Physician Assisted Dying

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Introduction:

The push towards physician assisted dying represents an ideological and philosophical issue, not just a health care issue. It requires nuanced thinking that explores the more complex problems within our society that cause human despair, unresolved pain, and hopelessness. I'm concerned that the process is being conducted within a silo (looking at this issue in isolation) rather than connecting it to the related issues of the need for more palliative care, better mental health treatment, and other factors that may cause a person to want to end their life.

Government funding for community programming is generally awarded when organizations demonstrate an evidence-based approach, grounded in solid research, and with a framework for monitoring results, successes, and challenges, with an evaluation mechanism to measure processes and outcomes. The Prime Minister emphasized in his campaign a commitment to evidence-based decision making. The field of medicine has led the way in evidence-based research. I suggest that the same principle needs to be applied to developing this policy and implementation strategy.

As a program designer and program evaluator, I have observed the importance of not only tracking intended outcomes, but also **unintended outcomes.** Evaluators and researchers look at history (what can we learn from similar strategies implemented in the past?) and from other countries or jurisdictions that have already established euthanasia and physician assisted suicide, and are further along in the implementation process. (What can we learn from their implementation experience?)

It's also important to look at similar, and equally contentious policies, such as easy access to abortion, and learn from the past 50-60 years of experience of implementing an abortion policy that has created a significant divide amongst Canadian people. Again, that policy has been ideologically driven, without significant investment in evidence-based research and evaluation, and without transparency to the public.

It's important to consider the expected outcomes of a strategy or policy, and the unintended outcomes that resulted as well.

Example of a positive unintended outcome: building wells for clean water in the centre of a village can reduce rates of sexual assault and violence against young girls who were formerly compelled to leave the safety of the village to fetch water. The well was originally seen as a health strategy to provide clean water; the lowered rate of sexual violence is an unintended positive outcome.

Example of a negative unintended outcome: providing easy access to abortion was originally developed as a health and equality strategy for women. An unintended negative outcome that diminished women's equality is the use of abortion for gender selection, to kill females in favour of males.

Those who supported the legalization of abortion in the 1960's and 1970's likely did not anticipate the use of abortion for gendercide, coercive/forced abortions, abortion as normalized retroactive birth control, or that abortion would be used to allow men to avoid their responsibilities toward their partner's pregnancy, or to hide/cover up sexual abuse of minors or rape. In the 1950's and 1960's it was not widely anticipated that Canada would eventually face "demographic winter" caused by declining birth rates, influenced in part by approximately 100,000 abortions per year in Canada, compelling the need for aggressive immigration policies to replace the declining population.

The process of granting abortions began with tight controls and physician oversight, but within a few years was normalized and socially acceptable, and that oversight was removed. Considered currently as a "personal right" it is now considered to be the decision of the individual, with very little input from the medical profession apart from providing the procedure. This may account for the development of the unintended outcomes listed above.

Other historical situations from the 20th century that are worthy of consideration:

- Interest in eugenics in North America and Europe, and where that led Nazi Germany (they began with euthanasia of the "weak" and transitioned to widespread killing of Jews and others considered socially undesirable, included those who were mentally handicapped or physically disabled)

It will be very important for the current government to respond to this issue in a thoughtful way that will preclude unintended outcomes that may parallel what has happened with abortion policy.
Recommendation: If this is implemented, it should be accompanied by an evaluation and monitoring process that includes longitudinal data collected in an unbiased, transparent way.

Challenges that must be addressed:

Individuals may request physician assisted dying as their solution when they can no longer cope and their suffering is now overwhelming . This may be exacerbated by:

- Inadequate medical care
- Lack of palliative care
- Inadequate training for doctors in pain management and end-of-life care
- Lack of research and cures for existing medical problems (why not invest in curing the disease, rather than killing the person who has the disease?)
- Patient challenges, such as lack of hope, lack of options, lack of loving/caring relationships, lack of emotional support

Recommendations:

- Instead of providing death, address the underlying factors that are behind their decision to die
- Governments should invest tax money into policies/programs that enhance living and human flourishing – that foster wellbeing and increase the quality of life, rather than promoting death. Investing money into "death clinics" can become utilitarian, expedient, and a low cost mechanism to deal with health problems. It can be co-opted by those who see this as a potential money-maker, creating a conflict of interest between patient welfare and the financial gain of the clinic, as has been observed in abortion clinics in the United States. This runs counter to the spirit and nature of what Canada has always stood for, and contrary to the compassionate underpinnings of social welfare thinking that guides our health system.
- If a person is terminally ill and in the final stages of living, provide palliative support to enable them to die with dignity and without suffering. This must be available to every Canadian no matter where they live. In nations where palliative care is abundantly available, there is less impetus to encourage physician assisted dying.
- Invest serious money into curing cancer (not "managing" cancer), and other illnesses and health problems that show up frequently in the list of ailments that may cause a person to ask for physician assisted dying

Mental Health Challenges and Physician Assisted Dying

- Depression frequently causes people to experience suicidal ideation. This requires excellence in mental health care as a response strategy, not physician-assisted death. This is a curable condition, regardless of what the person may feel at the time.

Recommendations:

- We are only in the infancy stage of understanding the workings of the human brain. Invest seriously in research that will help improve the mental health of Canadians, and strategies/initiatives that address the risk factors for mental illness, social alienation, and other factors that decrease human resilience and increase vulnerability.
- Currently, depression is treated primarily with drugs. This is an incomplete, inadequate response. We need to do better than this, with holistic approaches that foster wellness and human thriving. How can we better address the stressors that are increasing mental health problems amongst children, youth, and adults at such a great rate? How can we be more proactive and responsive to help people recover, rather than waiting until someone wants to die?

Freedom of Conscience

- Physician-assisted death runs contrary to the ethical practice of doctors who want to promote health and life where they can, and who prefer to provide excellent end-of-life care within a palliative framework. Our Charter of Rights guarantees freedom of conscience; this needs to be protected for our doctors.
- Other doctors may feel comfortable with ending a patient's life. This creates an inherent conflict. Who will train these doctors? What will be the ethical principles guiding their work? How will you keep the process free from the potential for monetary gain? Should this become a money-maker for certain health professionals, as private abortion clinics have become?
- How will you guarantee "safe places" for patients and medical staff where no one will feel compelled or coerced?

Protection for the Vulnerable

- The elderly and the disabled need to be protected from those who consider their lives less useful, or less valuable than others.
- The human brain does not fully mature until a young person is between 23 and 25 years of age. The decision-making function of the brain is one of the last to fully develop. Given this, it is not recommended that this option be made available to children or young people. Even though teenagers are considered adults at 18 or 19 for certain privileges, it should not be assumed that they are developmentally mature enough to make the decision to end their own life at that age. **Recommendation: Physician assisted death should not be provided to people under the age of 25.**
- Evidence emerging from Holland and Belgium indicates an increasing rate of euthanasia, with trends towards "net-widening". This has progressed to allowing children to be euthanized. It's essential to review how/why this has happened. It seems that the

normalization of euthanasia creates social complacency and acceptance. This can increase the risks of "group think", social persuasion, and coercion.

The "Slippery Slope" and Canadian unity

Canadians are still very divided over the issue of abortion. Despite almost 60 years of no laws regulating abortion, the pro-life and pro-choice camps continue to battle it out with incredible hostility towards one another. For years now, elected members of parliament have declined to review abortion policy because it's too politically difficult. Will there come a time when our euthanasia policies need to be changed or withdrawn, but no one will have the political will to do so because it is too ideologically driven, and too politically "hot" to deal with it?

Parliamentarians who believe we should implement euthanasia and physician assisted suicide need to realize that they are creating another battleground of similar magnitude to the abortion debate. History teaches us that it is very difficult to reverse direction.

However, a widespread implementation of palliative care is unlikely to unleash a political storm of opposition, and will likely reduce the need for physician assisted suicide or euthanasia.

Recommendation:
Parliament should not be forced by the Supreme Court to produce legislation on this matter if it is not in the best interests of Canadians as a whole.

Parliament should not be forced to "hurry up" because Quebec has enacted its own legislation prematurely.

The Parliamentary Committee needs to decide if a rights-based framework is really the correct lens in which to see this debate.

The Parliamentary Committee needs to connect the desire for physician-assisted death with larger problems that need addressing within our society, rather than just viewing this issue in isolation. Those larger problems include lack of consistent and excellent health and social care across this country for mental health problems as well as inadequate palliative care for terminal illness and inadequate support for those with serious disabilities.

"Do the right thing in the right way at the right time for the right reason"