Fundamental Considerations in the Creation of a Minimally Intrusive Liberty of assisted Death

Prepared for the Joint Committee on Assisted Dying, Tithe an Oireachtas, Republic of Ireland

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a) An attempt to clearly identify competing alternatives, and logical outcomes[2]

In the interests of full disclosure, it remains my personal belief that the cumulative harms --of any permission of assisted death-- are much greater than those of a simple prohibition. However, faced with the imminent possibility of legalization, in Ireland, my immediate goal is to provide a usefully candid analysis, of competing legislative options, and a practical key, for avoiding the worst outcomes.

b) Basic principle is more important than detailed restriction[3]

In an attempt to create legislation which will not only be acceptable now, but coherently stable over time, lawmakers will naturally look towards detailed restriction.

Wide international experience has shown, however, that initial limits do not necessarily govern future expansion. Much more important, I suggest, is the stated justification at the root of legislation. For that is the conceptual DNA according to which the flower of policy will subsequently unfold.

c) Distinguishing between subjective, and objective, justifications of assisted death[4]

Should legislators wish to permit assisted death, it is the present opinion, that their single most important act shall be deciding whether to define that death as medical care (as in Canada and Spain), or to deliberately refuse that path (as in Switzerland and Germany).

(See appendix i -- duelling justifications of assisted death: subjective (choice), and objective (medicine); grouping of jurisdictions (table)

The underlying ethical question raised, concerns whether assisted death shall be considered only as a wilful act of subjective choice (and thus of undefined moral status), or if each case of assisted death should also be *objectively agreed upon*, as a positive (medical) good.

This second method may seem intuitively more attractive, for it promises to avoid the unsettling prospect of indiscriminate permission. But the moral confidence thus gained comes at a very high price.

For whereas the justification by pure subjective desire logically leads to a minimally invasive liberty, as in Switzerland, the objective logic of medical care necessarily creates entitlements, duties, and mandates, which produce an enormous systemic footprint, with profound secondary effects, as now observed in Canada.

(See appendix ii -- permission or entitlement?)

d) The economic context: a systemic interest in maximizing assisted death[5]

It must also be recognized that the assisted death question is not merely one of patient satisfaction. There are enormous, systemic economic interests at play, which favour the adoption of an objectively justified, and medically normalized recourse to maximal euthanasia practice.

(See appendix iii -- Economic analysis: utilitarian death medicine piggy-backing on the power of choice

II) Specific harms created by an objective, medical justification, of assisted death[6]

a) Assisted suicide is rapidly replaced by euthanasia[7]

When it is postulated that assisted death is medical care (not suicide), euthanasia (performed by doctors) is the logical result. Canadian assisted deaths are 99.9 % euthanasia; and so, also, in Belgium and the Netherlands.

b) The medical practice of assisted death cannot fairly be restricted to the end-of-life[8]

"Medical aid in dying" is proposed as a cure for suffering. If that logic is accepted, it is not ethically coherent to provide that option for a patient facing a few months of discomfort, but to deny it to another, expecting decades of the same.

c) Inevitable euthanasia of the incapable[9]

A coherent application of the objective justification cannot ethically stop at the consent boundary. For if euthanasia is once defined as a positive medical benefit, we cannot deny that benefit to the incapable.

(See appendix iv -- The logical inevitability of euthanasia for incapable persons)

d) Acute stress suffered by medical professionals[10]

With regard to medical professionals, the convenient moral absolution enjoyed by both patient and society (in declaring assisted death as medical care) is achieved at the expense of medical professionals, who are always ethically responsible for treatment prescribed, and who must shoulder significantly increased psychological burdens accordingly. [11]

(See appendix v -- protecting medical professionals)

e) Discriminatory dangers to the ill and disabled[12]

It is commonly held that any legalization of assisted death must compromise the social and physical security of the ill and disabled.[13] Clearly, an officially endorsed medical interpretation --that the precipitated deaths of such people are objectively "good"-- takes this problem to a new level.

(See appendix vi -- discriminatory dangers for the ill and disabled)

III) System-wide effect upon the citizen/patient/taxpayer[14]

a) Fundamental transformation of the medical industry: entitlements, permissions, duties and mandates[15]

In accordance with the Constitution of the World Health Organization,[16] should assisted suicide and/or euthanasia be legally defined as medical care, it is not enough to merely allow such practice. The State must also guarantee its provision. Hence, sweeping entitlements, duties, and mandates logically follow.

In Canada, these now include: guaranteed provision of assisted death to all eligible citizens; provision of assisted death in all institutions; provision of assisted death by all health professionals (subject only to individual conscience rights); and proactive obligatory discussion, with all eligible patients, of assisted death as a medically indicated treatment option.[17]

b) Depriving non-suicidal patients of traditional life-centred care[18]

One does not manufacture motorcycles in an ice-cream factory. Similarly: it is not possible to mandate the universal clinical penetration of assisted death, without depriving typical, non-suicidal patients, of the euthanasia-free clinical spaces, doctors, and care-teams, which they require.

(see appendix vii -- Specialization versus inclusion: maintaining an exclusively life-affirming clinical space)

(see appendix viii -- Creating a hostile environment for non-suicidal patients: the forced co-habitation of euthanasia and palliative care)

(see appendix ix -- Hostile environment (2): the new face of long-term care)

c) Quantitative dissonance: majority interests and opinions (of patients and doctors) are ignored[19]

From an economic perspective, the described prioritization of assisted death would require overwhelming patient demand. However nothing of the sort exists. There is no medical circumstance, whatsoever, in which it is typical for patients to demand death. On the contrary: in all categories, the vast majority of patients remain resolutely non-suicidal.

(see appendix x -- A quantitative analysis of the atypical demand for assisted death)

And doctors, in perfect symmetry, remain personally opposed.

(see appendix xi -- Doctor sentiment: naturally in harmony with majority patient interest

d) Economic harms thus created[20]

There are gigantic financial ramifications to these quantitative distortions. Modern healthcare represents 13% of Canadian GDP [21] and 32 % of combined government spending.[22] Despite socialization, medical service remains a form of collective insurance. People are paying now for care they expect to receive in the future. To normalize the substitution of death for care, is thus to *steal* untold contributions in premiums and in taxes.

Indeed, the weight of healthcare, in governance, cannot be over-stated. it is impossible to gauge what consequences might attend a general loss of citizen faith in this institution -- not over chronic questions of inefficiency and insufficient ressources-- but over a more fundamental perception: that the system itself has been deliberately structured to bury its clientele at the lowest cost.

IV) Conclusion[23]

a) Summary[24]

Beyond what many consider to be the intrinsic social cost of assisted death,[25] great and specific additional harms must be expected from the mandates, and entitlements, which are inseparable from an objective medical justification of that practice.

To avoid these harms, I believe it is preferable, if any legalization be envisaged for assisted death, that refuge be sought in a purely subjective justification; taking inspiration from the statement of ethical intent provided by the Swiss Academy of Medical Sciences: "Even if it is a legal activity, assisted suicide is not a medical action to which patients might claim to be entitled".[26]

Let there be no mistake: I remain personally opposed to any legalization whatsoever.

However, mindful of the painful experience of real outcomes, I feel it my duty to honestly discriminate between what is bad, and what is worse.

If assisted death is to be legalized in Ireland: I strongly suggest it be justified by choice alone, not by medicine.

b) Specific legislative provisions[27]

In any legislation legalizing assisted death, I would propose that a preamble be inserted, in which it is explicitly stated: that regardless of anything to follow, assisted death is only recognized as a subjectively justified act of personal will; that it is NOT to be considered as an objective good (in the medical sense or in any other); and that NO validation of any particular assisted death is to be implied or inferred.

I would strongly suggest avoiding "suffering" as an eligibility requirement, as this leads to the open-ended expansion of euthanasia, as medical care, which has been observed in Canada, Netherlands, and Belgium. If possible, "terminal condition" or "six months to live" should be maintained. This, along with self-administration, would appear to be the key to comparatively low rates in the American States. Above all, the State itself should remain neutral, such that any permission of assisted death remains a liberty, not an entitlement.

(see appendix xii -- Model legislation for a minimally intrusive permission of assisted death)

V) (Coda) A final defence of absolute prohibition: the stopped clock[28]

As Lewis Carroll once pointed out,[29] a stopped clock is right twice a day. But a clock which loses only one minute in twenty-four hours will be right only once in two years.

Like the stopped clock, the multi-millennial moral precept "Thou shalt not kill", is a simple blunt instrument with no moving parts. Easy to understand. Generally easy in application. Its principal benefit (and over-arching civilizational significance) is that it points clearly to an absolute moral conclusion: killing of any sort (including killing of oneself) is wrong. Full stop.

Unfortunately however, in the complexity of human life, situations necessarily arise, where such invariable conclusions lead to apparent injustice. The idea becomes very appealing, therefore --for legislators as for watchmakers-- to seek ever-more subtle mechanisms, which will enable more finely adapted judgments, in more cases.

But in this pursuit, the watchmaker has a huge advantage over his legislative counterpart: being the fact that he is able to verify the accuracy of his work, through direct observation (of the sun, or other time-reliable phenomena). For the lawmaker, on the other hand, it is the intellectual and spiritual crisis of our time, that there exists no such agreed higher standard, which might allow us to effectively verify, and reset, our moral bearings; and should our complex post-modern legislative construct go slightly out of whack (like the minimally slowing clock), we have no means to verify or correct that fact.

In other words: once simple moral maxims are set aside, subtlety in judgment will be inversely proportional to shared agreement on the justice of those judgments.

Moral simplicity is not always bad

Today, for instance, there is a tendency to examine, not the act, but the intent. In this view, the act of killing, itself, has no moral attribute. Killing may be right or wrong depending on why it is done.

And perhaps that might be true for a perfectly informed, perfectly disinterested, ideal intelligence. But in the real world, such thinking immediately leads to subjectively indulgent attempts, to morally justify violent acts, which just happen to coincide with the personal interests of the perpetrator.

In a simpler time, on the other hand, it was assumed (however problematically) that there might be exceptions to a rule, without invalidating its core meaning. An aggressor, for example, might be killed in self-defence, but that killing, although pardonable, was still considered a regrettable wrong.

This in no way solves the problem of agreeing on *which* exceptions are legitimate, and in *which* cases; but it does impose a certain solemnity of deliberation, when compared to the nonchalance of assuming, from the start, that there is nothing intrinsically wrong about killing.

It is also a very significant fact, I submit, and too often ignored by clever social theorists, that in spite of our post-modern philosophical malaise, the vast majority of people still instinctively think, feel, and behave in this manner.

Advocates of assisted death are therefore always faced with a strong social discomfort before the facts of suicide, and homicide. And to the extent that relativist arguments have proved insufficient to counter that bias, they have undertaken to perpetrate a direct assault on the foundations of common language, and understanding.

When killing is not killing

With astounding simplicity it is declared (and in my country, decreed, with the full force of parliamentary power) that euthanasia is a positive "good". And since deliberate "killing" is universally considered to be "bad" (regardless of intent), it therefore follows (by definition) that euthanasia (although technically identical in every respect) *is not* killing.

There may be a small satisfaction in remarking the complete rational bankruptcy of such a position --similar to that of a small child who covers his own eyes in order to become invisible-- but that satisfaction in no way compensates for the vandalism incurred.

Most importantly, as with our touchingly deluded child, wilfully ignoring the basic facts of assisted death --whether assisted suicide or euthanasia-- does not make the deeper social implications of those practices go away.

Examining our three options, side by side...

First of all, the absolute prohibition of homicide (including the killing of oneself) implies an affirmation that life must be protected in all circumstances. This shared conviction offers the greatest support, both internal and social, for all those who are struggling on the cusp of existential despair. It does not make the universal relief of suffering any more immediately possible, but it does imply a constant civilizational effort (and hence a reliably constant progress) towards that goal.

Secondly, The simple social permission of suicide, including *assisted* suicide, is postulated upon the idea that for some people, in some circumstances, life is simply not worth living. But from this first theoretically admitted exception, the practical bar of application is arbitrarily lowered, through a general liberty of autonomous subjective choice. In the end, therefore, the threshold of "intolerable suffering" is set by the most marginal suicidal wish among us. And the despair, of that one, is allowed to justify and to nourish the despair, of all others.

In third place, the justification of assisted death as a positive medical benefit (objectively appropriate for the treatment of suffering in defined clinical situations), leads directly to a pseudo-scientific crusade, aimed at the elimination of all defective (suffering) life. For in the objective view, deaths by euthanasia (in keeping with the Greek etymology) are literally "good" deaths. And the promotion of such deaths thus becomes, itself, a worthy goal.

Furthermore, since death is now embraced as a simple and infallible cure, there will quite naturally be less perceived urgency, in any other relief of present suffering, or in any committed social effort to improve the means of that relief.

And again, since both the social acceptance of suicide, and that of euthanasia, imply that there is no intrinsic value in resisting death, these phenomena are rooted in a philosophy which is optimally suited to validate suicidal desire and despair; and to validate the self-perception of those few who --for whatever reason-- abandon themselves to those forces.

The "stopped clock" of absolute prohibition, on the other hand, is optimally suited to socially sustain the efforts of that majority who will ultimately choose to survive in all circumstances. And since it is these survivors (and perhaps their descendants) who must live, in the future world governed by present policy, it is my belief, that their interest should be given far greater weight, than that of their more ambivalent counterparts.

Prohibition: the best of our imperfect choices

Clearly there is no perfect solution. We must weigh the scale of comparative harms.

Is it really so egregious, that a few people be asked to live a little longer, in order to unambiguously protect the lives of those --much more numerous-- who do not wish to be killed?

In view of such questions, it is my sincere belief that jurisdictions studying the assisted death question should not allow themselves to fall into the trap of that curious (but uncommitted) potential customer, who has allowed the clever salesman to convince him that he must choose between the red one, and the blue one.

On the contrary, there is no urgent necessity to make any choice at all. The current, time-tested, absolute prohibition of homicide (including assistance to suicide) carries much less social hazard than either the Canadian (objective), or the Swiss (subjective) justification and model, of assisted death.

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Appendices[30]

Appendix i -- duelling justifications of assisted death: subjective (choice), and objective (medicine)[31]

The two justifications normally presented for the legalization of assisted death, are the purported need to respect autonomous --meaning subjective-- choice concerning one's own life; and the popularly shared sentiment that some medical circumstances are *objectively* unbearable.

Unfortunately, each of these ideas has logical implications which are problematic.

On the one hand, a thorough-going respect of subjective choice would create an unlimited, death-on-demand situation which most policy theorists have thus-far been unwilling to contemplate; on the other, the proposition that death may be provided as a legitimate cure for suffering (an idea which was incidentally rejected as a defence of euthanasia when presented at Nuremberg) leads directly to the notion that some people really should die, in the same way that we believe diabetics really should take their insulin.

There is no pain-free solution to this dilemma. The complacent conflation of choice and medicine, which has been evident in legislation to date, is ultimately unsustainable. For these two justifications contradict one another in fundamental ways. Choice does not necessarily care about medical science, and medical science does not necessarily care about choice.

That these conceptual paths are indeed distinct, is technically illustrated, in Canada, by the existence of two different laws: one (Federal) of criminal exemption; and the other (Provincial) of medical implementation.

(see appendix xiv The Canadian definition of euthanasia as medical care)

Most happily, however, we now possess extremely detailed and cogent statements of intent, on this subject, from both Spain and Germany. For the first time it is openly admitted --with diametrically opposing conclusions from these two-- that of choice or medicine, any purportedly coherent ethical system must pick only one.

Germany: A general liberty, which confers no social validation and creates no entitlements

In keeping with Swiss tradition, German theory is utterly opposed to a medical, or any other objective justification, of assisted death. Nor do they mince words. For the Germans, whether assisted or not, suicide remains suicide. No more, and no less. Of euthanasia, they do not even speak.

The decisive High Court ruling in this matter (February 2020)[32] was rendered in response to litigation contesting existing federal law, which statutes prohibited the operation of dedicated private services offering access to assisted suicide. Specifically: it was determined that the prohibition, of such services, was an infringement on what is considered, in Germany, a fundamental right to a self-determined death.

In explaining this decision, it is further declared that a true freedom of self-determined death cannot be defined by external causes such as serious or incurable illness. For restricting such a right, to particular situations, would "amount to a *substantive evaluation*... of the motives of the person" which exterior judgment would be "alien to the Basic Law’s notion of freedom".

In other words: the German doctrine refuses to declare which suicides are "good" and which are "bad", and this, on *any* basis (of "general values, religious dogmas, societal norms, or considerations of objective rationality"). It is thus the suicidal person's sovereign right to decide on his or her fate, alone, for any reason whatsoever, and with no obligation of furnishing any other justification.

The self-limiting nature of subjective freedom

At first glance, such a regime might well appear of extraordinary and unacceptable scope. However, this purely subjective freedom is actually self-limiting. Firstly (because there is no public approbation of the act) there can be no duty of society to provide, or to ensure the provision, of assistance to death. On the contrary, all that is positively required of the State is to "leave sufficient space for the pursuit of autonomous self-determination". Or more succinctly: the affirmed right is one of liberty only, not of entitlement.

Secondly, and most importantly from a wider social perspective, it is recognized that (individual rights not withstanding) the legislator may "pursue, as a legitimate purpose, the aim of preventing assisted suicide from becoming recognized within society as a normal way of ending life... (and) may intervene to counteract social expectations pressuring individuals to take their own life based on considerations of usefulness".

Most emphatically: it is *only* the official refusal to validate any particular suicide (a refusal itself logically required by a truly free subjective liberty) which enables society to pursue these latter goals of suicide prevention.

In Canada, by comparison, it is literally *impossible* for the State to adopt any aim of "preventing assisted suicide from becoming recognized within society as a normal way of ending life...". On the contrary: the entire medical euthanasia system is objectively optimized to do precisely the opposite.

Spain: a State guaranteed entitlement of euthanasia, defined as medical treatment for suffering

The Spanish Organic Law Regulating Euthanasia (2021)[33] springs from a totally contrary view.

Setting the tone for all that follows, it is immediately stated that euthanasia etymologically means "good death", and is employed to "avoid suffering". There is, therefore, to be no confusion as to the objective moral status of the act. The deliberate termination of life (as medical care with the goal of avoiding suffering) is defined as a positive good.

But there is more: for certainly conscious of the emerging conceptual rift between the objective medical justification (as advanced in Canada), and the purely subjective justification (as practically applied in Swiss tradition, and now judicially defined beyond the Rhine), Spanish legislators felt the need to clearly express themselves on these subjects. And they have rendered us a great service in doing so.

A universal protection (with discriminatory exceptions)

"It is not enough simply to decriminalize conduct that involves some form of aiding the death of another person", states the opening text (in what is perhaps a veiled rebuke of their German counterparts) "Such a provision would leave people unprotected under the right to life that our constitutional framework requires".

"Instead (we) wish to respect the autonomy of those who are in a situation of serious, chronic, and disabling suffering... what we call the euthanasia context."

"To this end, this Law regulates and decriminalizes euthanasia in certain cases, clearly defined...".

We thus see, that similar to so many contributors to the euthanasia debate, the Spanish authors of this law saw no difficulty in the obvious contradiction highlighted here: for if *all* people would be left unprotected (should assisted suicide be simply legalized), then it is an inescapable fact that all people who are *eligible* (for any narrowly defined exception) will be left unprotected in an even more immediate (and frankly discriminatory) fashion. Or, to the extent that this difficulty is recognized, it is magically waved away, with the invocation of ideal measures described as "sufficient guarantees that safeguard the absolute freedom of decision, ruling out external pressure of any kind."

Unfortunately however, there is no "safeguard" in the real world, which would be "sufficient" to "guarantee" a freedom that is "absolute" or to "rule out" interference of "any kind". Honestly evaluated, these terms can only be viewed as pious assertions of ideal intent. It is thus assumed that, in practice, the benefit of the exception is more valuable than the loss of protection; or in other words: that if accidental harms should occur, the greater harm would be to inflict undesired suffering on one who wishes to die, rather than to ambiguously take the life of another who would typically wish to live.

General safety, then --and a righteous sense of objective morality-- are thus attained, but only at the expense of a specific group, whose safety is fatally impugned by the reinforced perception, that their own continued existence is objectively at odds with what is now agreed to be "good".

From which flow abusive entitlements and mandates

From this conceptual beginning, all of the entitlements and mandates associated with an objective justification naturally flow, and to a degree even superior to that of practice in Canada.

It is thus established: 1) that aid in dying be included in the common services of the National Health System, and publicly funded; 2) that all eligible people have an entitled right to request and receive euthanasia; 3) that the Public Health Service will use its competencies to guarantee the exercise of that right; 4) that all health institutions and services, public, private, subsidized or at home, *will* provide euthanasia, such that neither the location, nor the exercise of personal conscience rights, might interfere.

Speaking to this last point: the intention of the Spanish model is revealed, with particular clarity, in the treatment reserved for non-participating doctors.

The freedom of medical professionals, and of the medical profession

In Germany, there is no notion of professional obligation at all. In fact, one reason for permitting dedicated assisted suicide services (the specific context of the judgment discussed) is postulated on the perceived fact that, "Without the availability of assisted suicide services, the individual is largely reliant on the willingness of physicians to provide assistance".

"Realistically, such individual willingness can only be expected *in exceptional cases*. To date, physicians have shown little willingness to provide suicide assistance *and cannot be obligated to do so*; the right to a self-determined death does not entitle the individual to request suicide assistance from third parties. The laws and codes governing the medical profession further curb the willingness to provide suicide assistance. The prohibition of suicide assistance from physicians, which has been incorporated into the professional codes of most State Chambers of Physicians, not only makes the effective exercise of individual self-determination contingent upon geographical coincidence but also guides the actions of physicians in practice even where the relevant codes are not considered legally binding."

We thus see, that in Germany, the freedom of individual doctors to determine their own ethical standards (and collectively that of their associations), is a given; and that no interference in this self-governing ethical model is even contemplated. Rather than radically transforming the nature of medical practice therefore, (and thus forcing physicians --collectively-- into doing that which they do not naturally wish to do), German theorists prefer to allow the formation of alternative voluntary services outside the bounds of mainstream medicine. This is the essential meaning of the High Court decision cited. And this is the actual status of assisted suicide, as presently practised in Switzerland

The Spanish legislator, however (in imitation of Canadian precedent), has no compunction about wading straight into medical tradition, medical ethics, and medical prerogative, with the heavy hand of the law. Henceforth, the deliberate termination of patients' lives will be part of the standard practice of Spanish physicians. Dissident doctors will only be allowed to claim a personal "right of conscience" which must be provided in writing and in advance. This requirement, in turn, will permit the State, to maintain a "register" of objectors, such that institutional administrators might plan the unimpeded provision of euthanasia services.

Freedom vs mandates; public neutrality vs deliberate public policy

Despite the dual justification of medicine and choice, it has always been the right of individual freedom which has created the greatest public support for assisted death, and it is this support which has been most effectively used to overcome opposition.

Even the obviously objective medical law of the Spanish, claims to be based on a respect of "autonomy". However, it is the mandates and entitlements which give the game away.

Entitlements and mandates have nothing to do with autonomy. As the German jurist rightly affirms: freedom means State neutrality, and not choosing sides. But mandates are all about choosing. They are the flip side of prohibitions. They are instruments of public policy. And whether intended, or even understood, the policy of the Spanish model, as demonstrated in Canada, will be to maximize the practice of euthanasia.

As a purely quantitative matter, indeed, assisted death is proportionally three to four times more prevalent in Canada, than in Switzerland (where there are no eligibility criteria at all). It would therefore appear, that in fleeing the perceived dangers of unfettered subjective liberty (for the comforting security of objective medicine), assisted death legislators have figuratively jumped out of the frying pan into the fire.

A jurisdictional grouping: the relation of justification and volume of practice[34]

In the tables below we see how different jurisdictions are placed with regards to this conceptual duality; and the practical footprint which is associated with those positions.

I) Where assisted death is declared (or assumed) to be medical care

A) Euthanasia Group

jurisdiction	explicit medical status	entitlements and mandates	medical eligibility criteria	method	years of legality	percentage of all deaths
Quebec	yes	complete	suffering	euthanasia	8 yrs.	6.6% [35]
British Columbia	yes	complete	suffering	euthanasia	6 yrs.	5.5%
Netherlands [36]	no	no	suffering	euthanasia	22 yrs.	5.1% [37]
Canada [38] [39]	yes	complete	suffering	euthanasia	6 yrs.	4.1% [40]
Belgium [41]	no	Note 3	suffering	euthanasia	19 yrs.	2.5% [42]

Notes:

1) Active euthanasia is performed, by doctors, as a standard remedy for both physical and psychological suffering, regardless of life expectancy.

2) This group produces (by far) the greatest incidence of assisted death.

3) The degree to which the objective medical justification of euthanasia is affirmed, by each jurisdiction, is reflected in the scope of entitlements and mandates adopted. For example, in Belgium:

a) all institutions must permit euthanasia;
b) all professionals must participate, or claim a conscientious right of refusal.
c) euthanasia is publicly funded

In addition to these provisions, Canada requires that:

a) Euthanasia be provided, as a guaranteed entitlement, to all eligible citizens;
b) conscientious objectors, must themselves make "effective referrals" to other doctors who will, in fact, proceed with requests;
c) all doctors (whether objecting or not) must proactively "inform" all eligible patients, of their eligibility.

It may be hypothesized that these factors explain the higher Canadian incidence noted.

4) In explaining the seeming contradiction --that the Netherlands has both less mandates and greater incidence than the Canada average-- the following observations are made:

a) Two Canadian Provinces (Quebec and British Columbia) comprising together more than a third of the Canadian population, do indeed display higher incidence than the Netherlands.

b) Dutch eligibility requirements are currently much wider than those of Canada (as regards children, the demented, the elderly)

c) The average Dutch rate of euthanasia growth has been 10% per year (over 22 years), whereas that of Canada has been 31% per year (over 6). With any continuance of these trends, Canada will soon overtake the Netherlands in this measure.

B) Assisted Suicide Group

jurisdiction	explicit medical status	entitlements and mandates	medical eligibility criteria	method	years of legality	percentage of all deaths
Oregon [43]	no	no	terminal	assisted suicide	25 yrs.	0.6% [44]
Wash. State [45]	no	no	terminal	assisted suicide	12 yrs.	0.5% [46]
Colorado [47]	note 3	note 4	terminal	assisted suicide	6 yrs	0.45% [48]
Hawaii [49]	no	no	terminal	assisted suicide	4 yrs	0.38% [50]
Maine [51]	no	note 4	terminal	assisted suicide	4 yrs	0.3% [52]
California [53]	no	no	terminal	assisted suicide	6 yrs.	0.15% [54]
Vermont [55]	no	note 4	terminal	assisted suicide	8 yrs.	0.12% [56]
Wash. D.C. [57]	no	no	terminal	assisted suicide	5yrs.	0.1% [58]
N. Jersey [59]	no	note 4	terminal	assisted suicide	3 yrs.	0.06% [60]
N. Mexico [61]	note 3	note 4	terminal	assisted suicide	1 yr.	no data

Notes:

1) Rates of incidence are roughly 1/10 of those shown in the euthanasia group (one entire order of magnitude less);

2) Method of delivery (assisted suicide) and eligibility criteria (terminal condition, but NOT suffering) discourage conceptualization (and normalization) as a medical act:

a) Because euthanasia is an exterior procedure (performed by a doctor), and assisted suicide is a wilful act (performed by the patient), the sense of physician -- meaning medical-- responsibility, is much less.

b) It would be illogical to propose assisted death as a medical response to suffering, but restrict its use to terminal conditions.

3) And yet, the assumption of medical status is nonetheless validated, because:

a) eligibility depends on medical condition

b) assistance to suicide is provided by medical professionals

c) Established law in New Mexico and Colorado (plus proposed legislation in other States) employs the term "Medical-aid-in-dying", defined as "the medical practice of..."

4) This assumption is further reinforced by adding entitlements and mandates, as in Canada, which cannot be justified in any other way:

a) It is universally expected that professionals and institutions will (normally) practice assisted death, while institutional and personal refusal, are accommodated as conscience-based exceptions only (not as medical dissent);

b) With varying degrees of clarity (through reference to normal "standard of care", or by explicit mandate), Colorado, Vermont Maine and New Mexico require that eligible patients be proactively "informed" of the assisted death option.

c) New Mexico requires that objecting doctors personally make effective referrals to professionals who are willing to proceed with the patient's request.

d) New Jersey confers an explicit right to "obtain" (not merely request) assistance in suicide

Analysis:

1) Limiting assisted death to assisted suicide, and to terminal condition (with no mention of suffering), apparently results in much lower rates of incidence than legislation enabling euthanasia as a treatment for suffering.

2) And yet, the underlying assumption, of medical justification, places such laws in the condition of a coiled spring, set to expand explosively, if and when the euthanasia/suffering question is revisited.

3) Recent legislative projects increasingly containing medically-based mandates (right-to-know, effective referral, limited right of private institutional refusal) clearly indicate movement in that direction.

4) American pro-euthanasia advocacy is well coordinated across the nation, and is apparently wedded to a long-term incremental strategy. It makes perfect sense in that context, to seek minimal legalization (on Oregon standards) in as many States as possible (while simultaneously seeking specific mandates, which tend to create a de facto medical definition), *before* pushing for a general shift to euthanasia.

The proposed antidote to this eventuality is an explicit non-medical statement of intent (in any enacted legislation), such that a shift to euthanasia/suffering would require a complete repeal of that statute (and focused public discussion on the radical significance of such a change).

II) The Swiss singularity

jurisdiction	explicit medical status	entitlements and mandates	medical eligibility criteria	method	years of legality	percentage of all deaths
Switzerland [62]	no	no	no	assisted suicide	81 yrs.	1.5% [63]

Notes:

1) The unique Swiss legal context of general permission (no eligibility criteria at all), has the least reliance on any medical justification. It avoids both the safe-guards, and the mandates, which derive from that source.

2) The incidence of assisted death, observed in Switzerland, is roughly halfway between that of the euthanasia and assisted suicide groups, and shows relative stability over time.

Analysis:

1) As the Swiss experience is based upon a practical evolution, which is itself dependent upon specific cultural and historic currents, it cannot be assumed that imitating Swiss parameters will ensure similar results elsewhere, especially over time.

2) The conceptual condition for achieving such a result depends, rather, upon explicitly adopting the philosophical bias at its base; rejecting any assumptions of medical justification, or status as medical care.

To be effective in the current context, these principles should be clearly laid down in any text of law which would wish to avoid eventual substitution of death for care; drawing upon German legal doctrine, which is conceptually unique in this regard, in just the same way that Swiss experience is unique in the practical domain.

The meaning of these facts in jurisdictions now flirting with assisted death: an ethical duty to choose clearly between the justifications of objective medicine and subjective choice

Unlike circumstances in 1998, when the Oregon law was introduced as a global novelty, it is no longer appropriate for jurisdictions planning assisted death legislation to ignore the fundamental questions which are now highlighted by twenty-five years of experience. Lawmakers must be pressed to define exactly what their intentions are. Is the proposed justification for assisted death to be one of subjective choice? or of objective policy? Will a simple liberty be created, accompanied by the organic evolution of private services designed to enable its exercise? Or will the entire medical industry, profession and ethos, be altered by design, in accordance with a new utilitarian paradigm of managed death?

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Appendix ii -- Permisssion or entitlement ?[64]

In Canada, the declared intention of decriminalizing euthanasia, was to grant an exceptional liberty, meant to satisfy the atypical wishes of a small suicidal minority. And that exception has now been enshrined as standard medical practice, provided and promoted, with the full authority and resources, of the State.

But how can that which was criminal homicide (a short while ago) become a professional obligation at the stroke of a pen? Why must assisted death, if no longer forbidden, become mandatory by the same occasion? Why can assisted death not be practised by permission only? Why the Manichean duality of either/or? Must everything not compulsory be forbidden? And must everything not forbidden become compulsory?

I would remark that the Irish Constitution contains no right to a self determined death. It would therefore seem that there is no pressing need to create a legislative entitlement.

In any scenario of legalization, I would strongly recommend a more nuanced approach, where assisted death is practised by mere permission, and where the footprint of that practice is not artificially inflated, but a faithful function of the number of people wishing to seek it out, and the number of people willing to provide it.

**

appendix iii -- Economic analysis: utilitarian death medicine piggy-backing on the power of choice[65]

Enormous, impersonal, economic interests

Contrary to a simple permission of death-by-choice, the transition of post-modern medicine, to a utilitarian model of managed death, does not result from philosophical considerations alone. The main impetus behind medically justified euthanasia is provided by huge, impersonal, economic forces.

A shift of consumer power from patient to system

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[66], but ultimately, with public medical systems, of which the monopoly in Canada provides a supreme example.[67]

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".[68] 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.[69]

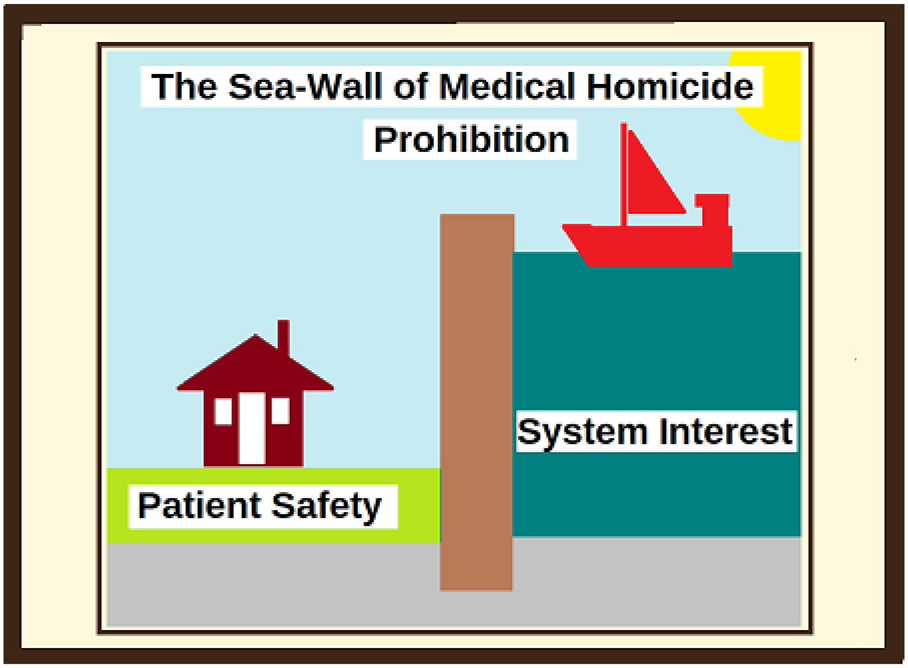
Conflicting patient and system interest

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 (presumably to do the most good with limited resources), it is obvious that doctors will attempt to strategically withhold care from expensive cases;[70] and given an option to prescribe euthanasia, there can be no doubt that maximum recourse will result.[71]

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 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.[72]



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.[73] 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.[74] 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. And that is what is meant by "utilitarian death-medicine, piggy-backing, on the power of choice".[75]

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Appendix iv -- The logical inevitability of euthanasia for incapable persons[76]

Ironically, even at this late date, it is glibly affirmed, that all depends upon patient "choice". Indeed, the requirements of "major" and "capable" stand at the head of eligibility criteria as universally proposed.

However, it is in the nature of a true medical justification of assisted death that its implementation cannot ethically stop at the consent boundary. For we do not bind wounds or set bones any differently depending on whether or not a patient is capable. Nor will the prescription of insulin be more necessary in one case or the other. And in exactly the same fashion: if euthanasia is once defined as a positive medical benefit, we cannot, in all ethical coherence, deny that benefit to patients incapable of consent.

This is perfectly clear in Canada ("major and capable" not withstanding). For current vectors of euthanasia expansion now include infanticide (up to 12 months),[77] euthanasia of mature minors (down to ten years),[78] euthanasia of patients with mental illness as sole underlying condition,[79] [80] and euthanasia of demented adults by virtue of advance requests.[81]

Mental illness

There exists a fundamental civil rights argument, to the effect that the autonomous choices of the mentally ill, even if at odds with common wisdom, must be honoured. Unfortunately however, in the context of voluntary euthanasia, this right of autonomy has arguably become a lethal trap.

Authors of a recent article rejecting euthanasia treatment for anorexia, observe that: "The delusional level of cognitive distortions regarding food and body image is the irrational lens through which the decision ... to seek MAID is filtered. ... Accordingly, the clinician who assumes that the patient has the capacity to consent ... is actually furthering and colluding with the disease itself."[82]

I would submit that this statement applies equally to any number of psychiatric conditions. Certainly, the typical citizen, assuming that euthanasia would be limited to those capable of informed consent, might never have imagined that this possibility could be extended to the mentally ill.

Mature minors

The notion of capacity among "mature" minors (as well as medical capability theory more generally) is postulated on the idea that professionally prescribed medical care is (generally) a positive benefit, and that consent thereto is therefore desirable in and of itself; but in any case, it is not clinically desirable to do things against a persons will. It is thus allowed that consent may be accepted, even if it is obtained through the significant involvement of third parties, whose role is to encourage, to facilitate, and to interpret the patients understanding and decision making.

Once again, the typical citizen (and certainly the typical parent) would not likely agree that children however mature --or even young adults-- should be considered capable to demand and receive euthanasia, especially under the effect of extensive coaching.

Infanticide

In the case of infanticide, no further pretense or ambiguity is possible: babies are not capable of consent.

The proposition now under consideration would involve Canada adopting the reassuringly named Groningen Protocol, which sanctions euthanasia of children up to 12 months of age.[83] [84] The Groningen Protocol itself, however |(as devised and practised in the Netherlands), has already been extended to 12 *years*,[85] and deliberate Canadian use of that term, under these circumstances, would clearly signal an eventual intent to do likewise. Between mature minors, and infanticide, then, the gap is effectively closed.

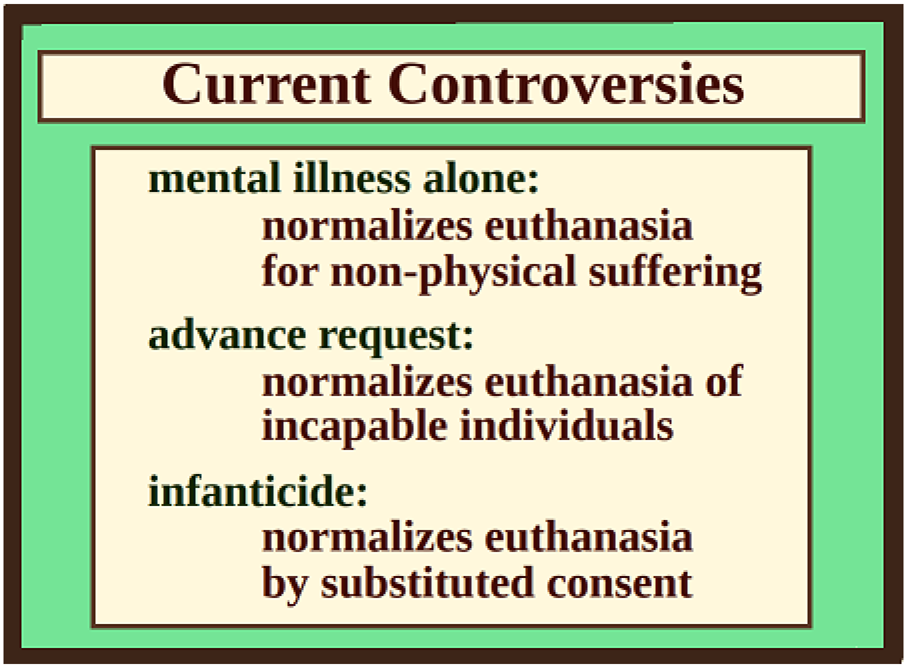
The most important precedent set by the practice of infanticide, however, involves the principle of parental consent. For if it is once admitted that incapable children might be euthanized by substituted consent, the case becomes virtually irresistible for allowing the same with regards to other classes of incapable persons.

Advance request

In euthanasia by advance request, it is maintained that informed consent has in fact been obtained. However, there is no doubt that the person euthanized is incapable at the time of administration. Moreover, people change their minds, and the mechanism usually provided to protect against that eventuality, being a confirmation of intent immediately before administration, is no longer possible.

And yet the advance request scenario takes us far beyond those concerns, for the fundamental motive invoked, to justify such deaths, is fear of incapacity itself. Or in other words: people are not merely euthanized *in spite* of incapacity, as with mature minors, infanticide, and mental illness. They are being euthanized *because* they are incapable.

(It is of course, earnestly affirmed that this is not true, that other criteria of serious medical condition must be met. However the fact remains, that as long as such a patient remains capable, no euthanasia is performed. It is the shift from capacity to incapacity which triggers the procedure; and when asked why they have made advance requests, most people honestly reply: it is because they do not (hypothetically) wish to live in an incapable state.



Current Controversies

mental illness alone:
normalizes euthanasia
for non-physical suffering

advance request:
normalizes euthanasia of
incapable individuals

infanticide:
normalizes euthanasia
by substituted consent

Incapable euthanasia beyond the end-of-life context

Because euthanasia in Canada is no longer contingent upon a reasonably foreseeable death, all of the problems noted above are aggravated in consequence.

For the mentally ill, for instance, it is no longer merely the case that terminally ill patients might be euthanized, even if suffering form mental illness. Eligibility to euthanasia has now been opened to patients having mental illness as their sole underlying condition. Like demented seniors, therefore, the mentally ill are not merely to be euthanized, *in spite* of mental illness, but euthanized *because* of it.

In addition, of course, there is the sheer scale of life that is lost: demented seniors who might have many years to live; mentally ill patients with decades of the same; mature minors, and young children with an entire lifetime erased.

A lucid glance at the future of incapable euthanasia

Far from any speculative warning --of some reputedly hypothetical "slippery slope"-- all that apparently 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.

The potential exists, therefore, for a wholesale liquidation of this dependant population, based upon exterior evaluations of their alleged suffering.

Nothing, I submit, could be more perilous than to present cash-starved medical administrators with such an opportunity. And nothing, most certainly, could be farther from the assumed ideal of competent, voluntary and informed choice.

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

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Appendix v -- Protection of doctors[86]

Why them?

It is far from evident that doctors (or nurses) should be the professionals chosen to administer lethal substances with the purpose of deliberately causing death. These individuals represent a rare and strategic human resource which should be managed, and utilized, with the greatest discernment. To qualify as a physician requires an unusual degree of intelligence and discipline, seconded by an enormous public investment in the education of each one.

The stress associated with the medical professions is already extreme. Rates of suicide among doctors are typically 140% the norm for men, and 230% for women.[87] To wantonly add the risk of serious distress, reported by many doctors providing euthanasia,[88] would appear to be indefensible.

Elective Certification Requirement

It seems very strange that this death mandate might be imposed on all as one; that 22,000 Irish people, drawn purely at random (other than professional status) might be effectively issued an administrative licence to kill. No such thing would ever have been considered, I submit, were the chosen profession bartenders or taxi-drivers, lawyers, engineers, or university professors.

It is simply assumed that doctors will perform euthanasia, and under typical assisted death laws, require a specific right of conscience to avoid doing so. I would suggest that these assumptions are completely upside-down: that if it is decided that doctors must absolutely be the ones entrusted with the charge of assisted death, then those doctors exercising these functions should be holders of a restricted, and purely voluntary certification, which distinguishes them from their peers.

Such a formality would allow society to properly select, train, and support these professionals, in order to protect them (and us) from any number of perfectly foreseeable harms.

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Appendix vi: discriminatory dangers for the ill and disabled [89]

Medically justified assisted death causes a most grievous rupture in the social status of the sick and disabled. For if it is officially decreed that the precipitated deaths of these people are objectively "good" deaths, then it is idle to pretend that no assumption is created to the effect that such people should in fact die. In particular, the oft repeated claim that the ill and disabled are merely provided with a neutral "choice" (containing no inherent danger in itself) is clearly belied by the fact that it is NOT considered appropriate to offer that choice to anyone else.

The popular notion of "safeguards", while well-intentioned, is fundamentally absurd. For the existing criminal prohibition of assistance to suicide IS the safeguard; and it is precisely that protection which is removed --in blatantly discriminatory fashion-- from that group of persons for whom an exception is publicly deemed to be desirable.

In typical discussions of this problem, such dangers are treated only as speculative possibilities. For instance, Douglas W. Heinrichs, MD. describes the situation as follows:

“Spokespersons for the disability community have raised concerns that if MAID were extended to individuals based on pain, suffering, or dignity-depriving dysfunction, it could lead to a judgment that individuals with disabilities have lives not worth living and result in pressure for those individuals to request MAID.” [90]

On the contrary! Legalization of MAID does not “lead to” anything. The offer of assisted death to individuals suffering from severe medical conditions is a result of *preexisting* judgment ("that individuals with disabilities have lives not worth living"). For if the political majority did not think such lives were worthless, the option of assisted death would never have been created for them in the first place.

What MAID really does is create a conduit for the actualization of that prejudice. The harms, therefore, are not hypothetical, but real and immediate.

In sum: from the moment that any medically justified version of assisted death is legalized, one specific group of individuals is exposed to the dangers of officially sanctioned suicidal suggestion. That group is targeted, not because they want to be, but because a widely held atavistic popular prejudice presumes that they *should* be.

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appendix vii -- Specialization versus inclusion: maintaining an exclusively life-affirming clinical space [91]

Assisted death implies a radical transformation of the medical industry

It has largely been through a categorical rejection of medical homicide --both physician-assisted suicide and euthanasia-- that the healing profession has historically defined itself. To make the philosophical adjustments required to reverse that stance --to integrate these acts as standard medical care-- implies philosophical and practical changes so complete, that the entire medical industry must be fundamentally transformed.

Specialization versus inclusion

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.[92] 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. Should a given doctor be confronted with two patients, presenting exactly the same symptoms and prognosis, it is wildly unreasonable to expect that his *professional* opinion might change so greatly, in passing between beds, that he would consider it *medically* appropriate to kill 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.)

It thus appears that although a medically justified regime of assisted death requires doctors and nurses who consider death to be an objectively indicated treatment, the continued life-centred care of the non-suicidal majority, requires professionals (and institutions) which do not.

Loyally serving the non-suicidal majority, and their economic interest

To be clear: Euthanasia and traditional medicine cannot properly share the same clinical space.[93] These two visions are not only different, but mutually exclusive. Euthanasia cannot be "added" to Hippocratic medicine any more than steak 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.

There is, moreover, an enormous financial dimension to this conflict. The utilitarian cost-benefit of systematically maximizing the prescription of assisted death is clearly at odds with the interests and security of typical non-suicidal patients. Modern healthcare is based upon collective insurance. People are paying now for care they expect to receive in the future. To substitute death for care, is to *steal* untold contributions in premiums and in taxes.

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 standard care is incompatible with that conclusion

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Appendix viii) Creating a hostile environment for majority patients: the forced co-habitation of euthanasia and palliative care[94]

The essential opposition between traditional medicine, and euthanasia, is sharply illustrated by the current transformation of both Palliative, and Long-term Care, where we now observe the emergence of a new clinical environment, objectively hostile to majority, non-suicidal, patient interests.

Palliative Care

The basic definition of Palliative Care [95] includes the provision that PC "Intends neither to hasten nor postpone death, affirms life, and recognizes dying as a natural process". [96] In any common understanding of those words, it is evident that Palliative Care and euthanasia are fundamentally incompatible.

In planning assisted death legislation, therefore, these two paths have generally, and correctly, been recognized as mutually exclusive alternatives. Palliative care is even granted a certain preferential status, often accompanied by requirements that assisted death seekers be at least informed of (and ideally offered) Palliative Care before assisted death is authorized. It is thus assumed by legislators, that integral Palliative Care and assisted death will coexist, side-by-side.

Unfortunately however, experience now shows that a medical justification and definition of assisted death render that parallel coexistence impossible.

Impossible coexistence of true Palliative Care and assisted death

As a standard medical practice, assisted death cannot ethically be excluded from any public clinical environment. This is very clear in Canada. Residual conflicts continue concerning the possibility for purely private, and faith-based Palliative Care facilities, to exclude assisted death. But the outlook for these initiatives is very bleak.

In British Columbia, one iconic non-profit, the Delta Hospice Society, had built a Palliative Care Home across the street from a major public hospital, in what was then heralded as an exemplary public-private partnership. After legalization, however, Delta was adamant about excluding assisted death. The threat and reality of withdrawn State operating subsidies did not change that resolve. But the fact that the facility was built on public land, made it possible for the State to effectively seize the building (which had incidentally been built by Delta with millions of dollars of private charitable donations).[97]

In another episode, a patient was actually euthanized, against faith-based facility policy, by a doctor who entered the building surreptitiously as a visitor. [98]

As of this writing --well beyond the passing controversy raised by such transitional episodes-- it is settled British Columbian policy that no Palliative Care facility, faith-based or other, may exclude the practice of euthanasia. And so also in the Province of Quebec.

But the most distressing trend, from the perspective of traditional practitioners, has been the growing claim that assisted death, as symptom relief, *is itself* Palliative Care.

The "hostile takeover" of Palliative Care in Canada

It is now common for assisted death providers to present themselves as Palliative Care specialists. No longer are patients simply given a choice between euthanasia and PC. They are now increasingly treated in a continuum of care where palliative measures are but a prelude to assisted death. The penetration of this practice is so deep, at this point, that 20% of all Canadian euthanasia is now performed in dedicated PC facilities. [99]

Considering that the two paths are now effectively combined, with competing factions and teams active in the same institutions, it is obvious that leadership will be drawn from among those doctors who profess to be comfortable with both.

One particularly celebrated case involves a high profile triple leadership position in the

Nation's capital, Ottawa, which includes heading palliative care at the University of Ottawa, The Ottawa Hospital and at (Catholic) Elisabeth Bruyère Hospital. The former holder of these responsibilities was Dr. Jose Pereira a leading spokesman of established Palliative Care and a strong opponent of assisted death.[100] His replacement was Dr. James Downar, an equally prominent provider and advocate of assisted death. [101]

Faced with this new institutional reality, many traditional Palliative Care practitioners (who were universally opposed to the introduction of euthanasia) have now withdrawn from that domain, to be replaced with younger additions trained in the new paradigm.

The cynical claim of expanding Palliative Care... by adding funds for euthanasia

As one might recall, the conception of Palliative Care, as an independent (and preferred) alternative, was initially so strong that lawmakers had demanded expansion of funding, and access to Palliative Care, as a condition for legalization of euthanasia. But today, in a truly Orwellian exercise of redefinition, this promise has indeed been kept. But only by administratively funding the provision of euthanasia itself (and the training of new euthanasia providers) under the mantle of Palliative Care.[102]

In sum: It is now increasingly difficult for Canadian patients to access what is commonly understood to be Palliative Care. Even though the same facilities continue to operate under the same name.

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Appendix ix) hostile environment (2): the new face of Long-term care[103]

In the cash-starved Canadian environment of public healthcare, admission to long-term care is competitively based on severity of medical condition. It is therefore a logical certainty that any patient so admitted would also be technically eligible for Medical Aid in Dying.

In the updated Quebec Law 52 "Concerning End of Life Care" (which serves as a de facto standard across the nation),[104] detailed modalities are laid out requiring euthanasia delivery plans in each institution "concordant with ministerial policy" and the identification of people delegated to implement them. All staff are expected to participate in the provision of euthanasia, saving individual conscience protection only. And there is no expectation that conscientious objectors shall be hired in future.

All patients, and if relevant their families and representatives, are to be informed, at admission, of their potential euthanasia eligibility and of the modalities for gaining access to that procedure, beginning with the understanding that speaking to any member of the care team, at any time, will be sufficient to set that process in movement.

It is certainly possible to interpret these facts as the reflection of a sincere institutional wish to ensure that all patients have effective access to all services to which they are entitled. However, it is equally obvious that if the real goal were to maximize the incidence of euthanasia in these institutions, the modalities chosen would be identical to those described.

As with the new model of Palliative Care, it would therefore appear that Long-term Care is now provided, more or less patiently, only as long as institution and staff are obliged to await some minimal indication of patient consent to euthanasia.

Repercussions, moreover, are felt far beyond the individual patient. For to the extent that the utilitarian strategy of early death is normalized, all motivation to improve standards of care --and research of new methods of care-- is reduced accordingly.

Such a model may well be in agreement with the budgetary interests of the State; but it is also contrary to the natural desires, and interests, of an overwhelming majority of patients.

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Appendix x: A quantitative description of the atypical demand for assisted death[105]

There is clearly widespread support, among the able-bodied public, to provide a choice of assisted death for the sick and disabled. What is less clear, however, is why this is so. Certainly there is no organic majority demand for such a choice, emanating from the group for which it is intended. On the contrary, patient opinion and real patient choice have been overwhelmingly opposed.

Political activism

In North America, there are two major disability-based organizations which are dedicated to opposing the practice of assisted suicide and euthanasia. These are: Not Dead Yet,[106] and the Patients' Rights Action Fund.[107] Not Dead Yet, in particular, is run by, and for, people with disabilities. There is no equivalent to be found among supporters of assisted death.

In Canada, disabled groups, and disabled intellectuals, have been very active, and virtually unanimous, in opposing assisted death at each stage of the legalization process. It is instructive, in this light, to review the critical passage of Bill C-7 (2021)[108], enacted to extend euthanasia to individuals not at the end of life.

Every single one of the testimonies and briefs introduced before Parliamentary Committee[109], by disabled individuals and their organizations, was opposed to the expansion. Moreover, in a theatrically orchestrated Open Letter, the Vulnerable Persons Standard[110] presented the signatures of no less than 147 nationally representative disabled organizations (and their allies) in opposition to the Bill.[111]

If informed and engaged opinion are to be our guide, therefore: it can be confidently stated that the "disabled community" (being the stable and enduring core of the larger patient population) is unconditionally opposed to euthanasia eligibility for its members.

And yet this united action was ignored, and the offending legislation was carried, 213 votes to 106.[112]

Real demand

More important than what people say, of course, is the way they actually behave. And by this measure, we see that regardless of any medical circumstance, very few people, indeed, will ever request, or consent, to a hastened death.

There are three main fetish groups for whom popular culture and mass enthusiasm have decreed that assisted death must definitely be provided. These are: catastrophic injury, degenerative disease, and terminal cancer. Such is the stuff of romantic speculation, of novel and of film. And at the base of these fantasies lies a widely shared able-bodied conviction that in such and such a case, any one of us would naturally wish to die.

Real-world experience, however, totally contradicts this seemingly universal intuitive conclusion.

The real numbers

Among victims of catastrophic injury (such as para- and quadriplegics), only one percent actually commit suicide above normal expectation.[113] [114]

And so also for degenerative disease (like A.L.S.,[115] or AIDS before the arrival of effective therapy in the mid-nineties).[116] [117]

Even among terminal cancer patients (that unfailing source of terrifying description), even in those nations where euthanasia is legally and widely practised: only one in ten will consent to die in that manner.[118]

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.

But that is precisely what has been in done, in Canada (and will surely be done elsewhere) due to the mandates and entitlements associated with assisted death as medical care.

What, we must ask, can possibly explain these facts?

Iconic, yet atypical, protagonists of assisted death

Every one in Ireland who is aware of the assisted death question, knows the name of Mary Flemming. In Canada, we had a very similar, very beautiful, and charismatic individual, who also challenged the prohibition of assisted suicide before the highest Court.

Media accounts and popular sentiment were universally supportive. And although she formally lost her case (as did Mary Flemming) from a practical and cultural perspective, Sue Rodriguez clearly prevailed. For some time later, she did in fact die by assisted suicide, with the help of a generally known but never legally identified doctor, and in the publicly reported presence of one of Sue's principal allies, a sitting Member of Parliament, Svend Robinson.

The practical proof of Sue Rodriguez' victory is to be found in the fact that that this studied provocation was ignored by the State. No charges were laid, and indeed, since that time, no doctor has been legally sanctioned anywhere in Canada, for rendering assistance to a voluntary suicide.

An inescapable recognition of profound and dangerous prejudice

It is in no way my intention to sully the memory of either of these exceptional women. I do, however, wish to raise the troubling question of why public opinion so universally endorsed their atypical desires, rather than those of their much more numerous adversaries. Why was the fear of future physical decline, evoked in the courtroom, given so much more consideration than the brute will to survive, demonstrated by those heavily disabled individuals --who braved near insurmountable difficulties and dangers-- in registering their protest, outside?

Troubling questions indeed! But why are the true quantitative facts so little known? And why do these facts arouse so little interest when they are provided?

Many of my disabled friends would point to the concept of Ableism[119], a highly developed social theory of injustice based upon systemic discriminatory oppression. Others, prefer to remain within the bounds of common language, in identifying an innate negative perception of disabled life.

Whatever explanation is chosen, however, there would seem to be no doubt that exceedingly stubborn popular prejudices are at play. And in clear opposition to the will (and to the basic physical security) of the large majority of patients, Canadian legal and clinical conditions now permit of the unfortunate expression of such prejudice, under the reassuring cloak of routine medical care.

Most troubling again, in our era of evidence-based policy, is the general ignorance and nonchalant dismissal of these easily observable facts.

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Appendix xi Medical ethics and doctor opinion: evolved in harmony with majority patient demand[120]

As in most other jurisdictions, a solid majority of Irish physicians (and their representative organizations) are opposed to the legalization of any form of medical homicide. [121] [122]

It is often suggested that doctors opposing assisted death are arbitrarily imposing their own personal values. And wide public support for assisted death further suggests that physicians are thus disconnected from social reality. But we must realize that it is not the able-bodied public which doctors must strive to serve, and as noted elsewhere: the vast majority of patients logically require doctors whose allegiance to life-affirming care is never in doubt. Indeed, that is the historical bond of trust upon which the entire medical edifice has been constructed.

Despite popular narrative, therefore, medical ethical tradition is not the result of some arbitrary moral dogma or corporatist design. It has resulted from a long and symbiotic relation with patients and their needs, organically coalescing in the extraordinarily successful, multi-millennial medical paradigm whose origins, reputedly, date to the influence of Hippocrates of Cos, 2400 years ago.[123]

Hippocrates revisited

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.[124]

As we are well aware, the ethical standards of Hippocrates have been severely tested in recent years.[125] 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 it should therefore come as no surprise, that it has been toward this majority demand, that doctor sentiment has naturally adapted.

Organic doctor sentiment plainly stated in opposition to assisted death

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).[126] The American Medical Association (despite legal status in eleven States) considers assisted death as "fundamentally opposed to the physician's role as healer" (2022).[127] The American Psychiatric Association specifically opposes assisted death for mental illness alone (2016).[128] Even in the Netherlands, official doctor sentiment persists in declaring that "There is no right to euthanasia" (2017).[129] 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).[130] 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".**[131]**

Contrary to radical Canadian doctrine, therefore, euthanasia remains a highly controversial act in the medical realm.[132] In no case has this lethal mandate ever been accorded in response to organic, internal demand among medical professionals. Quite the contrary: where decriminalization has occurred, it has always been imposed from without, by judicial fiat and legislative decree. Most certainly then: expert (doctor) opinion does not support an objective justification of euthanasia as medical care.**[133]**

Admittedly, we must note that there has been a recent tendency for doctors' organizations to adopt a more neutral stance in this matter. However, such movement (as illustrated by recent statements from the French Ordre des medecins) [134] [135] is most correctly interpreted as a pragmatic adjustment to political circumstances, not as a true change in professional sentiment.

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Appendix xii -- Model legislation for a minimally intrusive permission of assisted death[136]

I) Preamble

1. The subject of this legislation is assisted suicide, understood here to mean the voluntary and deliberate act of persons ending their own lives, with the willing help of third parties.

2) The justification for such an act is deemed to be purely subjective.

3) Responsibility for that act, and all collateral effects thereof, lies solely with the persons concerned.

In particular: No claim may be made that assisted suicide itself, or any individual instance of assisted suicide, is objectively justified. No collective social approbation, validation, endorsement or approval of any particular assisted suicide may be inferred or implied; social acceptance is limited to a neutral collective tolerance of individual liberty; individuals are free to approve, or to disapprove, of assisted suicide, as they wish, in both the general and in the particular case.

4. Access to assisted suicide is conceived as a liberty of permission only. No entitlement may be claimed. And no third party bears a duty to assist in any way.

In particular: Society and the State have no duty, nor indeed any legitimate interest, in providing, in guaranteeing, or in facilitating the provision of assisted suicide.

5. (and for greater certainty)
i) assisted suicide is not medical care;
ii) there is no special class comprised of medically justified assisted suicides;
iii) there is no special attribute, of medical distress, which might render medically motivated assisted suicides objectively justified in a way that others are not;
iv) the permission of assisted suicide which is accorded here must not be construed to imply any of the personal, professional, or public entitlements, duties, or mandates, which are normally associated with the provision of medical care.

II) Eligibility

1) It is assumed that all competent persons have the legal right to take their own lives, and thus, by virtue of the present statutes, to seek the assistance of third parties in so doing.

2) (Clause II-1 notwithstanding) In consideration of over-riding social interests, which would discourage the accordance of an overly broad liberty of assisted suicide, only persons having a medically determined life-expectancy of six months, or less, may avail themselves of this permission.

III) Third parties providing assistance to suicide

1) Third parties providing assistance to suicide may be individuals, or societies and enterprises, registered and recognized for that purpose.

1) Participation of medical professionals is not required, except insofar as medical expertise is necessary for the respect of modalities laid down herein.

3) Third parties may have no special connection to the person assisted, such that they might benefit by that persons death.

4) No permission is granted to positively counsel, suggest, or promote suicide by any means whatsoever, in either the general, or in the particular case.

5) Third party assistants are entirely responsible for their own actions, and in counterpart, have an absolute discretionary right of refusal to participate in any particular assisted suicide, regardless even of normal non-discriminatory policy governing commercial activity; (and for greater certainty) under no circumstances may any person, or society of persons, be obliged to assist in any suicide, whatsoever.

6) It is the responsibility of third parties to exercise due diligence, and as required, to provide proof of same, in determining that the individual whose suicide they are assisting:

- i) is acting in a fully voluntary fashion and is deemed capable of so acting
- ii) is of major age
- iii) is not acting under the effect of suggestion, pressure, or coercion
- iv) is not acting under the effect of psychiatric pathology

7) Failure to comply with third party obligations as laid down in these statutes, will be met with the full application of relevant criminal sanctions.

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Appendix xiii -- On the use of language[137]

What's in a name ?

"That which is called a rose by any other name would smell as sweet"

Thus runs the amazingly fertile thought of the single most quoted speaker of the English language. And within the context of Romeo's love for Juliet we are happy to approve.

However the exact correspondence of words to their objects is crucial to coherent thought, and doubly crucial when those words are found in written texts of law.

When two words are assumed to refer to the same object, but actually point to different things, we have a problem. And when one key word is legally enshrined, and charged with marking the limits of stable policy --but is none-the-less in a state of dynamic flux-- we have another.

Sadly, with "Physician Assisted Suicide" and "Medical Aid in Dying" (and indeed with all of the terms surrounding the assisted death debate) we have both of these problems in spades.

Voluntary euthanasia drops its defining adjective

All the way back to the beginnings of modern euthanasia discussion, in 1870,[138] it has been commonly understood that our subject is the *voluntary* death, of a dying patient in unbearable suffering, at the hands (or with the help) of his or her doctor. This is what the public believes, and this is the basis on which the results of polls and votes have been consistently returned.

However, recent changes in vocabulary are by no means accidental, and by no means innocent. The new words do not have the same meaning. Most importantly, without any widespread understanding, the "thing" we are discussing has changed dramatically. And the most dramatic change lies in the progressive removal of the requirement that any such death be "voluntary".

To demonstrate this change, one common theme in the semantic component of the assisted death debate concerns a vigorous (even indignant) rejection of the word "suicide", under the charge that it's use is pejorative and disrespectful to those who avail themselves of a doctor's assistance to die.

And yet the most common definition of suicide ("an instance of taking one's own life voluntarily and intentionally") is no more than a technical description of fact.

Similarly, the time honoured term "voluntary euthanasia", is no longer anywhere in use at this time. The last instance I am aware of occurred in the pivotal Canadian Supreme Court "Carter" case, where it was decided that a complete ban on *all* forms of assisted death was not compatible with Canada's Charter of Rights and Freedoms. During that trial, counsel representing the litigants used the then novel term "Medical Aid in Dying".

When challenged to show how the meaning of that phrase (as defined in that trial) differed from the old term "voluntary euthanasia", it was grudgingly admitted that there was no difference. However, in hindsight, that answer was either disingenuous, or ill informed. For the practice of "Medical Aid in Dying" has now departed considerably from "voluntary euthanasia", not in detail, but in the fundamental character of its voluntary nature. For MAID, if rigorously admitted as a true medical procedure, can not be fundamentally voluntary. And, indeed, MAID as currently practised, does not (necessarily) require even capacity to consent, let alone voluntary intention.

For that is the true meaning of "medical aid in dying" as it is now evolving in practice: not an "option" to autonomously request and self-administer lethal substances, exercised by fully competent individuals at the extreme end of life (as the context is still so carefully delimited to this day, in legislative discussions such as that taking place in Ireland), but entirely differently... a standard medical response to suffering in virtually any circumstance whatsoever.

Certainly the practice in Canada, Belgium and the Netherlands, where patients are now euthanized as infants or young children, as demented adults (with advance directives), and for mental illness as sole underlying condition (including even for drug addiction),[139] would suggest this as the logical direction of policy.

It would appear, then, that the abandonment of assisted (or physician assisted) "suicide" and "voluntary euthanasia" for the umbrella term "medical aid in dying" is simply the linguistic component of what remains (for many) an unsuspected --but radical-- shift in real policy.

This, to be clear, is precisely the meaning of claims that ingesting poisons under a doctor's supervision is "not suicide". The affirmation is that there is something else, "something" requiring a different name, which is neither "assisted suicide" (where the voluntary nature of the act is inherent to the definition) or "voluntary euthanasia" where the word "voluntary" is actually part of the literal term employed.

It is, in sum, precisely the *excision* of this voluntary component which is the key to substituting the term "medical aid in dying".

A shameful linguistic suppression of complaint from potential victims: the disability community

A special case, of vocabulary manipulation, concerns the disability community, whose members feel mortally targeted by assisted death policy. Indeed they (we)[140] have long been following the evolution of this debate, much more closely than the general population, simply because we believe it poses a lethal threat to ourselves. There is a powerful feeling among this group that our concerns are being ignored by a public who is much less well informed than we.

In particular, disability theorists see, with the arrival of assisted death, a growing resurgence of one of the darkest ideologies of the Twentieth Century, the systematic purification of the human species: Eugenics.[141]

Unfortunately, it is not possible to simply dismiss such claims, because we do in fact hear Neo-eugenic voices clearly raised in mainstream academia.[142]

We thus see the strange dissonance of disability activists (who would like to use the strongest language possible --and direct references to the worst relevant historical atrocities-- in order to alert the public to what we perceive as a clear and present civilizational danger) contrasted with outraged advocates of assisted death (who would like to avoid any unsanitized vocabulary whatsoever, including perfectly innocent, and technically accurate, terms like "suicide" and "killing").

Will they be allowed to be heard?

It is frequently stated that the voices of the disabled *must* be heard (and perhaps even listened to). But how might that be possible if words like "killing" and "eugenics", and references to the true history of the T-4 euthanasia program,[143] are declared to be off limits?

To be blunt: I believe we must provide great latitude for personal perspective.

Figuratively speaking, it would be unjust, in my view, to tell the lamb that she must not use the word "slaughter", for fear of impugning the character, of the butcher.

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Appendix xiv -- The Canadian definition of euthanasia as medical care[144]

This definition was at least partly the result of political manoeuvring 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,[145] and a generic decriminalization bill had also been defeated (2009) by a convincing margin.[146] Regional opinion, however, varied widely. In particular, the Province of Quebec was largely united in favour 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),[147] where both Palliative Care and Medical Assistance 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, that a complete prohibition of assisted death was unconstitutional (Carter, 2015).[148] Seizing upon this convenient fig leaf, the federal government chose to acquiesce in the interests of political stability, and passed a bill decriminalizing "Medical Assistance in Dying" (2016).[149]

As a result:

1) The term "Medical Assistance 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.

Notes (on following page):

1 **I) Introduction**

2 **a) An attempt to clearly identify competing alternatives, and logical outcomes**

3 **b) Basic principle is more important than detailed restriction**

4 **c) Distinguishing between subjective, and objective, justifications of assisted death**

5 **d) The economic context: a systemic interest in maximizing assisted death**

6 **II) Specific harms created by an objective, medical justification, of assisted death**

7 **a) Assisted suicide is rapidly replaced by euthanasia**

8 **b) The medical practice of assisted death cannot fairly be restricted to the end-of-life**

9 **c) Inevitable euthanasia of the incapable**

10 **d) Acute stress suffered by medical professionals**

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15 **a) Fundamental transformation of the medical industry: entitlements, permissions, duties and mandates**

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19 **c) Quantitative dissonance: majority interests and opinions (of patients and doctors) are ignored**

20 **d) Economic harms thus created**

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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.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2020/april/15/jaarverslag-2020/RTE-jaarverslag2020_Engels.pdf
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"

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