8, Valley Glen Heights, N.W.
Calgary, AB, T3B 5R2.
January 30, 2016

Senators and Members of the Legislature
Appointed to the
Joint Special Committee on Physician-Assisted Dying

Dear Committee Members:

I thank you for this opportunity, to present my brief on Euthanasia, as proposed for use here in Canada. I heard on the CBC Late News, the evening of Jan. 25, 2016, that public submissions were being accepted, so I contacted the committee Co-chair's office, the next day. I was quickly sent a copy of the '*Final Report'* and the necessary information to submit this brief.

I am a Canadian citizen, a self-employed working wife, mother and grandmother. The reason I have followed, this development of proposed social change, is that from 1969 -1972, I was part of another social change that greatly impacted my life and career as a Registered Nurse in the Operating Room at the Calgary General Hospital, here in Alberta…. but I'll expand on that later.

I am presenting for two separate reasons:

1. From my past experience, where I believe that my own rights and conscience, were neither protected nor taken into consideration.
2. For the future, as our daughter is now completing her third year of Medical Education. I am concerned how this could impact her and her profession.

The views, ideas and recommendations that I am presenting in this brief are my own. They are based on my own life experiences and from my research on this topic, which is important to me.

I have been instructed by the PDAM Joint Clerk, Cynara Corbin, that you are seeking concrete, specific recommendations about what legislative changes are needed at the Federal Level.

I will be focusing on *Point #3 Roles and regulation of Healthcare practitioners. (i.e.) who should do what, rights of conscience, discipline and penalties. The* Penalties topic I will not be commenting on.

As a layperson, I only read through a short summary of the Supreme Court's Ruling, as the legal arguments, were beyond my expertise.

I have read through, underlined, made notes, and pondered on the 132 pages of the **Consultations on Physician-Assisted Dying Summary of Results and Key Findings. Final Report.**
This Committee of three experts, Dr. Chochinov and Professors Frazee and Pelletier should be lauded for the time and effort they put into this Report. I am pleased with the emphasis the panel placed on the need for expanded palliative care, which in my opinion would reduce the requests for Euthanasia.
This may not have been within their mandate, but they did not explore (1) the actual physical mechanics of the ending of a patient's life in this Report. (2) Possible long term ramifications on the mental health (Post-Traumatic Stress Disorder) of the one who, even though it has now been legalized, has taken the life of another human being. I will give my recommendations on this later in my brief.

1) <u>There should be no hurry in formulating this final solution:</u>
On Page 4 of the Final Report under Section D it states …. *'We learned that Canadian society has a real opportunity to establish itself as a world leader by establishing a robust, modern and innovative oversight system that builds upon the lessons of other jurisdictions currently offering physician- assisted death while setting the standard for those to follow.*

I've learned over the years, in the business world, that there it is a common ploy, of those negotiating on the other side of the issue, that of some imaginary deadline or urgency, as to why the negotiations need to be concluded quickly. One used against me, was that … they had a plane to catch, when in fact there were other flights, later in the day, to that city.
I bring this issue up because, if our society wishes to proceed on this issue, then there are many issues and problems that need to be addressed first and this will take time and diligent work to resolve. The few terminal patients presently seeking Euthanasia should not be used as reason to fast track this Legislation.

I recommend that these patients (terminally ill and wanting to end their life) be granted special exceptions until the Act is fine tuned.

Certain innovative changes have been made to our Canadian society over time. Some have been bad i.e. residential schools and some have been (as a woman, I think) good, i.e. women's right to vote.

Future generations will be our judge. A very graphic example of this was when my husband and I visited, Andrew Jackson, 7th U.S. President's slave Plantation. On the museum wall was posted a clipping that Jackson had placed in the newspaper. He explains that his Mulatto slave had run away. Jackson was offering a $50. reward to any one who returns this slave. The bonus offered at the end of the ad was $10. extra for every 100 lashes that the captor gave the slave*…'to the amount of three hundred.'* (lashes)
Although we had paid our admission, my husband said he had no desire to go into the house, but after a moment he changed his mind and said "What are we doing in our society today, that will be judged with equal horror in the future ?"

I recommend that in the fine tuning of this issue we don't say this is how Countries or States X, Y and Z do it, therefore we will do it that way as well. The Report encourages Canada to think outside the present Euthanasia box.

2) <u>That in legislating that one person may end their life, that their rights do not supersede the rights of the enabler, or adversely effect the consciences, rights and future mental health of the person who has to assist them in this wish</u>.

The person requesting death will not be around, to experience or express any regrets, in this world, but, the assister, will have many years with this action in their memory. Some will regret it, others won't… but only time will tell. i.e. as in war, which soldier will suffer from Post Traumatic Distress and which ones won't.

I recommend that the person who has to carry out the act is not pressured in any way. My concern here is for the junior members of the group, that is legislated to carry out the death. Could they fear, that if they don't comply, they are jeopardizing their expensive education and future careers.

3) Labelling of a procedure:

I've learned from my past experience with Abortions that often a procedure or product is re-labelled with a name that is less disturbing to the general public and so is less likely to create a negative backlash.
i.e. Abortion labelled as Therapeutic D & C
i.e. Aborted fetus labelled as Products of Conception.
i.e. Ethnic Genocide - Rather than the Murder of your fellow countryman who are of a different ethnic group, may be referred to as Ethnic Cleansing.

Likewise, I've noticed that Euthanasia has evolved with its labelling.
It seems to have been rebranded, as of today's date and labelled as '*Physician Assisted Dying*.'
I believe this terminology is used to avoid the term '*Assisted Suicide'* which shows more clearly who implemented the action.

Repackaging the name of an unpleasant procedure does not necessarily change the impact of the act or make it less unpleasant to the person who is legislated to carry it out. Nor does it necessarily change the impact on them in future years.

The label 'Assisted Dying' to me puts the blame more on the one who commits the act of Euthanasia, i.e. I could 'assist' someone to die- without their permission. We live in a very open society and so I do not believe that we need to hide behind euphemisms.
i.e. In a recent, Calgary Herald Obituary-…it was stated that…*died peacefully ….at a time of his own choosing in Basel, Switzerland.*

I recommend that the name of this procedure should revert back to 'Assisted Suicide', as this shows, more clearly, who implemented the Request/Action. I believe that by not labelling, in a Euphemistic way, that the general public would better understand the seriousness of this final solution.

4) The Action of manipulating another human being into ending your life:

This happens in other areas of our society as well.

1. The criminal, who comes at the police armed, with an empty gun so the police will shoot him. On one program the traumatised policeman who had just killed a criminal asks the psychologist, "Why? The psychologist reply was…" Because, he was chicken" He wanted to die but did not want to take his own life. This had a devastating effect on the policeman.
2. I lived in London, England back in 1990 and while there I noticed reports of people jumping in front of the Underground train at the last moment to commit suicide. This had a devastating effect on the train engineers.

In the above two examples the parties who were killed could have committed suicide without involving an innocent party.

I recommend that termination of life should be kept as close to suicide as possible so as not to traumatise other persons, as the long term impact of assisting with this is not fully understood.

5) Post-Traumatic Stress Disorder:

Our Society now recognises this disorder and that it can be precipitated by a wide variety of traumatic experiences, some of which involve injury to the moral dimension.

Soldiers are diagnosed with PTSD, as are Paramedics. Etc.

I believe the taking of a human life, whether requested or legislated is a very difficult act, to participate in.

In a recent survey by the CMA, Doctor's willing to preform Euthanasia has decreased from 42 % in 2013…. to 20 % in 2014. This would indicate to me that, as this procedure moves closer to being enacted by legislation, they are becoming more concerned about it.

It's not the Army Generals who issue the orders in a war, that do the killing. It's the foot soldiers.
Similarly, it is not the Judges, the Politicians, Professors, the Dying with Dignity and the Civil Rights Groups who will be doing this procedure. This is academic for them.

6) Protection from Future Prosecution:

It was brought to the attention of the Reader in *'The Final Report*' that *…'for all health care providers who choose to participate in assisted dying in accordance with the Carter decision and do so in good faith need assurance that they will not be subject to criminal prosecution*. '(page 98).

I believe that today's Government, cannot guarantee protection from a future government's change in legislation.

i.e. In Germany, people who worked in concentration camps are being rounded up. The list has about 30 living men and women on it, ages 86 to 97. The German Government is wanting to bring them to trial. How so… There is a new interpretation of the German Criminal law.

Following the demise of a dictatorship, people are often rounded up and charged with war crimes, crimes against humanity, etc.
It is irrelevant that they were carrying out orders of the toppled regime.

I recommend that future employees of this procedure should be required to sign an Informed Consent form acknowledging the possibility of future prosecution should societal pressure change the legislation once again.

7) Certain Psychological Protection for Persons carrying out Government Ordered or Legislated Executions.:

Part A: Firing Squads:

A form of capital punishment in by a group of military men or law enforcement officers. Usually they are all told to fire at the same time. This prevents a member of the squad disrupting the event and also prevents the squad members from knowing who fired the fatal shot.
Sometimes one or more members can be given a gun with a blank cartridge instead of a bullet. No one is told ahead who is getting the blank ones.
It is hoped that by doing this, that there is a diffusion of the responsibility of the death of the victim. This also allows each squad member to believe, following the execution, that he did not fired the shot that killed the prisoner. The use of these blank bullets are called the 'conscience round.'

Part B: Capital Punishment in the U.S:
I had numerous conversations with Anne at the Death Penalty Information Center located in Washington D.C. (1-202 289- 2275)
The identity of the executioner is protected by State Law. They are usually selected from Correctional Staff or they can be a lower level medical professional i.e. An Emergency Medical Technician. Prison staff usually start the I.V while a second one prepares and loads the syringes.
In some jurisdictions private citizens do the injecting of the meds. As in the Judicial process civilians are called to jury duty. They do not have legal training, only common sense and the willingness to listen and take some legal instruction.

I recommend that Canada adopt the protocol of using private citizens in this process. This would allow groups such as the Civil Rights Association and the Dying with Dignity to have an active part in a process they are so passionate about. People can be passionate about something they only have to deal with on paper. The reality is not always as pleasant. (See my story #10)

Regarding US executions, a Doctor does not have to carry out the procedure. None of the Execution Protocols specify that a Doctor or a Coroner has to witness the death. They only have to confirm that the death has occurred. The I.V tubing is hooked up, often in both arms as a precaution against blockage or mechanical failure. In Delaware and Missouri there are two I.V. and computer components so that two people can insert the drugs or the saline via a computer which starts the drugs electronically. The participants are not aware if their syringe, held the lethal drug. This is supposed to ease the guilt factor as in the above blank bullet of the firing squad.
(More in-depth information can be obtained from this center, but unfortunately I was operating under a four-day time frame deadline to compile this brief.)

Both of the above types of executions have in place practices that help the executer deal with the guilt of this process.

I recommend that due diligence by extensive research and practices be put into place so as to offer the person who has to do the act of Euthanasia, some of the same psychological safeguards that the executioner's are granted. Who will succumb to Post-Traumatic Stress Disorder is only known after the fact and then the damage has been done to the person.

8) Euthanasia Devices:

It would appear by my research on this topic that a doctor would not be required to physically stand by a patient's bedside and inject the lethal drugs as there are numerous machines that can administer the drug.

1) The Thanatron- the individual pushes a button that releases drugs that would end their own life.
2) The Deliverance Machine – computer asks questions to confirm the patient's wish to die. If they affirm then the machine triggers a lethal dose of meds. No Doctor present, which allows the patient to be alone with his family when they die.
3) International Euthanasia device involves a plastic bag and a canister of Nitrogen. The inventor says this gives people access to a means of feeling that they're back in control and may actually prolong life.
4) The Poet Henley expressed this thought at the end of the Invictus Poem*…." I am the Master of my fate, I am the captain of my soul.*

I recommend that should the Government proceed towards Legalized Euthanasia, due to pressure from certain groups and individuals even though other groups and individuals are adamantly opposed, that they investigate the use of machines that can facilitate this death wish without the presence of a human facilitator, who will have to live with these memories. I recommend that this procedure be carried out in a manner as close to suicide as possible, thereby not implementing other parties who may have concerns or regrets over what they had assisted with.

9) Euthanasia Centers:

My view is that this procedure should be carried out in the patient's home -like home births or at a Euthanasia Clinics- like abortions. I believe in this environment the patient would not come into contact with or upset other patients whose energies are focused on trying to live. Also the staff's opinions would be pro -Euthanasia as they would have been screened to work there, much like those who work at the Abortion Clinics.

In paragraph 2 on page 1. I stated that I would tell you a bit of my nursing history.
I was a R.N. Graduating from the Calgary General Hospital in the fall of 1969. The year that Abortion was legalized in Canada. I had won awards in my nursing education and was excited to be accepted to work in the O.R. at the General. I loved the excitement of rotating through the different specialities, learning set ups, instruments, Doctor's preferences etc. You knew you had arrived when you got to circulate or scrub in the Neuro Theatre. By November of my first year I was rotated through Charge on nights, by the next summer I was rotated through Charge nurse on evenings. Life was good. Abortions, although legal did not seem to impact me yet. Abortion is considered a minor O.R. procedure so they may have been drippling in at a slow rate.

In late January I took a six-month unpaid leave of absence to have our first son. Upon my return to the O.R. I thought I had parachuted into another world. Abortions or Therapeutic

D& C's were being done on a regular basis. In order to keep up with the increasing demand we had, what the nurses nick named 'Bloody Saturday's', where up to 22 abortions were done on those days.

The patients came in the morning early and were discharged that evening. The standing joke was ...'*they wouldn't even have to miss a date night*.'. (Medical staff can have a sarcastic sense of humor.)
I asked an older nurse if we could avoid the Abortions, I was told no I couldn't and that these ladies had all been screened by a panel of experts and had convinced the panel that their lives were in danger if they continued with the pregnancy. I was not to be the judge but only perform my duties. We were also told that we were saving the lives of women who would be dying from blotched back alley abortions. However, in that year after I returned we were getting repeat clients coming back for their second abortions. We nurses felt that it was becoming a form of birth control for some of the patients.
Fortunately for me, most of the time, my talents were required for surgeries requiring a more experienced O.R. nurse, in theatres away from that of the minor abortions surgeries.
However, there was an another shock looming for me on the horizon.

About ten months after my return, I was booked to scrub for a Hysterotomy, which is the cutting into the uterus. (Hysterectomy is the removal of the uterus.).
The case was proceeding nicely, as she lay on the O.R. table, her abdomen did seem distended. Maybe she had fibroids? The abdominal incision was made fat, fascia navigated through, but when the peritoneal tissue was cut, up popped a large uterus.

The surgeon sworn, "Oh my--- she's farther along than I thought she was." He cut open the uterus and pulled out a beautiful baby boy. The surgeon held the child, it spanned both of the palms of his hands. I'll always remember the golden arch of his urine under the harsh OR lights. He turned and handed it to me

"What do I do with it" I asked in horror.

"Put it in the specimen basin," he replied. It was left to die.

Following the surgery, the circulating nurse could not find a specimen jar big enough to accommodate the size of the 'specimen 'so I was told to fold it in half and push it in the jar of formalin. I wheeled it out with the cart of dirty instruments, with my first stop, the lift that went to the Pathology Lab. As I placed it on the lift I looked at the label, there was her room number, the Unit 4W and the patient's name. For one fleeting moment I thought of marching up to her bedside and leaving it so she could view the remains of her son. I questioned…why did I have to participate in this, while you got to sleep through it.

Instead I placed the jar on the lift, pressed the button. The lift moved out of sight. I put my back to the lift and cried and cried. A short time later I resigned from my O.R. position.

I recommend that the euthanasia if unable to be performed at home be performed at specified centers so the staff know what type of care they are going to be required to give. This would prevent staff from being blind sided like I was.

My personal stories also show that unlike 'true to textbook' projections as portrayed by academics, there can be blotched incidences that can be very traumatic to the participants.

10) Proposed panels and safeguards:

I guess I'm a little jaded on this subject, as I've noticed that shortly after the social crusaders attain their first goals of social change they progress on to the next goal. My only hope is that the safeguards are not eliminated as they were, over time, with abortion. No recommendations on this point, you can only try and do your best to create the necessary safeguards, but will our society respect them? Will pressure be placed once again on the elected M.P.'s to change them.

11) The Medical Doctor's Involvement With This Death Process:

My recommendation is that because:

1. **The Doctors already face horrific stresses, during the course of their duties.**
2. **The Doctors are overworked and are in short supply, at least here in Alberta. People who want care for their illnesses often can't find a Doctor.**
3. **I prefer a Doctor who is focusing on maintaining life. Not side tracked by the unpleasant task of providing death.**
4. **I would certainly be leery of a Doctor if I knew he had a sideline of Euthanasia.**
5. **I believe that they are overqualified for this job. They have spent years perfecting their knowledge and skills to preserve and safe lives.**
6. **The legal profession is better educationally positioned for determining who meets certain criteria as stipulated by the Supreme Court of Canada.**
7. **I have concerns about burn-out and PTSD should this unpleasant task be downloaded on them.**

That to meet this new demand of society that a new technical program should be formulated, so that students entering this program would be aware of what they would be required to do and that this unpleasant task is not placed on the Medical profession.

Conclusion:

Please don't dump it on the Doctors.
Please save their energy,
Expertise and experience
For those who want to live. J.E.D.

Respectfully submitted,
(Mrs.) Joan Dyrholm