Lessons from the Canadian euthanasia experiment:
Utilitarian death-medicine piggy-backing on the power of choice

Gordon Friesen, April 4, 2023

Table of Contents

Part I: A description of medically justified euthanasia in Canada

Part I A) The nature of the beast

Part I B) The economic cause

Part II: A choice-justified alternative to medical euthanasia

Part II A) A duality of justification: medicine or choice?

1) Separating medicine from choice

2) Suggested indicators of legitimacy

a) Expert opinion

b) Popular desire as democratic support

c) Popular desire as real economic demand

3) Gross discrepancy between theoretical expectation and real policy

Part II B) The rational accommodation of a choice-based right to die

Part III Conclusion

Notes

Part I: Description of Euthanasia in Canada

Part I A) The Nature of the Beast

1. Canadian euthanasia: a cautionary tale[1]

For a little while, it seemed the assisted death question had been settled; that dying patients with unbearable suffering would be allowed to end their lives; that medical professionals would be legally free to help them. And as long as euthanasia was presented in that way --as a free choice affecting no one else-- Canadians seemed willing to accept, if not to approve.

Recently, however, so-called "Medical Assistance in Dying", has returned to public attention [2] with stories of horrible unintended consequences: [3] [4] Canadian soldiers offered MAID for PTSD;[5] patients bullied to accept MAID;[6] [7] people seeking MAID to avoid disabled homelessness.[8]

In short, the reality of euthanasia has turned out to be very different from what we were led to expect. But worse still, behind these terrible anecdotes lies a more fundamental story: which is nothing less than the transition of our entire public healthcare system, to a new utilitarian model where death is prescribed as "care"; where patient liquidation becomes the cure.

In this article, I would like to examine how this has happened, what it means, and what we can do about it.

2. Death defined as Medical Care[9]

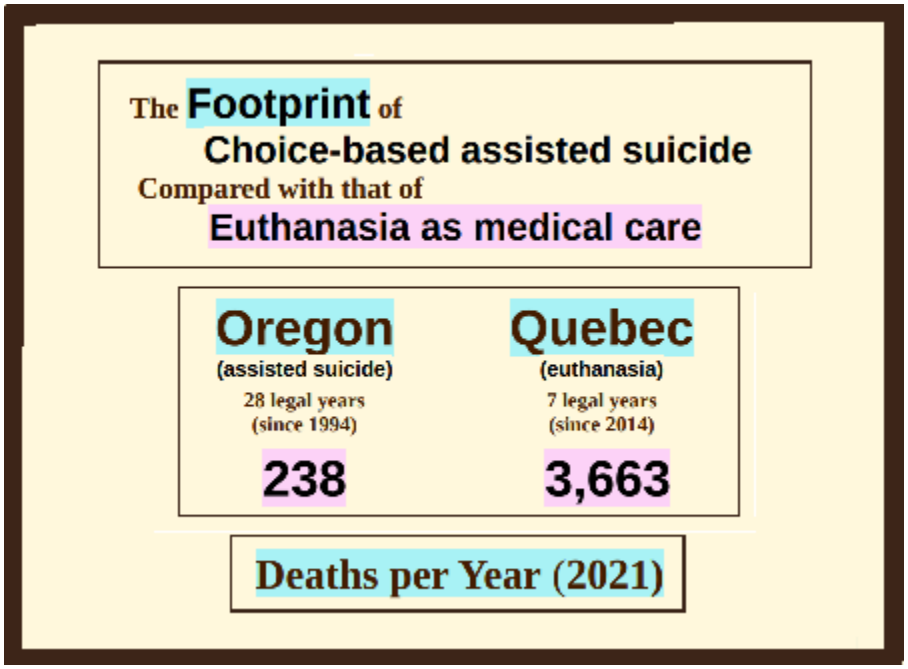
That which sets Canada apart from nearly all the world, including those jurisdictions permitting some form of assisted death, is that our country has explicitly defined euthanasia as medical care, and indeed, as essential medical care guaranteed by the State.[10]

That is the crucial point. Unlike other countries, we are no longer merely talking about the right of people to choose death. That most thorny issue remains, of course[11], but completely apart from choice (and in fact largely foreign to it) is this much more devastating concept of euthanasia presented as objectively indicated treatment. For when euthanasia is defined in that way, it becomes possible for doctors to treat death like any other tool in their medical kit. And that, in turn, enables utilitarians[12] to promote euthanasia, systematically, in what amounts to a vast collective cost reduction scheme[13]; akin to a sort of veterinary herd-management; practised at the expense of individual patients, and indeed, at the expense of patient-centred medicine itself.

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

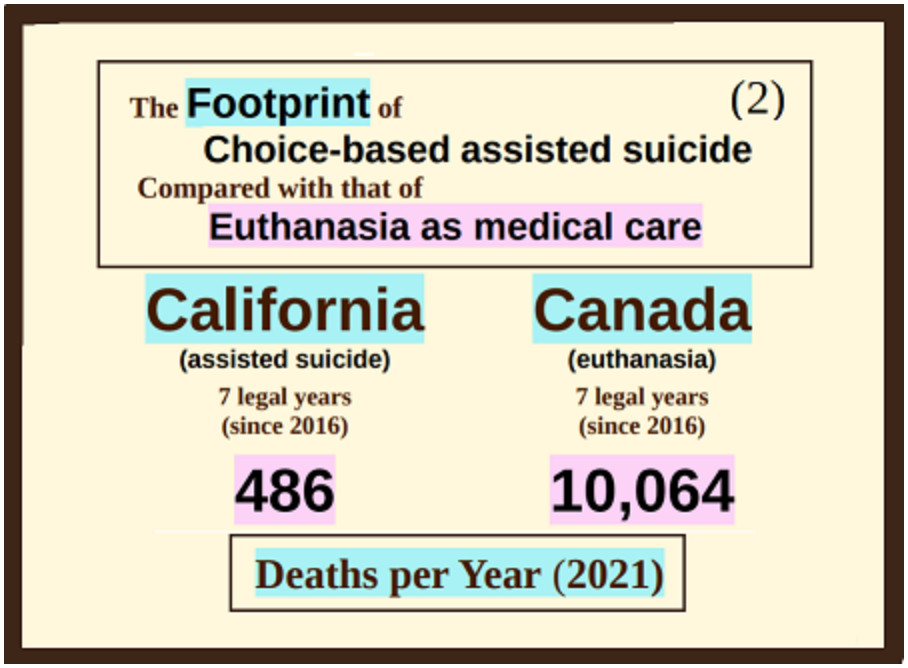
3. A quantitative comparison: Oregon versus Quebec[14]

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[15]. Twenty-seven years later (2021), we notice 238 reported deaths.[16] By way of comparison, during the same year, in the Canadian province of Quebec (only *seven* years after legalization) three thousand six hundred and sixty-three people died (3,663)[17]. For 2022 these numbers are expected to be 278 and 5,000, respectively[18].[19] Admittedly, the Oregon population[20] is roughly half that of Quebec,[21] however Canadian numbers continue to rise rapidly.[22] It would appear therefore, that Quebec rates are soon to be *ten times* those of Oregon: one full order of magnitude greater.

3. b) Canada vs the State of California[23]



A second, dramatic comparison can be made between Canada and the State of California. Both have populations of about 40 million. Both legalized assisted death in 2016. But whereas California notes five *hundred* deaths in 2021 (486),[24] Canada shows no less than ten *thousand* (10,064),[21] twenty times the California rate.

Clearly, in comparison with the choice-based assisted-suicide of Oregon and California, medically justified euthanasia represents, not a difference in degree, but a difference in kind. How may we explain this astounding numerical discrepancy?

4. Medicine vs Choice: a crucial ethical distinction

To make a long story short: When assisted death is justified only by choice, its *objective* moral status is simply undefined.[25] 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 obliged to accept euthanasia as *categorically good* 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 responsibility for his, or her, own death. For it is always the doctor who is responsible for medical treatment prescribed.[26] While the patient's "choice", is clinically replaced with the much more ambiguous term "consent".

5. Professional and social obligations thus created[27]

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[28]. 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.)

6. Professional permissions granted[29]

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.[30] 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.

7. Resulting Canadian policy[31]

As a matter of principle, euthanasia must now be practised in all Canadian medical facilities (with

extremely limited exceptions, many of which are the subject of litigation[32]). This includes hospitals, community clinics, long-term care facilities, home care programs, and hospices.[33]

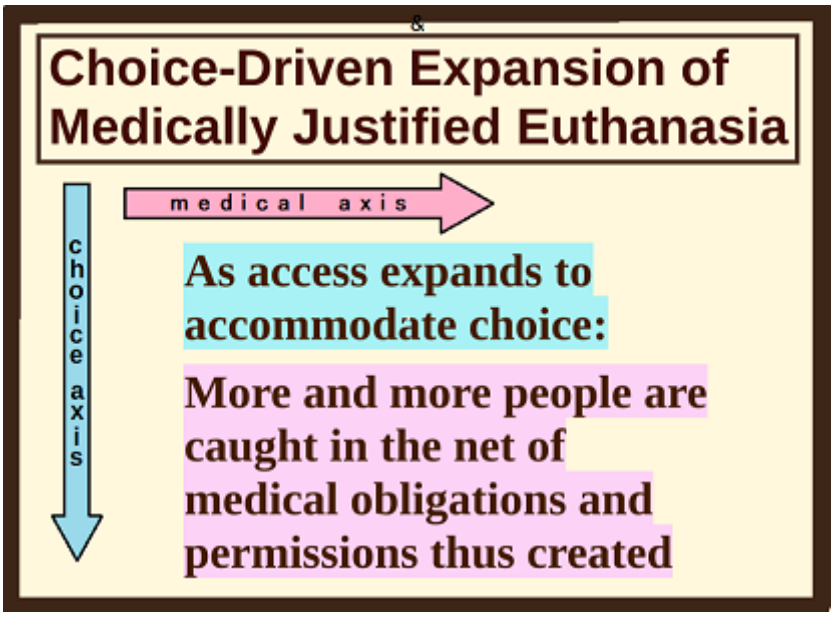
As concerns doctors and nurses: there exists an assumed "Duty to Perform" euthanasia. Limited conscience exemptions apply, but no professional objections are possible[34]; all professional (that is, medical and scientific) opposition to the practice of euthanasia in Canada is now officially disallowed. Practically speaking, euthanasia compliance has become a condition of employment, advancement, and increasingly: even of training and certification[35] [36]. Effective referrals are mandatory, and a most insidious "Duty to Inform" whereby all eligible patients are "informed" of their "right" to euthanasia; and thus, whereby previously criminal suicidal suggestion has become part of the doctor's normal duty to discuss treatment options [37] [38] (as, for instance, at admission to long-term care where patients are universally subject to direct institutional steering towards doctor-proposed euthanasia, even before other treatment has been envisaged).[39]

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

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 the practice of 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.



9. Choice-driven expansion: medical obligations and permissions[40]

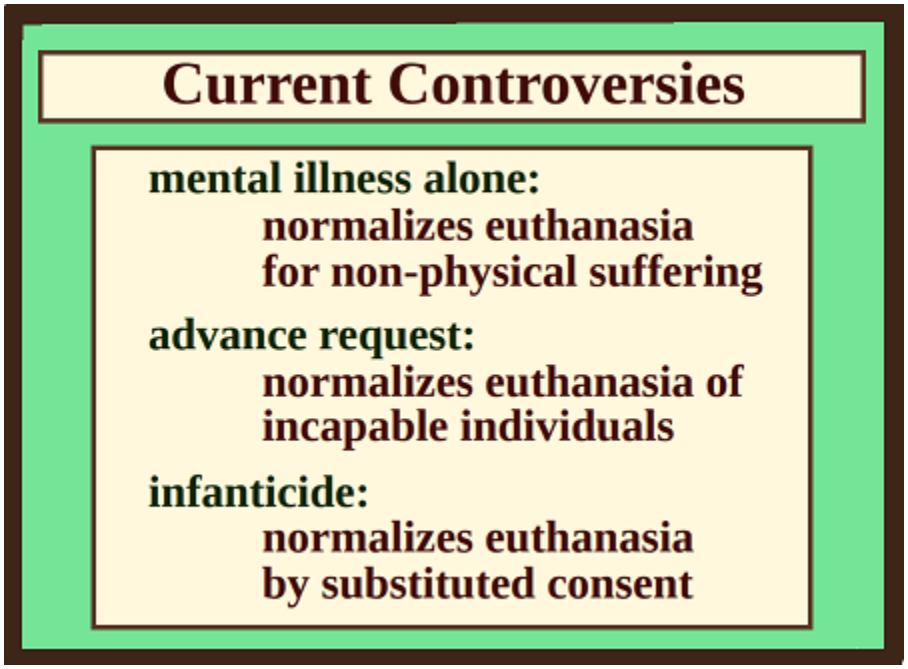
As eligibility proceeds upon the choice axis (as in Canada)[41] from intolerable suffering at the end of life --to viable patients of all kinds-- it is not the limits of choice alone which are altered. For If *all* legal euthanasia is deemed to be medically justified (which it is by definition), then 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. *A*nd this objectively: not for request alone, but for prescription as well.

10. Ideal claims of patient autonomy[42]

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, 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[43]; in those with mental illness[44] [45]; in those having made advance requests[46]. 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 all other life-critical decision-making; in other words: nothing but a small and logically inevitable formality.



11. The final irony of incapable "choice"

Apparently then, the ultimate destination of a regime supposedly 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 is what is meant by "utilitarian death-medicine piggy-backing on the power of choice".

Part I B) The economic cause

12. Enormous, impersonal, economic interests

Without doubt, what has been described thus far is a complete transformation of medicine as we understand it; and indeed, of the way which we care for one another more generally. Neither 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 provided by enormous economic forces.

13. A shift of consumer power from patient to system[47]

Until very recently, individuals were entirely responsible for their own 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[48], but ultimately, with public medical systems, of which the monopoly in Canada provides a supreme example.[49]

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".[50] 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.[51]

14. Conflicting patient and system interest[52]

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 (supposedly to do the most good with limited resources), it is obvious that doctors will attempt to strategically withhold care from expensive cases;[53] and given an option to prescribe euthanasia, there can be no doubt that maximum recourse will result.[54]

15. Death medicine does not require a deliberate plan[55]

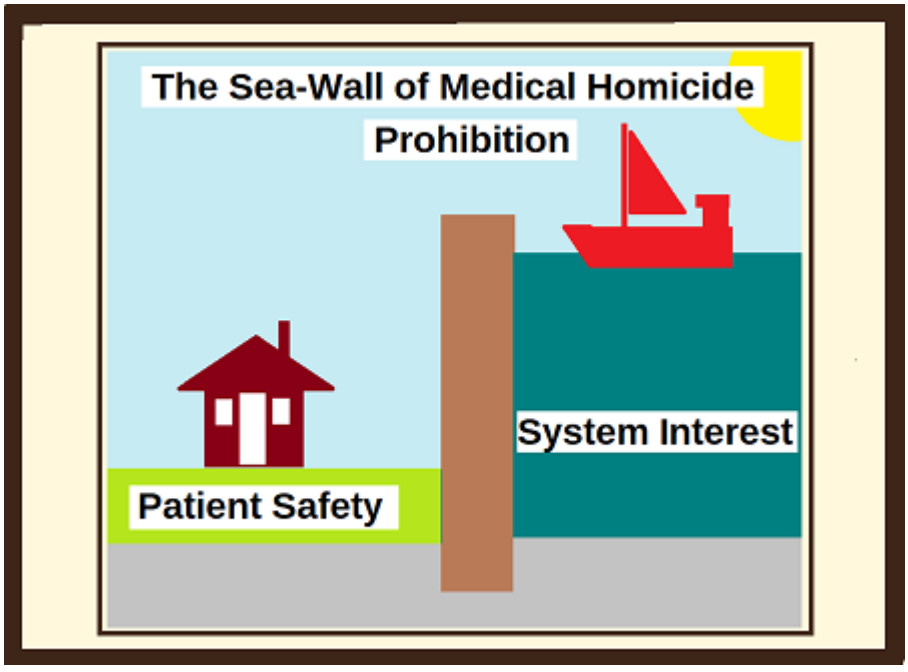
Nor do these motives need to be explicitly stated, or even understood, in order to work their formidable effect. For economic forces have an impersonal power like that of water running down hill. To the extent that doctors juggling budgets in the public system come to believe that euthanasia can be represented 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.[56]

16. The dam of moral certitude removed[57]

In past days, these dangers were commonly recognized and the equivalent of moral sea-walls were maintained to restrain them.[58] 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.[59] But that, of course, is exactly the prohibition which has now been removed.

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. The desirability of such sudden and sweeping changes demand the greatest scrutiny.



Part II: An alternative to medical euthanasia: justification by choice

Part II A) Duality of justification

1) Distinguishing medicine from choice

17. Moral relativity, and coherent policy

In the first part of this text, I described the extraordinary effects of defining euthanasia as essential medical care. Reaction to that description will depend upon the attitude of each individual reader.

It will come as no surprise that my own bias is to the side of life in all circumstances. I do understand the logic of rational suicide, but I also suspect that it has no fixed limit short of complete annihilation. For life itself is a complication from which death alone promises escape. Or, as I remember one clever epigram (without remembering its author): "The Earth would be a perfectly clean rock... if it wasn't for all this green slime."

More pragmatically, if there is to be a policy argument which divides those who have chosen life, from those who prefer to die, I believe that the only legitimate choice must be that of the intentional survivors, for they alone are arguing for the conditions in which they themselves will continue to live.

Others, of course, may have very different ideas; And yet, even if no agreement exists on moral principle, there are two areas where a common objective policy understanding may still be sought: first, on the quantitative measure of who actually desires what; and second, on whether or not the organizing principles chosen will logically lead to the results desired. In other words: will proposed policy really give people what they want?

18. Medical Aid in Dying: An incoherent conceptual construct[60]

Apart from any other consideration, the proper evolution of policy depends upon a coherent conceptual foundation.

Unfortunately, the extraordinary conceptual hybrid that we call Medical Assistance in Dying, is founded upon a reassuring fallacy, that purely subjective personal choice might be rigorously justified by objective medical science; that suicide and homicide might both disappear, beneath the wings of a magical medical construct, where those eternal enemies, subjective and objective, might figuratively lie down together, like the lion and the lamb.

Loosely invoked in this scheme, medicine and choice provide a circular succession of two claims, where the alleged truth of each is used to excuse the weakness of the other.

First, because there is no agreement on a voluntary right to die, it has been argued (with tragic effect)[61] [62] that exceptions be made for medical circumstances.

But,

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

made for choice. (And so on)

Hidden in the operation of this logical merry-go-round, lies the fact that defining euthanasia as medical care absolutely makes a mockery of choice (as shown in Part I), both by ethically guaranteeing the euthanasia of those who are incapable even of consent, and by placing an enormous coercive burden upon those capable patients who obstinately refuse to die. Moreover, choice makes a mockery of objective science also, by subjugating medical judgment to the arbitrary operation of subjective desire (even where resulting suicides are motivated by factors other than the medical criteria which guarantee their satisfaction).[63]

It is of the greatest possible importance, therefore, to recognize that these two justifications of euthanasia --medicine and choice-- although mischievously juxtaposed in the idea of Medical Assistance in Dying, are entirely distinct, and that they logically lead to very different practical outcomes. In particular, it is the unwitting tolerance of this conceptual confusion which has allowed medically standardized euthanasia to be established on the coat-tails of death-by-choice.

19. We must pick one or the other

It is the present thesis that coherence demands we consider choice and medicine separately; that we decide to what extent we will permit the influence of each, and hence: that we deliberately decide to which pole --either choice or medicine-- our implementation of assisted death will be primarily moored. I say "primarily", because in many jurisdictions it may now be practically impossible to entirely separate these two. Nonetheless, in view of the policy implications of unbridled confusion, I believe we must decide (at least) which justification will be dominant, and thus, to the limits of which justification our policies shall adhere.

Happily, there are two principal indicators which, I submit, may usefully inform our judgment in this matter. These are: a) expert opinion, and b) popular desire; while popular desire can itself be separately considered as i) democratic support, and ii) direct economic demand.

2) Suggested indicators of legitimate justification

a) Expert opinion

20. Traditional doctor opinion largely opposed to all medical homicide[64]

If we are to respect the organic tradition of medicine, as a self-defining ethical and scientific enterprise, then expert opinion should be taken, in this case, to mean *medical* opinion.

As of this writing, and after extensive formal consultation on all continents, the World Medical Association remains "firmly opposed" to euthanasia and assisted suicide (2018).[65] The American Medical Association (despite legal status in eleven States) considers assisted death as "fundamentally opposed to the physician's role as healer" (2022).[66] The American Psychiatric Association specifically opposes assisted death for mental illness alone (2016).[67] In the Netherlands, "There is no right to euthanasia" (2017).[68] And in Switzerland (long considered the assisted suicide capital of the world), the Swiss Academy of Medical Sciences states that "even if it is a legal activity, assisted suicide is not a medical action to which patients might claim to be entitled", and euthanasia remains a "criminal

offence". (2022).[69] As for Canada, the state of doctor opinion immediately preceding legalization (2016),was described by a key representative of the Canadian Medical Association: "Infrequent polling had consistently demonstrated that physicians, by a large majority, were not in favour of legalizing these activities".[70]

Contrary to radical Canadian doctrine, therefore, euthanasia remains a highly controversial act in the medical realm.[71] In no case has this lethal mandate ever been accorded 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. Most certainly: expert (doctor) opinion does not support an objective justification of euthanasia as essential medical care.[72]

b) Popular desire expressed as democratic support

21. when medicine is trumped by choice

Without doubt, it is democratic support for personal freedom which has most powerfully favoured the legalization of assisted death. Again and again, objective arguments of medical ethics (and the larger social good) have been waived away with appeals to the apparently unquestionable principle of personal choice. It appears, therefore, that many people are willing to set aside their own feelings in a generous desire to validate the experience of others. And where physician opposition had so long kept medical homicide at bay, it is now vigorously asserted that paternalistic doctors have no right to deny patients' autonomous wishes. However, we must not confuse this support of death-by-choice with that of death-as-care.

As a practical matter, the regulation of Death-by-choice is about deciding which patients should be allowed to ask for death. Objectively justified Death-as-care, more simply, requires us to decide --quite apart from choice-- which patients *should* die. Unfortunately, this question has yet to be frankly considered as such. And most significantly: the observed transformation of our entire medical industry (to prioritize euthanasia-as-care), has never been presented for public debate, let alone for informed democratic decision.

Nor does popular support predict voluntary individual behaviour; a vote for the ideal freedom to choose death, does not imply any eventual euthanasia request (or consent) on the part of the voter.

In short: democratic support extends only to an ideal respect of personal autonomy, and provides no indication of legitimate scale for actual practice. In consequence, I would submit that beyond ideal principle, the best measure of popular support for assisted death lies in the quantitative demonstration of real demand.

c) Popular desire expressed as real economic demand

22. Economic balance as a substitute for moral truth

In applying direct measures of economic demand, we have the advantage of avoiding any judgment on the value of euthanasia itself, either in the general or in the particular case. This is true with regards to both common morality and medical ethics. The central question of this paper, concerning whether or not euthanasia should be defined as medical care, is thus presented economically as one of number, not

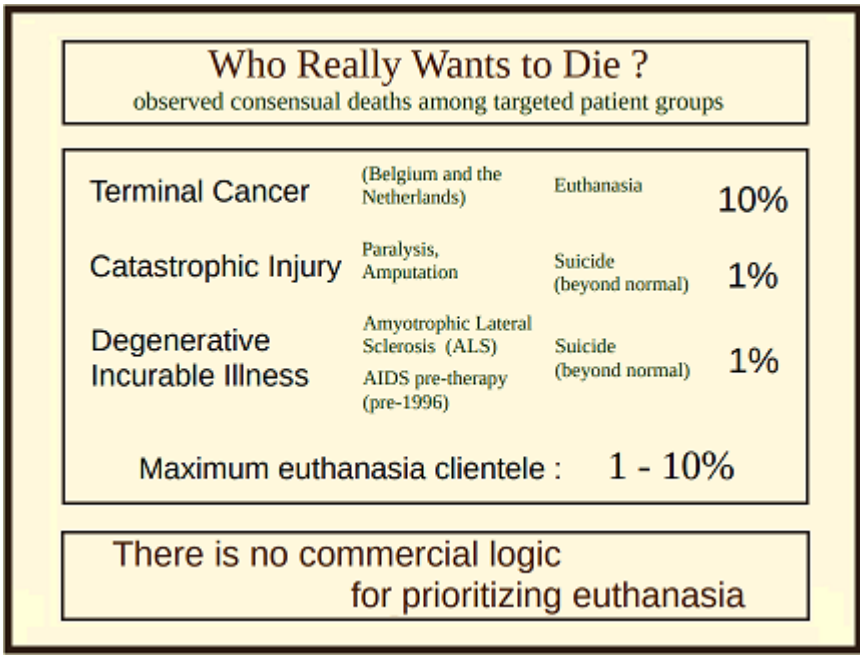
of philosophy. It is simply assumed that the scope of euthanasia practice (if legal), should be determined by the number of people actually seeking that service, and by the number of people willing to provide it.

23. Real patient demand for euthanasia: those who wish to die[73]

Admittedly, it is an indisputable fact that some apparently capable people really do wish to die. And it is the poignantly described desire of these persons that has resulted in the legalization and expansion of assisted death.[74] However, it is extremely important to provide a faithful proportional portrait of this phenomenon. For contrary to common perception (and regardless of any 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 will actually commit suicide above normal expectation[75]. And so also for degenerative diseases such as A.L.S.,[76] or AIDS (before the arrival of effective therapy in the mid-nineties).[77] Even among terminal cancer patients (according to twenty years of Dutch experience) *only one in ten* will consent to die by euthanasia.[78]

Categorically then (from the dispassionate perspective of commercial market share): potential *customers* for euthanasia are never more than one to ten percent. And quite obviously: one does not rationally design any industry to prioritize the satisfaction of a one to ten percent market share.



24. Real patient demand for euthanasia: Hippocrates and majority consumer choice[79]

Beyond public attention to the needs and rights of competing minorities, what we have little seen to this point --and what I suggest we most urgently need-- is a lucid appreciation of what is required to protect *majority* needs, and *majority* rights, especially in an environment where assisted death is legal. What (we must ask) do patients of the non-suicidal majority want?

Nor do we have far to look in answering this question. For medical tradition is not the result of some arbitrary moral dogma or corporatist design. On the contrary: previously established doctrine prohibiting medical homicide reflects a long and symbiotic evolution of mutual trust between patients and their doctors; an evolution which has organically coalesced in the extraordinarily successful, multi-millennial medical paradigm, whose origins reputedly date to the influence of Hippocrates of Cos, 2400 years ago.[80]

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, or, First do no Harm.[81]

As we are well aware, the ethical standards of Hippocrates have been severely attacked in recent years.[82] What is less generally understood, however, is that questioning the moral hegemony of Primum non Nocere does nothing to diminish its phenomenal *commercial* importance. For patients as consumers, following their own natural instinct, 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. And that, to be clear, is the objective client demand whose satisfaction should logically dominate the medical marketplace.

25. Specialization versus inclusion: maintaining an exclusively life-affirming clinical space [83]

Considering the coexistence of these radically different medical paradigms, there exists a most pernicious assumption that one clinical model might serve for both; that assisted-death might simply be added to standard medical practice without depriving typical patients of the service which *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 satisfaction.[84] This is true even of complementary services, but much more so in the present case. For the exact same doctors so bitterly denounced as paternalistic moral zealots (by the advocates of assisted death), are precisely those whose professional tradition responds, most faithfully, to majority patient needs and desires.

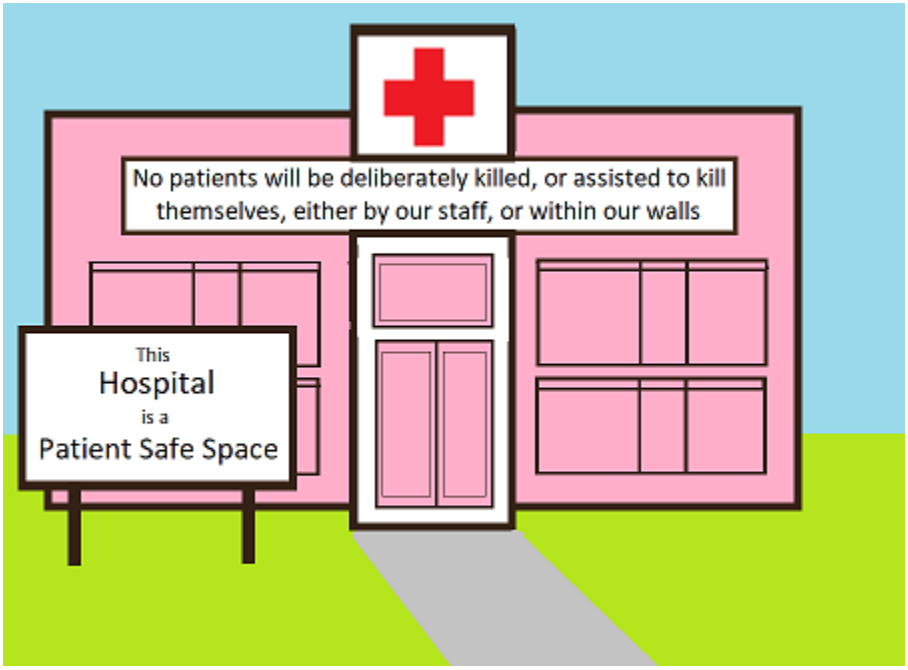
Indeed, one cannot be all things to all people. Doctors are not robots. It is impossible to imagine that the same doctor might pass from one patient to the next (presenting medically in precisely the same manner), but to change between-times so radically, in his opinions, as to promote the death of one but not the other. And the same can be said, even more confidently, of entire care teams. For how can nurses and auxiliary staff be expected to care, differently, for patients in the same circumstances?

(Yet even were carers able to behave with such mechanical indifference of purpose, patients observe them passing from bed to bed. And perception, formed in the fertile tumult of patient imagination, is just as important as fact.)

To be clear then: Euthanasia and traditional medicine cannot properly share the same clinical space.[85] These two visions are not only different, but mutually exclusive. Euthanasia cannot be added to Hippocratic medicine any more than meat can be "added" to a vegetarian diet. The non-suicidal

majority of patients today, just as in ages past, simply cannot place their trust in doctors (and nurses) who are known to kill.

Expressed in economic terms: standard medical practice should be structured (by default) to cater exclusively to life-affirming care. And most certainly, the justification of euthanasia as essential medical care is incompatible with that conclusion.



3) A Gross discrepancy between theoretical expectation and real policy

26. All indicators align on death-by-choice; But implementation is based on death-as-care

I believe we may now confidently judge of the coherence and legitimacy of euthanasia policy, justified only by choice, and that justified as medical care.

As we have seen, medical opinion is historically opposed to any form of homicide whatsoever; whereas public support depends almost entirely upon a purely subjective justification by choice; and lastly (but perhaps most importantly) impartial quantitative analysis, of real patient demand, heavily favours the primacy of a euthanasia-free clinical practice (which practice would be impossible under a true medical interpretation). In other words, of the three indicators originally chosen to validate euthanasia policy: two are fundamentally incompatible with the medical justification of euthanasia (expert opinion and real demand); while the third positively endorses a justification by choice alone (democratic support).

And yet our institutional implementation of Medical Assistance in Dying has been built upon the logically rejected objective justification of euthanasia as medical care!

This is a monumental conceptual mismatch. It has nothing to do with whether euthanasia is right or

wrong. It has nothing to do with whether or not we choose to allow assisted death. It is a simple conceptual incoherence, resulting in gross policy distortions.

27. The scale of harms created[86]

As presented through the lens of choice, opposition to assisted death has focused almost entirely on the interests of specific groups, such as the "conscience rights" of objecting doctors, or special "risks" to the "most vulnerable". Aside from these, it has been comfortably assumed that that no one else would be negatively impacted. And when weighed against the supreme value of personal liberty, specific harms to these populations have been largely discounted as regrettable (but manageable) sacrifices to a higher good. For such is the logic of choice.

Death-as-care, on the other hand, has no such limits. Despite socialization, Canadian healthcare remains a form of insurance. Active people are contributing, now, for care that they expect to receive in the future. *To substitute death for care*, is to STEAL untold yearly contributions paid in premiums and in taxes.[87] The entire active population is thus directly affected, as both immediate purchaser, and eventual recipient, of medical euthanasia.

Nor is the compromised service one of trivial proportions. Canadian healthcare represents over 32% of combined government spending.[88] Yet it is the one charge that taxpayers do not resent. Along with social security, monopoly public healthcare forms the core of our Canadian welfare system, and critically supports the federal State which is now built upon it. Indeed, the weight of healthcare, in Canadian politics, cannot be over-stated. It is simply impossible to gauge what consequences might attend a general loss of citizen faith in this institution, not over chronic questions of inefficiency and incompetence, but over a more fundamental perception: that the system itself has been deliberately structured --not to sustain and to protect-- but to bury its clientele, at the lowest possible cost.

Wisdom and prudence, therefore, would have us reconsider the offending justification of euthanasia as medical care.

Part II B) The rational accommodation of a choice-based right to die

28. author disclaimer

In what follows, it is not to be inferred that this author approves of any form of euthanasia. However, it is the present thesis that death-by-choice is infinitely less harmful than medical homicide defined as care.

29. Respecting the limits of arbitrary choice

It is the essence of all liberties, justified only by choice, that the objective "value" of those choices remains undefined. To teach that people *might*, of their own free will, be allowed to seek assistance in death, is a completely different proposition from saying that human life *should* be ended according to objective (medical) criteria.

In the first case, there is no assumption that the person exercising such a liberty is behaving "correctly" in doing so. And therefore, just as the suicidal subject has the right to determine his (or her) own

actions, so also do those people who are asked to assist him.

In consequence, euthanasia-by-choice entails none of the mandates and obligations which are required by euthanasia-as-care, whether these be professional, institutional, or societal. In accordance with a justification by choice (for greater certainty) there could be: no barriers to the creation and maintenance of euthanasia-free clinical environments; no tacit coercion of non-compliant patients; no persecution of non-participating professionals; and no euthanasia of the incapable. Nor could society be expected to guarantee access, or provide funding, for any form of medical homicide.

In sum, justification by choice is self-limiting. For opposing choices enjoy equal ideal status, while practical dominance depends solely on quantitative demonstration. Hence, the eventual scope of euthanasia, justified by choice, can only be determined by the number of people who seek it out; and by the number of those willing to provide it.

30. what economic structure for delivering such a service?

One may well ask how access to euthanasia should be provided under these conditions. And although it is not my role to design a functioning system for that which I find personally undesirable, I will at least remark that it is not at all evident that we need to answer such a question in advance. For it is the genius of commercial markets to address the satisfaction of diverse market segments, in the greatest detail, and with the greatest accuracy.

Public administration, therefore, need have no further role in the provision of choice-based assisted death, beyond the declaration of that practice as a legal activity.

31. To what extent can euthanasia be removed from medicine?[89]

It would clearly be desirable (ideally speaking) to separate death-by-choice from medicine entirely. This would ensure the continued clinical presence of life-affirming medicine, prevent the liquidation of incapable persons, and remove the discriminatory dangers suffered by all persons medically eligible for assisted death. Let us admit, however, that nothing is perfect: that we live in a world of precedent and compromise; that antecedent facts cannot be entirely ignored in the accommodation of ideal principle; and that just as "assisted death" is commonly assumed to signify "*physician* assisted death", so also, medical criteria will certainly be used (in many jurisdictions) to determine eligibility.

There is, however, no reason to agree that such politically imposed criteria actually *justify* suicide in a medical sense. Mere legality does not confer medical status. Many disputed procedures, are legally performed. But that does not make them medically necessary.[90] It is the present view that euthanasia should be treated likewise: as a choice-based, morally neutral, quantitatively marginal service, of a merely *para*-medical nature, bearing none of the obligations and mandates demanded by euthanasia as medical care.

Or to borrow the Swiss formulation: "even if it is a legal activity, assisted suicide (and euthanasia) are not medical actions to which patients might claim entitlement".

It is true that the ill and disabled are inevitably subjected to grave discriminatory danger from the moment that any medical eligibility criteria are employed. However this danger will be considerably

less in jurisdictions where the objective medical "good" of euthanasia has been explicitly rejected, as will be the total volume of assisted death.

32. A final word of caution[91]

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

The simplicity of the observations, and prescriptions provided above, is both reassuring and unsettling: reassuring because we clearly possess effective precautions to prevent the worst of outcomes; but unsettling, because little or nothing is actually being done to that effect.

Incredibly, current policy discussion barely touches on the crucial distinction between death-by-choice, and death-as-care (which are so disingenuously confused in the MAID construct). Public perception remains years behind actual events, while debate is typically limited to life-centred morality, disabled oppression theory, and the mantra of personal choice. The more revealing influence of some modern bioethics[92] is largely omitted, as is the relevance of generally repudiated 20th century ideological strains (due to Post-War taboos governing the permissible context of their consideration)[93] [94]

With regards to the utilitarian transformation of medicine described here, it would seem that the entire euthanasia program is now flying on operational auto-pilot. Euthanasia has been politically defined as fully ethical medical treatment; and in the absence of any counter-instructions, the system itself is retooling to apply that definition literally: following its own economic imperatives --like a rogue Artificial Intelligence-- preferentially killing the patients it was created to protect.

It thus becomes an unavoidable conclusion, that (for whatever reason), our decisional and managerial class has espoused policies (passively or deliberately), which are objectively aligned with radically impersonal political views: that medical opinion, democratic support, and even real organic economic demand, are not deemed to be the legitimate standards by which the nature of medical practice should be determined. It has rather been decided (or at least allowed) that such practice shall be aligned with very different ethical and economic interests, effectively linking individual survival to medically determined utilitarian value.

Naturally, this conclusion will be deeply disturbing to those who believe that human social systems should be moulded to reflect the desires of the persons inhabiting them, rather than the reverse.

33. A truly global question[95]

In previous versions of this text, I was able to speak of the Canadian medical interpretation of euthanasia as a unique exception. Sadly, that is no longer the case. For Spain has since enacted a similar law (2021)[96] which espouses the objective medical paradigm in even more explicit fashion. Moreover, multiple US States have bills, either in force or under discussion, which do not actually claim full medical status (for assisted death) but which nonetheless seek to impose mandates which might only be coherently justified in that way.[97] Plainly, the juggernaut of utilitarian euthanasia is now gaining momentum, globally, without any general understanding of how, or why.

It is of the greatest importance, therefore: that a clear distinction be established, between the justification of death-by-choice, and that of death-as-care; that the social implications of each be publicly debated; and that we choose our course accordingly.

My personal recommendation (in jurisdictions where assisted death is legally practiced) lies with a coherent justification by choice.

Gordon Friesen, Montreal
April 4, 2023

Notes (on following page)

1. A Cautionary Tale

Coelho R., Lemmens T., Gaind K. S., Maher J. Normalizing Death as “Treatment” in Canada: Whose Suicides do we Prevent, and Whose do we Abet?. World Medical Journal. 2022;70(3):27-35. https://www.wma.net/wp-content/uploads/2022/11/WMJ_2022_03_final-1.pdf

Avis Favaro, Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing, CTV National News Wednesday, April 13, 2022, accessed Jan.25, 2023 https://www.ctvnews.ca/mobile/health/woman-with-chemical-sensitivities-chose-medically-assisted-death-after-failed-bid-to-get-better-housing-1.5860579

Daflos P. Police investigation, public outcry following B.C. woman’s medically assisted death CTV. 2022 https://bc.ctvnews.ca/police-in-vestigation-public-outcry-fol-lowing-b-c-woman-s-medical-ly-assisted-death-1.5881294 accessed December 23, 2022

Bryan Passifiume, Canadian veterans were offered assisted suicide in five instances, committee hears, National Post, Nov 24, 2022 https://nationalpost.com/news/canadian-veterans-assisted-suicide accessed December 23, 2022

Roger FoleySTANDING COMMITTEE ON JUSTICE AND HUMAN RIGHTS TUESDAY, NOVEMBER 10, 2020 https://parlvu.parl.gc.ca/Harmony/en/PowerBrowser/PowerBrowserV2?fk=10999898 (intervention at 11:10) accessed December 23, 2022

Geoff Bartlett · CBC News · Jul 24, 2017 Mother says doctor brought up assisted suicide option as sick daughter was within earshot https://www.cbc.ca/news/canada/newfoundland-labrador/doctor-suggested-assisted-suicide-daughter-mother-elson-1.4218669 accesed December 23, 2022

LEWIS PENNOCK, DAILYMAIL.COM, 9 December 2022 'I don't want to die, but I don't want to be homeless': Canadian man, 65, has a doctor's approval for euthanasia despite admitting becoming POOR is a main reason he's applying to die https://www.dailymail.co.uk/news/article-11516989/Canadian-man-doctors-approval-euthanasia-despite-admitting-POVERTY-main-factor.html accessed December 23, 2022 (video) https://videos.dailymail.co.uk/video/mol/2022/12/08/6442938775083438055/640x360_MP4_6442938775083438055.mp4

2. Death defined as Medical Care

QC, Bill 52 An Act Respecting End of Life Care (2014) https://www.legisquebec.gouv.qc.ca/en/document/cs/S-32.0001 accessed December 28, 2022

Basic right to die position articulated by Exit International: https://www.exitinternational.net/about-exit/our-philosophy/ accessed December 27, 2022

National Collaborating Centre for Healthy Public Policy (NCCHPP), Public Health Agency of Canada accessed December 27, 2022 http://www.ncchpp.ca/docs/2016_Ethics_Utilitarianism_En.pdf

Office of the Parliamentary Budget Officer accessed December 27, 2022 https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf

3. A quantitative comparison: Oregon versus Quebec

Oregon Death with Dignity Act (1994) accessed December 28, 2022 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf

Oregon 2021 Data Summary accessed December 28, 2022 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

Quebec annual report 2021 https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_185931&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz accessed December 28, 2022

Oregon 2022 Data Summary accessed April 1, 2023 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf

Radio Canada, Santé, Davide Gentile, Daniel Boily, 16 février 2023 https://ici.radio-canada.ca/nouvelle/1956764/aide-medicale-mourir-quebec-commission-soins-fin-vie-consultation-medecins accessed April 1, 2023

United States Census Bureau https://data.census.gov/all?q=Oregon accessed December 28, 2022

Statistics Canada accessed December 28, 2022 https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?DGUIDlist=2021A000224&GENDERlist=1&HEADERlist=0&Lang=E&STATISTIClist=1&SearchText=Quebec

Third annual report on Medical Assistance in Dying in Canada 2021 https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html Accessed December 31, 2022

3. b) Canada vs the State of California

24 CALIFORNIA END OF LIFE OPTION ACT 2021 DATA REPORT https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20_Option_Act_Report_2021_FINAL.pdf accessed December 31, 2022
25 ethical subjectivism, definition accessed December 28, 2022 https://www.philosophybasics.com/branch_subjectivism.html https://en.wikipedia.org/wiki/Ethical_subjectivism https://www.bbc.co.uk/ethics/introduction/subjectivism.shtml
26 The Duties of Doctors Towards Patients https://educaloi.qc.ca/en/capsules/the-duties-of-doctors-towards-patients/#:~:text=Diagnosing%20and%20Treating%20the%20Patient,up%20on%20their%20patients%27%20progress. accessed December 28, 2022

27 5. Professional and social obligations thus created

28 claim rights and liberty rights Wikipedia https://en.wikipedia.org/wiki/Claim_rights_and_liberty_rights accessed December 28, 2022 Stanford Encyclopedia of Philosophy, Rights, accessed December 28, 2022 https://plato.stanford.edu/entries/rights/#CateRigh

29 6. Professional permissions granted

30 Michèle Marchand, L'aide médicale à la mort : réflexions et débats en cours au Québec, Retour sur la réflexion menée au Collège des médecins du Québec, https://www.erudit.org/fr/revues/fr/2011-v24-n1-2-fr0357/1013082ar/ accessed December 28, 2022

31 7. Resulting Canadian policy

32 DISPARITÉS DANS L'ACCESSIBILITÉ À L'AIDE MÉDICALE À MOURIR, LOUISE LEDUC LA PRESSE 23 janvier, 2023 https://plus.lapresse.ca/screens/5b6dfb0a-1dec-4ad3-a56e-a2efb8e7a5f1__7C___0.html?utm_content=email&utm_source=lpp&utm_medium=referral&utm_campaign=internal+share accessed Aprio 1, 2023
33 QC, An Act Respecting End of Life Care, sec 3-1, sec 7, sec 9 accessed December 28, 2022 https://www.legisquebec.gouv.qc.ca/en/document/cs/S-32.0001
34 QC, An Act Respecting End of Life Care, sec 50, sec 31accessed December 28, 2022 https://www.legisquebec.gouv.qc.ca/en/document/cs/S-32.0001
35 Sarah LeBlanc, Susan MacDonald, Mary Martin, Nancy Dalgarno, Karen Schultz (Queen's University) https://assets.researchsquare.com/files/rs-799267/v1/eb1c85e0-318b-42a6-83e3-e7d598903fba.pdf?c=16469739200 accessed December 28, 2022
36 Projected text of QC Bill-11 (2023) An Act to amend the Act respecting end-of-life care and other legislative provisions , Sec 48 "Nurses Act" https://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-11-43-1.html accessed April 2, 2022
37 College of Physicians and Surgeons of Ontario, Professional Obligations and Human Rights (2015) https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights sec 5, sec 9-17 accessed December 28, 2022
38 CPSO Professional Obligations and Human Rights draft revision (2022) http://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Human-Rights-in-the-Provision-of-Health-Services_Draft-Policy.pdf accessed December 28, 2022
39 QC, Bill 52 An Act Respecting End of Life Care (2014) sec 8 https://www.legisquebec.gouv.qc.ca/en/document/cs/S-32.0001 accessed December 28, 2022

40 9. Choice-driven expansion of medical eligibility

41 Bill C-7 An Act to amend the Criminal Code (medical assistance in dying) (2021), sec 1 https://parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent accessed December 28, 2022

42 10. Fallacious claims of autonomous choice

43 Catherine Levesque, National Post, https://nationalpost.com/news/quebec-college-of-physicians-slammed-for-suggesting-maid-for-severely-ill-newborns?fbclid=IwAR0WjT-O35SZ6IqcP0mq_qHIn3RvxmgIpthQ_Az2Jq7yIgB1EpC9_LJp07o accessed December 28, 2022
44 Bill C-7 An Act to amend the Criminal Code (medical assistance in dying) 2021, Preambule https://parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent accessed December 28, 2022
45 Mark S. Komrad M.D., Psychiatric Times, June 1, 2021, "Oh, Canada! Your New Law Will Provide, Not Prevent, Suicide for Some Psychiatric Patients" https://www.psychiatrictimes.com/view/canada-law-provide-not-prevent-suicide; June 15, 2021 (video) Are Psychiatrists who Assist in Suicide Betraying Their Professional Values? accessed December 28, 2022 https://www.psychiatrictimes.com/view/psychiatrists-suicide-betraying-values accessed December 28, 2022
46 Projected text of QC Bill-38 (2022) An Act to amend the Act respecting end-of-life care and other legislative provisions , Sec 16 " Special provisions applicable to advance requests for medical aid in dying" https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_183415en&process%3DDefault%26token%3DZyMoxNwUn8ikQ%2BTRKYwPCjWrKwg%2BvIv9rjij7p3xLGTZDmLVSmJLoqe

%2FvG7%2FYWzz&usg=AOvVaw2N_e17ld5pDd50apJcajDe accessed December 28, 2022

14. A shift of consumer power from patient to system

Melissa Thomasson, Miami University, Economic History Association, Health Insurance in the United States https://eh.net/encyclopedia/health-insurance-in-the-united-states/ accessed December 28, 2022

Canada's Health Care System accessed December 28, 2022 https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html

Medicare Rights Center, definition: beneficiary accessed December 28, 2022 https://www.medicareinteractive.org/glossary/beneficiary

DOUGLAS R. RICHMOND, Trust Me: Insurers Are Not Fiduciaries to Their Insureds, KENTUCKY LAW JOURNAL 1999-2000 https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1528&context=klj accessed December 28

15. Conflicting patient and system interest

Leo Alexander, M.D., New England Journal of Medicine, 1949, Medical Science Under Dictatorship, (See Section: The Situation in the United States) accessed December 28, 2022 https://www.catholicculture.org/culture/library/view.cfm?recnum=492

Third annual report on Medical Assistance in Dying in Canada 2021--Highlights--Growth in the number of medically assisted deaths in Canada. https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html#highlights accessed December 28, 2022

16. Death medicine does not require a deliberate plan

Cross reference to note 53 Leo Alexander, Medical Science under Dictatorship

17. The dam of moral certitude removed

J. Budziszewski, THE REVENGE OF CONSCIENCE, June 1998, accessed December 28 https://www.firstthings.com/article/1998/06/the-revenge-of-conscience accessed December 28, 2022

University of Michigan, Hippocratic Oath, Francis Adams, 1849 http://websites.umich.edu/~uc260/Library/Hippocratic.pdf accessed April 3, 2023

18. Medical Aid in Dying: An incoherent conceptual construct

Friesen, Gordon, Medical Aid in Dying Is not a Hypothetical “Slippery Slope,” but a Clear and Present Danger, Dec 8, 2022, accessed Jan, 3, 2023 https://www.psychiatrictimes.com/view/medical-aid-in-dying-is-not-a-hypothetical-slippery-slope-but-a-clear-and-present-danger

Friesen, Gordon, The Harms of Assisted Death Are Not Just a “Disabled Thing” Dec 19, 2022 accessed Jan. 3, 2023, https://www.psychiatrictimes.com/view/the-harms-of-assisted-death-are-not-just-a-disabled-thing

Quebec man seeks euthanasia based on changes to home-care, Alex Schadenberg, October 4, 2022 https://alexschadenberg.blogspot.com/2022/10/quebec-man-seeks-euthanasia-based-on.html accessed March 31,2023

20. Traditional doctor opinion largely opposed to all medical homicide

World Medical Association: Firmly opposed to euthanasia and physician-assisted suicide https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/ accessed December 28, 2022

American Medical Association: Euthanasia and assisted suicide fundamentally incompatible with the physician’s role https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf accessed December 28, 2022

American Psychiatric Association Position Statement on Medical Euthanasia (2016) accessed March 11, 2023 https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Medical-Euthanasia.pdf Mark Komrad, Psychiatric Times, Feb. 25, 2017 accessed March 11, 2023 https://www.psychiatrictimes.com/view/apa-position-medical-euthanasia

Royal Dutch Medical Association: No right to euthanasia for patients in the Netherlands accessed December 28, 2022 https://www.knmg.nl/actualiteit-opinie/nieuws/nieuwsbericht/euthanasia-in-the-netherlands.htm

Swiss Academy of Medical Sciences: assisted suicide not a medical action to which patients could claim to be entitled (even if legally permissible) section 6.2.1 ; euthanasia categorically excluded 6.3.0 - 6.3.2 https://www.samw.ch/dam/jcr:3154cd58-a2bf-4d2a-b11c-27a46174bbe0/guidelines_sams_dying_and_death.pdf accessed March 11, 2023

Canada (immediately pre-legalization): doctors by a large majority opposed, Dr. Jeff Blackmer, CMA Vice-President, International Health (World Medical Association Journal, October 2017, second paragraph).

J. Donald Boudreau and Margaret A. Somerville, “Euthanasia is not medical treatment”, *British Medical Bulletin* 2013; 106: 45–66, DOI:10.1093/bmb/ldt010 accessed December 28, 2022 http://bmb.oxfordjournals.org/content/early/2013/03/26/bmb.ldt010.full?keytype=ref&ijkey=IKP7zm8pfcR3lNH

Rene Leiva, Gordon Friesen, Timothy Lau, World Medical Association Journal, Vol. 64, No 4, December 2018 (pg.33): "Why Euthanasia is Unethical and Why We Should Name it as Such" https://www.wma.net/wp-content/uploads/2019/01/wmj_4_2018_WEB.pdf accessed December 28, 2022

23. Real patient demand for euthanasia: those who wish to die

74 COUR SUPÉRIEURE CANADA PROVINCE DE QUÉBEC N° : 500-17-099119-177. 11 septembre 2019, JEAN TRUCHON ET NICOLE GLADU c. PROCUREUR GÉNÉRAL DU CANADA ET PROCUREURE GÉNÉRALE DU QUÉBEC http://eol.law.dal.ca/wp-content/uploads/2019/09/500-17-099119-177.pdf accessed March 3, 2023

75 G Savic, M J DeVivo, H L Frankel, M A Jamous, B M Soni & S Charlifue Suicide and traumatic spinal cord injury—a cohort study accessed December 28, 2022 https://www.nature.com/articles/sc201798 rate highest year 1; then 1-5; normal after year 5 M J DeVivo 1, K J Black, J S Richards, S L Stover Suicide following spinal cord injury https://www.ncbi.nlm.nih.gov/pubmed/1787986

76 Fang Fang, Unnur Valdimarsdóttir, Carl-Johan Fürst, Christina M. Hultman, Katja Fall, Pär Sparén, Weimin Ye, Suicide among patients with amyotrophic lateral sclerosis (2008) accessed December 28, 2022 https://www.researchgate.net/publication/23139851_Suicide_among_patients_with_amyotrophic_lateral_sclerosis

77 Roger Pebody, Massive decline in suicides of HIV-positive people since the introduction of combination therapy, but rate remains high (2019) https://www.aidsmap.com/news/aug-2019/massive-decline-suicides-hiv-positive-people-introduction-combination-therapy-rate homosexual suicide baseline Jay P. Paul, PhD, Joseph Catania, PhD, Lance Pollack, PhD, Judith Moskowitz, PhD, Jesse Canchola, MS, Thomas Mills, MD, MPH, Diane Binson, PhD, and Ron Stall, PhD, MPH, Suicide Attempts Among Gay and Bisexual Men: Lifetime Prevalence and Antecedents (2002) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447240/ accessed December 28, 2022

78 Note on Dutch cancer patients who consent to euthanasia
total deaths: 168,678 (2020)
https://www.statista.com/statistics/520011/total-number-of-deaths-in-the-netherlands/ accessed December 28, 2022
cancer deaths: 49,008
https://gco.iarc.fr/today/data/factsheets/populations/528-the-netherlands-fact-sheets.pdf accessed December 28, 2022
cancer as fraction of total:
49,008 / 168,678 = 0.29
all euthanasia deaths 6,938
cancer euthanasia deaths 4480
euthanasia as fraction of total deaths 0.041
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwij-cCK8_77AhVfxikDHZ6xC6wQFnoECCYQAQ&url=https%3A%2F%2Fwww.euthanasiecommissie.nl%2Fbinaries%2Feuthanasiecommissie%2Fdocumenten%2Fjaarverslagen%2F2020%2Fapril%2F15%2F accessed December 28, 2022
cancer euthanasia as fraction of total euthanasia deaths:
4480 / 6938 = 0.65
cancer euthanasia as fraction of total deaths:
.65 * 0.041 = 0.027
cancer euthanasia as fraction of total cancer deaths:
0.027 / 0.29 = 0.09 "less than one in ten"

79 **24. Real patient demand for euthanasia: Hippocrates and majority consumer choice**

80 cross reference note 59 hippocratic oath

81 Origin and Uses of Primum Non Nocere—Above All, Do No Harm! Cedric M. Smith,07 March 2013 https://doi.org/10.1177/0091270004273680

82 DEL GUERCIO, LOUIS R. M. MD, Triage in cold blood (includes famous Margaret Mead quote) https://journals.lww.com/ccmjournal/Citation/1977/07000/Triage_in_cold_blood.1.aspx accessed December 28, 2022

83 **25. Specialization versus inclusion: maintaining an exclusively life-affirming clinical space**

84 https://en.wikipedia.org/wiki/Market_segmentation accessed December 28, 2022

85 Friesen, G. Patients can no longer assume that doctors are committed to protecting life, July 30, 2020 http://alexschadenberg.blogspot.com/2020/07/patients-can-no-longer-assume-that.html accessed December 28, 2022

86 **27. The scale of harms created**

87 Legal Information Institute: Bait and Switch accessed December 28, 2022 https://www.law.cornell.edu/wex/bait_and_switch

88 Statistics Canada healthcare https://www150.statcan.gc.ca/n1/daily-quotidien/201127/dq201127a-eng.htm accessed December 28, 2022

89 **31. To what extent can euthanasia be removed from medicine?**

90 HealthLinkBC Cosmetic Surgery and Procedures December 28, 2022 https://www.healthlinkbc.ca/health-topics/cosmetic-surgery-and-procedures

91 **32. A final word of caution**

92 Peter Singer, Practical Ethics, Second Edition, Cambridge 1993 http://sites.nd.edu/ten-images-of-hell-fall-2019/files/2019/10/Singer-Taking-Life-Humans.pdf accessed March 31, 2023

93 The Role of Psychiatrists in the U.S. Eugenics Movement and the Nazi Holocaust: Yale Psychiatry Grand Rounds: February 28, 2020 Mark Komrad https://medicine.yale.edu/psychiatry/media-player/yale-psychiatry-grand-rounds-february-28-2020/ accessed April 2, 2023

94 Cross reference note 53, Leo Alexander, 1949, Medical Science under Dictaorship

95 **33. A truly global question**

96 Ley Orgánica, de 24 de marzo, de regulación de la eutanasia https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-4628 accessed March 31, 2023

97 Gordon Friesen, "Minnesota End-of-Life Options Act would decriminalize assisted suicide and is a dangerous road-map for future medical practice" https://alexschadenberg.blogspot.com/2022/11/minnesota-end-of-life-options-act-would.html accessed December 28, 2022