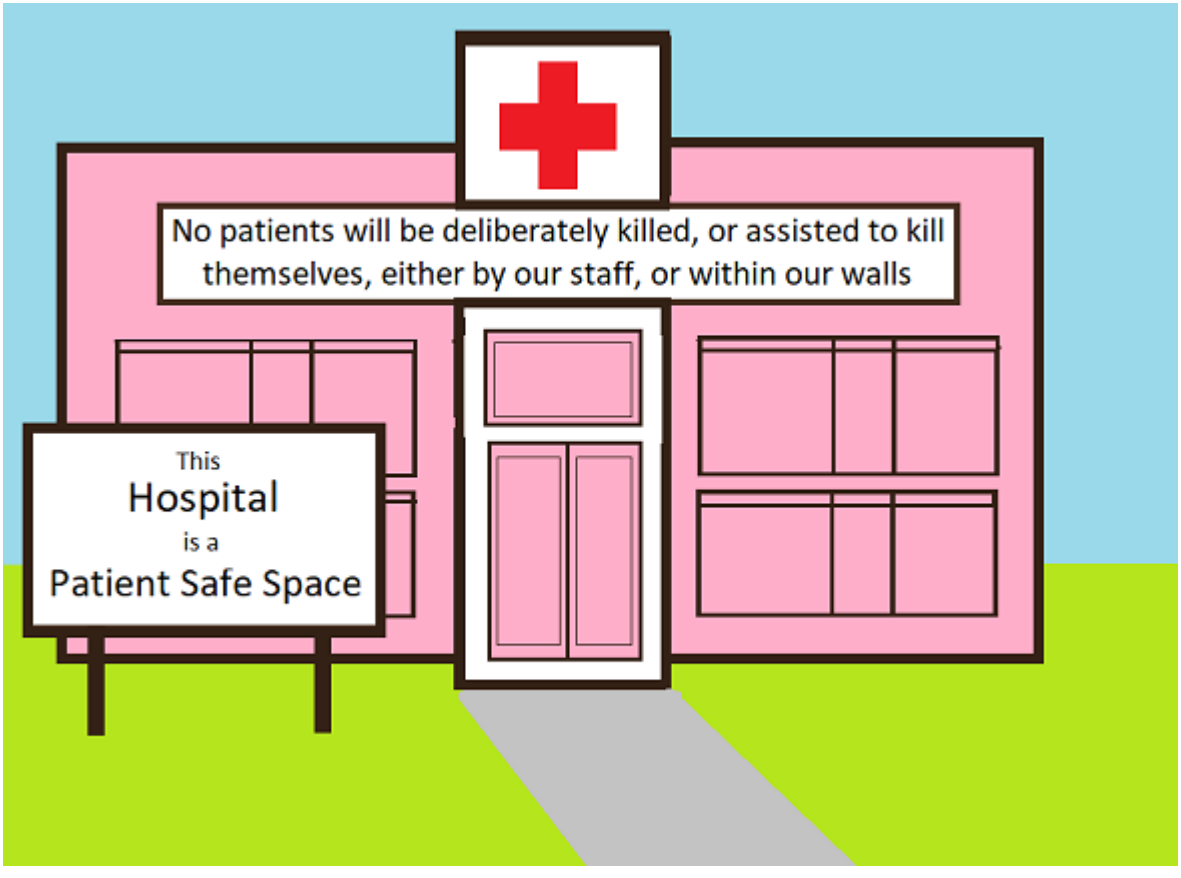
"Build it.
And they
will come !"

36. Build it and they will come

Beyond ideal arguments therefore, of morality, ethics and equality: all service providers --jurisdictions, networks, hospitals, clinics, hospices and individual doctors-- must be invited to benefit from the proven Hippocratic commercial advantage; while patients must be encouraged to insist on integral satisfaction thereof.

Our goal should be to force a deliberate social focus on the essential mission of the medical industry.

To the extent that this is done, I believe, the footprint and influence of assisted death, and utilitarian medicine more generally, will be minimized everywhere.


No patients will be deliberately killed, or assisted to kill themselves, either by our staff, or within our walls
This
Hospital
is a
Patient Safe Space

Part III Conclusion: A patient Safe Space

In this short talk, I have attempted to show how the question of death by choice has been used as a stalking horse to introduce something even worse: a complete paradigm of medicine based on utilitarian euthanasia.

I have described the philosophical and economic nature of this new death-medicine, and I have suggested conceptual, legislative, and commercial remedies which depend upon clearly distinguishing objective medicine from subjective choice.

At one time, it may have seemed that making this distinction would be counterproductive, as it might imply a willingness to accept death by choice.

In actual fact, I submit, quite the opposite is true.

For if the real adversary is choice, we can not even come to grips with that debate until we strip away the false cover of medical legitimacy.

For those who would object, that a market-based consumer strategy might benefit only the middle class: I would respond that demands of equal access are only meaningful for services which exist; and therefore, that the actual functioning establishment of a true life-affirming medical model, however limited, is to the benefit of all in ways that mere ideas are not.

Finally, if there are any who remain convinced that medical authority can be used to contain and to constrain choice: I must point once again to the Canadian experience, to show just how delusional such hopes may prove.

For in that country, the medical justification of euthanasia has multiplied the incidence of assisted death many fold.

In closing, then, please allow me to express my most sincere and fervent desire, that others may yet avoid a similar fate.

Thank you


No patients will be deliberately killed, or assisted to kill themselves, either by our staff, or within our walls
This
Hospital
is a
Patient Safe Space
Thank You !

Note: The Canadian definition of euthanasia as medical care

This definition was at least partly the result of political maneuvering specific to the Canadian context.

In that country, criminal law is a competency of federal government. At that level, there was no immediate interest in this issue. A typical "right-to-die" case (Rodriguez) had recently been decided against the plaintiff in 1993, and a generic decriminalization bill had also been defeated (2009) by a convincing margin. Regional opinion, however, varied widely. In particular, the Province of Quebec was largely united in favor of legalization. And plans were laid to circumvent the federal authority.

Although the keys to criminal law remain with the Federation, healthcare is a provincial competency. In defining euthanasia as medical care, therefore, Quebec lawmakers maintained that such deaths could no longer be deemed as either suicide or homicide, and as such, no criminal exception would be required.

The relevant dispositions are found in Quebec bill 52 "An act respecting end of life care" (2014), where both Palliative Care and Medical Aid in Dying are coequally established as "end of life care"; and where "end of life care" is declared as a right of all eligible citizens.

The stage was therefore set for a typically Canadian battle of jurisdictions. However, that unpleasant eventuality was avoided through a new Supreme Court ruling, (in opposition to "Rodriguez") that a complete prohibition of assisted death was unconstitutional (Carter, 2015). Seizing upon this convenient fig leaf, the federal government chose to acquiesce in the interests of political stability, and passed a bill decriminalizing "Medical Aid in Dying" (2016).

As a result:

1) The term "Medical Aid in Dying" had changed (through Quebec legislation) from a merely suggestive euphemism, to a legally defined essential medical treatment.

and,

2) That same term, *bearing its new meaning*, had been utilized (in federal legislation) to withdraw that practice from the application of criminal law.

As a practical matter, therefore, although other Provinces have not actually passed legislation to that effect, the new definition of euthanasia as medical care is now treated, everywhere, as the law of the land.