Brief to the Special Joint Committee on Physician-Assisted Dying, February 1, 2016
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EXECUTIVE SUMMARY

Euthanasia or physician assisted suicide should not be either legalized or facilitated in Canada at this time. Such actions would be premature, dangerous and unacceptable given a number of constraints presently existing. First, the lack of health care services will not allow someone to make a free and informed consent to end his/her life. Second, there are the risks and dangers resulting from an incorrect diagnosis and prognosis of a patient's ailments. Third, there is the added discrimination against people who suffer from depression, chronic conditions (i.e. the majority of Canadians), disabilities, poverty and old age. Indeed, why should people at the most vulnerable time of their lives and in dire need of medical care be forced to end their lives prematurely because they are not given necessary services due to a health care system that is inadequately funded by governments?

In response to the above dangers and the risk of needless death, Parliament has a responsibility to ensure the protection of all citizens including those facing health challenges and potential suffering. There is no emergency to enact legislation to euthanize or assist Canada's citizens to medical aid in dying. The emergency is for the federal government, within its jurisdiction, to enact legislation:
1. To adequately fund the provinces to provide high standards of health care.
2. To establish National Pharmacare, Cancer Care, Home Care and Palliative Care programs.
3. To establish a Royal Commission to oversee this process with particular attention to the health care needs of those with chronic medical conditions, life threatening illnesses like cancer or neurodegenerative disorders, disabilities, the poor, and seniors.

THE BRIEF

This brief focuses on the priorities of all Canadians, especially for those who become ill and are suffering either physically or psychologically. Also the particular needs of the disabled, the poor and seniors are addressed. Moreover, the role of the physician is considered. This discussion is within the context of Canada's Constitution and the Charter of Rights and Freedoms. Specific recommendations are presented at the end.

Why is euthanasia or physician assisted suicide not a medical practice?

1. Physicians have an obligation to care for and not kill their patients.
   Medicine has a mandate to heal but not to hasten death by lethal injection (euthanasia). Hippocrates: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." This is the basis of the medical ethic which the majority of physicians including myself, follow. Euthanasia is not a medical treatment. Dr. Margaret Somerville (a Professor and Founding Director of the Centre for Medicine, Ethics and Law at McGill University) has described euthanasia as a breach of a 2500 year tradition whereby physicians did not kill their patients. She says it is a "seismic shift in our (societal) foundational values." She has emphasized that "euthanasia is not a medical treatment." According to Dr. Somerville," the two institutions that carry the value for respect for life are law and medicine. Law says you must not kill. Medicine says we care always, we cure where possible, and we never kill." Otherwise, the doctor the healer becomes doctor the executioner. (Video coalitionmd.org "Life is Beautiful Conference", November 5, 2014).

2. As a physician I value each person's life right up to the end of life. This is consistent with the Canadian Charter of Rights and Freedoms (right to life, liberty and the security of person). Every moment is valuable. People need help to live in dignity up to the end of their life. Nowhere in the Charter is there an

obligation to end someone's life. The Supreme Court of Canada decision in the Lee Carter judgment states that there is no obligation to life, but, that does not place a societal obligation to terminate someone's life.

3. Modern medicine, including palliative care, fulfills that obligation to help people live their lives to the very end without suffering.

4. Canadians have a right to palliative care which is different than euthanasia. Canada is a member of the World Health Organization and signatory to conventions guaranteeing palliative care. The goal of palliative care is to relieve suffering in all stages of disease. It is not limited to end of life care. The goal is to provide care along with curative and disease-modifying treatments. The health care problems can be chronic lung or heart disease or cancer. Treatments can be given during exacerbations of these diseases and not only at the very end of life. On the other hand, euthanasia or assisted suicide, are intended to rapidly end the life of a person with a very brief accompaniment to administer the lethal injection or potion.(1)

5. In Quebec, where I practice medicine, euthanasia contravenes the Quebec code of ethics of Physicians which includes the following tenets for physicians:
   - (3) *Has (the) duty to protect and promote the health and well-being of the persons he attends to, both individually and collectively.*
     Euthanasia and physician assisted suicide does not protect and promote the health and well-being of the persons he attends to, both individually and collectively, whereas palliative care does.
   - (6) *Practices his profession in accordance with scientific principles.*
     Euthanasia and physician assisted suicide does not promote the practice of medicine in accordance with scientific principles, whereas palliative care does.
   - (13) *Must refrain from taking part in a concerted action of a nature that would endanger the health or safety of a clientele or population.*
     Euthanasia and physician assisted suicide endangers the health and safety of the Canadian population.
   - (44*) A physician must practice his profession in accordance with the highest possible current medical standards.*
     Euthanasia and physician assisted suicide does not constitute the highest possible current medical standards, whereas palliative care does constitute the highest possible current medical standards.
   - (58) *A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and (pain) relief.*
     Palliative care provides the appropriate support including pain control so that death occurs with dignity. Sadly palliative care is not presently available to the majority of Canadians.

6. In Quebec, where I live, palliative care is not available to the majority of Quebecers. In Quebec the availability of palliative care is between 20 – 60% depending on where the patient lives.(2) Statistics are similar in the rest of Canada.

7. Home care services are lacking especially home palliative care. Many people are afraid of dying alone with indignity because of lack of home palliative care services. (3)

8. Palliative care is a right of Quebecers and Canadians.
   « Le droit aux soins palliatifs et de fin de vie ainsi que l'équité dans l'accès à ces soins, ce qui suppose un accès sans égard à la maladie, à l'âge ou au statut social » (Soins palliatifs et de fin de vie Cadre de référence sur le développement des compétences, 30 juin 2015, page 4).

9. Physicians are limited in their ability to inform all patients with certainty at all times in regards to diagnosis and prognosis as required by the law.
   Euthanasia is dangerous as a form of medical practice with errors in diagnosis with life-threatening consequences 10-20%. (*JAMA.* 2012;308 (12):1211-1212)
   The following are some of my patients who have agreed to testify and have signed affidavits, demonstrate living examples of error in diagnosis and prognosis here in Quebec.

   A. M.
   A 65 year old truck driver was given a grim prognosis based on an erroneous diagnosis. In fact, he was discovered to have a fungal infection correctly known as blastomycosis of the lung after a partial lobectomy (removal of his lung). He was subsequently cured with anti-fungal medicines. A.M. believes that certain people could opt for euthanasia based on wrong diagnosis with subsequent wrong prognosis and may opt to be euthanized rather than going through the pain and suffering of investigations and treatment of potentially incurable diseases. Sometimes time is necessary to make the right diagnosis. A euthanized person does not have the luxury of time.

   J. B.
   A former clothing salesperson was diagnosed in 2012 to have lung cancer that was confirmed by her lung specialist by both CT and PET scans. She underwent a partial removal of her lung. To the surprise of all her physicians, she did not have lung cancer. J.B believes that certain patients because of diagnostic errors could opt for euthanasia fearing the worse and not wanting to suffer needlessly from grave and potentially incurable diseases.

10. Physicians cannot inform all patients with certainty at all times in regards to prognosis as required by the law. Errors in prognosis for serious chronic diseases like severe lung and heart disease can be as high as 50%. (4A)
    Models used to predict mortality in the sickest patients in intensive care (4B) or with terminal cancer with expected life of less than six months do not reach a satisfactory accuracy. (4C)

    Case Example 1: One of my patients Mona Latour (*coalitionmd.org*) was told by a lung specialist that her severe COPD (emphysema and asthma) would allow her to live for only a very short time. She states that she would have opted for euthanasia 8 years ago if it had been available. Today, with the availability of better treatment options, she is happy to be alive. Despite multiple health challenges, she helps care for her new granddaughter. Moreover, she states that if in fact one day she is truly at the end of life, she will opt for palliative care if it is available. She now understands that physicians can be wrong in their prognosis. Thus, wrong overly somber prognostic errors of certain physicians and a lack of real alternatives like palliative care, Mona Latour is concerned that patients might opt for euthanasia and short change their life and their happiness.

    Case Example 2: One of my patients is a 49 year old woman who had a work related accident in 1998. This caused a herniated cervical disc (in the cervical spine) causing chronic pain despite physical and occupational care. She was told at the time of diagnosis that she could not be operated on because of an “80% risk of becoming paralyzed” if operated on. In 2013, she developed numbness and weakness in an arm and leg. She underwent further studies which demonstrated progression of the hernia. A consultation by another neurosurgeon encouraged her to go ahead with surgery with a more positive outlook for surgery. Subsequently, the surgery was a success. According to the patient, “if you have the right doctor with the right skills and the right attitude and operates at the right time you can overcome a lot of illnesses.” She is concerned that the long waiting lists could cause some patients to have worse outcomes and some patients may opt for euthanasia and physician assisted suicide because of overly somber prognosis by some physicians. Exaggerated negative prognosis (physician dependent) may cause irreversible and avoidable loss of life by allowing euthanasia. Overly somber prognosis is demonstrated in patients refused admission to intensive care for asthma. (5)

11. There are many other reasons euthanasia will be wrongly applied and go against "informed consent." "Possibly" and "probably" are medical "guesstimates" that can misguide people to make decisions to prematurely end their lives through euthanasia or medically assisted suicide. Prognosticating is based on a large number of people each who can act differently to disease depending on many factors, including individual factors, the type of illness, environmental factors, the rapidity that the illness was diagnosed and treatment started and the different treatment options available.

12. Euthanizing the wrong person would cause an irreversible harm to a person. Medication errors include giving the wrong drug to the wrong patient. This is a major problem in our Canadian medical system. (7)

13. Palliative care is different from euthanasia.
    Palliative care is given for the purpose of relieving suffering when a person has a limited prognosis. Its goals are to preserve the best possible quality of life and provide support for the person and their entourage. It requires global care and a multidisciplinary healthcare team. (8)

14. Euthanasia is not a good alternative to high quality palliative care.
    People who have received quality palliative care report less suffering, better quality of life and improved survival than those not receiving palliative care. Its goal is to prevent and relieve suffering and provide optimal quality of life for both patients and families confronting serious illnesses. In fact, studies demonstrate that people who receive palliative care early on in their care live happier and longer lives. The classic study was reported in the New England Journal of Medicine: Patients with metastatic non–small cell lung cancer were given early palliative care with standard oncologic care. The result was better quality of life with less depression, and a longer median survival of almost 3 months than those who were assigned to cancer care alone.(9) In contrast, euthanasia or physician assisted suicide will shorten life and does not treat.

15. Palliative care can relieve all suffering including those with "refractory pain".
    All physical suffering can be alleviated by modern medicine including opiates and sedatives.
    For those who have increased suffering and want to remain conscious until death ensues, opiates and sedatives can be increased upwards (titrated) until the pain stops which may bring about the unintentional stopping of breathing causing death. This is known as the "double effect." The goal is to stop the pain, although the unintentional stopping of breathing is a known side effect. In the few cases of refractory pain, palliative sedation can be employed whereby a patient is placed into a deep coma until death comes naturally. This is also known as unconscious sedation since the person is made unconscious to alleviate the most severe form of pain.

16. Palliative sedation is not the same as euthanasia.
    In the few cases of refractory pain, palliative sedation can be employed whereby a patient is placed into a deep coma until death comes naturally. This is also known as unconscious sedation since the person is made unconscious to alleviate the pain. Most people who are placed in this situation do not come back, but a few do. My father-in-law is one survivor. At the age of 70 in 2010, he was operated for a ruptured appendix and was discovered to have a severely malignant cancer called "signet cell." The cancer had to be staged and subsequently he underwent a right hemi-colectomy removed half of his intestine. Complicating his surgery were multiple adhesions and a very friable bowel wall which led to multiple leaks as if his remaining bowel had sprung leaks like a faulty hose. This led to an abdomen full of pus described in medical terms as "bacterial peritonitis." He underwent no fewer than 4 re-operations over several weeks with continued infection. He had so much pain that the only way to control his pain was to put him under with palliative sedation. His chances of survival seemed poor. Most of the medical personnel did not believe he would leave the hospital alive. One surgeon finally suggested putting "drains" to allow all the pus to drain out of the peritoneal cavity. That last desperate move seemed to work and 3 weeks later, with amazing medical care, lots of antibiotics and a hopeful attitude of those caring for him, he was awakened from his coma. Today Tony not only has a busy life helping his son in

the body work shop, but also finds time to teach his grandchildren the skills of Italian gardening and pizza making.

17. Palliative care is less costly for the health care system. Early provision of specialty palliative care improves quality of life, lowers government spending, and helps clarify treatment preferences and goals of care for patients with advanced cancer. (10)

18. Euthanasia may be an expedient solution but is a poor choice to resolve human suffering.
    Society too often acts on the "most practical solution" at a point in time. The result may be that a practical consideration takes priority over the human consideration. Euthanasia is a poor solution to human suffering. When someone says "I can't take it anymore", a rapid response may be euthanasia. A compassionate society would commit itself to expending the time and energy to alleviate the suffering. The German T4 program in 1938 was a practical solution for severely handicapped children. It had its rules and regulations. It dealt with the suffering that would occur to the children and the financial hardship to the families and society. Similarly, Belgium, the Netherlands, Luxembourg and Switzerland, 5 US states and Quebec have adopted laws sanctioning euthanasia or physician assisted suicide. These laws are a very practical solution to the problem of human suffering. Unfortunately, it is too easy for a society to put a cost factor on human life when death is a less expensive alternative. Such practicality pushes us away from our humanity.

19. Countries and states that practice physician assisted suicide or euthanasia have been unable to establish workable safeguards. The following are case examples:
    - In Belgium, 32% of euthanasia deaths are performed without specific request or consent of either the patient or family despite "safeguards" (11). 47% of cases are unreported (12).
    - In Oregon, 20% of depressed patients do not have access to a psychiatric or psychological evaluation before physician assisted suicide is granted(13)
    - In Belgium, depressed people without terminal illness are being euthanized. A recent medical report demonstrated that 100 Belgian patients suffering from psychiatric disorders were euthanized from 2007 to 2011 (14).
    - In Belgium, the number of euthanasia deaths has grown from 235 (2003) to 2,021 in 2014 (15), an increase of 761%!

20. Presently only a handful of countries or states permit euthanasia or physician assisted suicide. Indeed, most civilized societies have refused to enact legislation because of the inherent dangers to its citizens.

    These countries and American states represent only 92.5 million people - only 1% of the total world's population of 7.4 billion people. It is clear that other progressive Western democracies including France and the United Kingdom including Scotland have refused to enact legislation for euthanasia and physician assisted suicide not only because of the dangers but also because of "fast tracking" people in need of quality palliative care who lack this as an alternative. This was eloquently presented by the testimony of MP Dr Philippa Whitford, a former breast cancer surgeon in the UK Parliament (33). The British Parliament recently rejected legislation on September 11 2015 by a vote of 330 to 118. In France there is a consensus between the National Assembly and the Senate to reject euthanasia and choose palliative care with a vote expected in February 2016 (35).

21. A law sanctioning euthanasia and/or physician assisted suicide will contravene international conventions, health norms and practices in the sense that it provides:
    - *No guarantee of "a fundamental human right of palliative care"* as defined by the World Health Organization. While the proposed law provides for "end of life care" guaranteeing euthanasia, it does not guarantee palliative care.
    - *No guarantee of access to pain treatment* as defined by the World Medical Association Resolution on the Access to Adequate Pain Treatment (2011).

- *No guarantee of full access to palliative care* as recommended in a United Nations 2013 Report that states "a person suffering from severe pain but has 'no access to appropriate treatment will constitute cruel, inhuman, or degrading treatment or punishment'."
- *No guarantee of the "right to the highest attainable standard of health"* as declared in various UN reports and studies.
- *No guarantee of palliative care for "children with life-limiting or life-threatening illnesses* and the adoption of the recent Order on Child Palliative Care" as requested by the UN Committee Resolution of the Rights of the Child 2011.

Moreover:

- Palliative care does not include the practice of euthanasia according to international norms and standards of medical practice,[The International Association for Hospice & Palliative Care]
- Euthanasia is denounced by the World Medical Association representing 9 million doctors in 100 countries April 2013, the WMA says that: *"Euthanasia, that is to say the fact to end the life of a patient by a deliberate act, even at his own request or that of his relatives, is unethical. This does not prevent the physician from respecting the will of the patient to allow the natural process of death to follow its course in the terminal phase of the disease and encourages "doctors to refuse to participate in an act of euthanasia, even if the national law authorizes it or decriminalizes it in certain situations."*

24. There is a danger that euthanasia will be extended in Quebec as well as, specifically, in the rest of Canada to vulnerable groups of people.
    a. In Canada, on February 6, 2015, the Supreme Court removed the criminal prohibition against physician assisted suicide for those who are chronically suffering from any psychological or physical reasons and want to die. The judgment permits physician assisted suicide even if there is no terminal illness. Even if a patient's suffering can be alleviated by medical care, treatment of the suffering is not mandatory. Indeed, the person can be directly authorized for euthanasia or physician assisted suicide.
    b. In Belgium, initially euthanasia was only to be practiced on adults suffering physically with an incurable disease. Subsequently, adults who are depressed (14) or tired of life are now being euthanized.
    c. The Quebec Human Rights and Youth Commission has already indicated to the Government that it would be discriminatory not to extend the right to euthanasia to, among other groups, those who are medically handicapped and children. (16)
    d. In Ontario, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying on November 30, 2015 made recommendations to include physician assisted suicide to children, even without parental consent and a waiting period. (17) (18) In subsequent interviews, the possibility of a 12-year-old deciding on ending his/her life without parental approval was suggested by the co-chair Maureen Taylor. (19)
    e. The dangers of extending euthanasia or physician assisted suicide to the very young and the unnecessary loss of human life is demonstrated by the personal testimony of Nadine who underwent 5 lifesaving chemotherapy treatments and a harrowing bone marrow transplant at age 14 and would have given up had she had not the support of her family. (20)

25. The lack of government pharmaceutical programs covering certain lifesaving drugs may unfairly direct certain people to euthanasia or physician assisted suicide.

26. A recent Quebec government document on "End of Life and Palliative Care" released on November 16 2015 acknowledges that there is a lack of palliative care. It proposes training physicians in palliative care for the next 5 years from 2015-2020. (21)

27. On the one hand, training doctors to euthanize, to inject with a lethal substance and quickly end someone's life will not take 5 years. On the other hand, training physicians in palliative care and providing institutional and home palliative care will take at least 5 years. This is clearly explained in the Quebec Government Plan to develop palliative care from 2015-2020. (22).

28. A free informed consent cannot be made by those seeking euthanasia or physician assisted suicide without available palliative care in place. The procedures of euthanasia and physician assisted suicide risk becoming a de facto treatment for suffering because of the lack of properly funded medical care including palliative care.
    a. This was eloquently stated by Quebec Premier Philippe Couillard when he was then Minister of Health in 2010 (23). At the present time, the availability of palliative care services has not appreciably changed in Quebec which is outlined in the Quebec Government Plan to develop palliative care from 2015-2020 (21).
    b. It was also described by an open letter on May 2015 by *the Comité national d'éthique sur le vieillissement* (CNEV) (24).

29. Even people with advanced neurodegenerative disorders normally will not request euthanasia or physician assisted suicide if they have the option of quality medical care, including supportive care.
    a. Dr. Ron Olivenstein, Medical Director of the Montreal Chest Institute, has described how patients with neurodegenerative disorders would rarely seek this option if provided good quality health care. Indeed, this includes even those with advanced amyotrophic lateral sclerosis (Lou Gehrig's) who are on life support (mechanical ventilators). (25) (26)
    b. One of my patients, Dr. Frank Humphrey is cared for primarily by his wife at home. He was diagnosed in 2005 with amyotrophic lateral sclerosis. He wrote a book just before going on a ventilator in December 2012. He continues to "write" with the help of a computer adapted program. He is opposed to euthanasia because it "allows the government to legitimately kill patients." Presently he receives no more than 10 hours per week of publicly funded home care on the island of Montreal (26). In cases like this, according to Frank and Daria Humphrey "families can be burned out and pushed to euthanasia." (Personal communication 2016).

30. The Quebec Health Care system illustrates how a provincial program may be discriminatory to people because of the inordinate waiting times to access acute health care for treatable illnesses. Also, in Quebec, the health system fails to address the problems of long waiting times for investigations, to see a specialist and get necessary lifesaving surgery (27). In Quebec where I live and practice medicine, there are long delays for screening such as colonoscopy where in some hospitals waiting times can exceed 1 or 2 years. Certain investigations such as ultrasounds extend beyond national norms.

31. Euthanasia is discriminatory to people with chronic health conditions and disabilities. Many of these people are depressed and need help - not euthanasia. A large proportion (around 65% of the Canadian population) has a chronic medical condition that could make many of them potential candidates for euthanasia or physician assisted suicide (28).

32. Some people have a medical condition that they do not want treated and have the right to refuse treatment.
    Many chronic conditions such as diabetes, heart disease and lung disease are treatable but cannot be cured. A person who refuses treatment, or who reduces treatment or who stops treatment has a right according to Quebec law. Standard medical care for the treatment of chronic conditions like heart disease does not include the administration of a lethal substance to end a person's life. However, the removal of the Canadian prohibition on physician assisted suicide opens the door for those with chronic severe illnesses and for those suffering from psychological distress to be euthanized or medically aided to die.

33. People faced with a serious diagnosis are more likely to be depressed and may seek to be euthanized. A review article of the Journal of the American Association, October 10, 2007 states that: "Stressful life events have been linked to major depressive disorder as well as to depressive symptoms. During the 3 to 6 months preceding the onset of depression, 50% to 80% of depressed persons experience a major life event, compared with only 20% to 30% of non-depressed persons evaluated during the same period. Approximately 20% to 25% of persons who experience major stressful events develop depression."
    a. It is well known that a person who is depressed cannot make an informed decision because of impaired interest, concentration, memory, feelings of hopelessness, sense that life is not worth living and suicidal ideation. A properly funded health system will treat the stressful situation through support and providing options.
    b. Depression is treated in medicine through psychological and psychiatric interventions. But other avenues should be explored including those from management and business One of the hallmark symptoms of depression is a sense of hopelessness. If we confirm to a depressed person that "everything possible has been done" and "life will probably not get better" we feed into that sense of hopelessness.
    c. In Belgium, there is a month delay between the times of request of euthanasia for a depressed person to the time of implementation. What is a month in the life of a human being? What life changes can happen in one year, three years or 10 years?
    d. A pharmacist friend described how his dad who is 92 repeatedly would say that he was depressed and that he wanted to die. He also drank gin on a regular basis "for medicinal purposes." He sustained many falls and traumatic bodily injuries. Recently he experienced the joys of being a grandparent with the arrival of a new grandson. He has given up drinking and is no longer depressed. He says now that he wants to live for his grandson.
    e. This concern is clearly presented in the State of Connecticut Suicide Prevention Plan 2020 which expresses concerns about discrimination in suicide prevention *of people with chronic health conditions and disabilities living with chronic or terminal physical conditions*. (29)

34. Quebec and Canada lack psychiatric and psychological services for those suffering depression. Thus, this prevents those who need to make a free informed consent from doing so.
    a. According to Montreal psychiatrist Dr. James Farquhar: "In Canada and especially Quebec, there are not enough psychiatrists and other mental health workers to treat them all. Without treatment for the depression aspect, (patients) may insist on having physician assisted suicide since the future looks so utterly hopeless."
    b. The Quebec government's own citizens' "watchdog", Ombudsperson Raymonde Saint-Germain, has emphasized the poor access to mental health services, in September 2015. For example, a person was in hospital for depression and then released. Even for her, the waiting time for an appointment in the psychiatry clinic was 6 weeks. She committed suicide before being seen.
    c. In response, the Quebec health minister, Gaetan Barrette, added more money, $70 million, to the mental health budget, by decreasing spending in other areas of health. Even that increase did not make up for the recent budget cuts. From March 2015 to April 2016, the budget cuts announced for all of health spending add up to $1.03 billion. Even more cuts are announced for 2016; but we do not have the figures yet.
    d. With mental health services so difficult and long to get, we can predict that some physician assisted suicides will occur in Quebec for severe depression, either alone, or on top of some other illness. (30)

35. The poor are facing discrimination across Canada because of lack of access to medical care. They are more likely to be euthanized because of worse health outcomes. (31)

36. The Supreme Court decision in *Chaoulli v. Quebec (Attorney General)* (2005) demonstrated the fundamental right of all Quebecers' to life and security of person under the Quebec Charter, with delays in diagnosis and medical treatment resulting in serious physical pain, or even death of citizens. This

decision highlighted the dangers of lack of health care services for Canadian citizens living in Quebec. The ruling only applied to Quebec. Nevertheless, the impact on lack of health care services affects all Canadians. Lacking health care services can lead some citizens to opt for euthanasia or physician assisted suicide. Thus, this is contrary to life and security of the person.

37. It is not right to euthanize someone even if they want to die and threaten to kill themselves. Those who express a desire to kill themselves do not necessarily kill themselves. Usually having a formalized plan and previous attempts are some warning indicators that need to be taken seriously but is not a guarantee that the suicide will be carried out. A colleague physician, who is a pilot and parachutist, explained to me that most people in a plane even with a parachute hesitate to jump out. In fact some wearing a parachute will refuse to jump. Of course they will leave the plane if they are pushed out. A person with an organized plan and available lethal substance is at a great risk for suicide. Euthanasia provides suicidal people with the plan, the lethal substance and the actual administration of the lethal substance. In fact it is similar to helping people into a plane without a parachute and pushing them out.

38. Although euthanasia has been passed by the Quebec legislature, and the criminal prohibition has been lifted by the Supreme Court of Canada, it is dangerous and wrong for a society to set up eligibility criteria, processes and procedures to euthanize or medically aid its citizens to die.

39. History has taught us that legal and political systems in many countries in the past have instituted measures including euthanasia to destroy lives that were deemed unworthy either physically, psychologically, politically or for many other reasons. Prior and during the Second World War, Germany enacted the T4 program to euthanize severely handicapped children. It was entirely legal. It gradually became extended to other categories including the mentally ill, the elderly, political dissidents, cultural and ethnic groups. Again this was considered legal. In recent times we have modern countries who have enacted legislation or in the process to euthanize its citizens including Belgium, the Netherlands, Luxembourg and most recently Quebec. The Canadian Supreme Court has decriminalized euthanasia and physician assisted suicide. In Belgium a recent study published in the British Medical Journal Open 2015 highlighted 100 citizens who were euthanized solely because of depression without any underlying terminal illness from 2007 to 2011. The youngest was 21 years old with a mean age of 47. Ten people were between 21 and 30 years old. Again this is considered legal. No one has been prosecuted.

40. Even though we know that the euthanasia and physician assisted suicide are dangerous and will cause needless loss of life, can we can ignore these facts and proceed at this premature time all in the name of individual freedom of choice? Can responsible legislatures ignore all the risks described above and proceed ahead with illusory safeguards to “satisfy” a Supreme Court of Canada Decision? Or does our legislature have a responsibility for the greater good of all its citizens to protect from abuse and harm that would clearly follow from legalizing euthanasia or physician assisted suicide.

41. Ignoring the facts about the collateral damage caused by euthanasia or physician assisted suicide does not obviate the responsibility for those who are involved in caring for those are in need in care or the legislature that has the responsibility to enact laws. “Voluntary blindness” is not a medical or legal justification for lives lost because of euthanasia or physician assisted deaths caused by the myriad inherent risks outlined above. We cannot ignore the facts. No-one will be excused. No one can wash their hands of responsibility.

RECOMMENDATIONS

In response to the above dangers and risk for harm including needless death, Parliament has a responsibility to ensure the protection of all of its citizens including those facing health challenges and potential suffering. There is no emergency to enact legislation to euthanize or assist Canada's citizens with medical aid in dying. The emergency is the following recommendations:

1. Adequate healthcare should be provided to all Canadians.

2. Adequate health care funding transfers to the provinces must be provided by the Federal government.

3. A national Cancer Care program should be created for cancer screening, diagnosis and treatment to ensure optimal national cancer care standards and patient support.

4. A national program should be established for Pharmacare to ensure that all patients have access to lifesaving medicines including life prolonging or lifesaving cancer medicines.

5. A national program for Palliative Care, Home Care and Hospice should be created for all Canadians. There must be adequate funding prior to consideration of any "medical aid in dying" (euthanasia or physician assisted suicide) legislation.

6. A Royal Commission should be established to oversee this process and to inquire on the health care needs of Canadians including Cancer Care, Pharmacare, Home Care and Palliative Care.

7. In particular this Commission's mandate should include but not be limited to focusing on physician assisted suicide. Repeating the theme of this paper, physician assisted suicide is a symptom of a general lack of good health care of people with varying health needs at all times of their lives. This Commission needs to examine and make recommendations especially for those:
   a. with chronic medical conditions
   b. with life threatening illnesses like cancer or neurodegenerative disorders
   c. with disabilities, the poor, and seniors
   d. lacking home care and hospice services.

8. Consistent with the mandate to provide global health care needs as defined by the World Health Organization, the Commission needs to also study and make recommendations for national standards that include not only medical services, but also housing, nutritional, and financial needs (work) amongst other basic life needs (34).

CONCLUSION

The lack of health care services in Canada including but not exclusively Pharmacare, Cancer Care, Home Care and Palliative Care will not allow someone to make a free and informed consent to end their lives. There are also the dangers of wrong diagnosis and prognosis. There is the added discrimination against depressed people, those with chronic conditions (which represents the majority of Canadians), the disabled and the poor. Thus, people who are in need of medical care but lacking adequate services at the most vulnerable time of their lives are forced to end their lives by euthanasia or physician assisted suicide prematurely because of a lack of appropriate care. People have a right to have their medical condition or suffering treated at the end of life and not their lives ended prematurely.

If Canadian society places little value on the majority of its citizens, then the cheapest way to prevent human suffering in Canada is to euthanize or provide physician assisted suicide.

This goes not only against common sense, our humanity and our health laws but also against our international agreements on health and life that the Canadian government has committed to and signed. We have an obligation by these conventions and agreements to implement quality health care including palliative care for our citizens which is greatly lacking at the present time. How we treat our fellow citizens' at the most vulnerable time of their lives is a measure of our humanity as a society.

In response to specific questions asked by the committee:

1. **Eligibility criteria** (e.g. age, capacity, condition, addressing vulnerability):

   Response: It is clear that the lack of care in Canada including palliative care (cf above) puts Canadian citizens at too great a risk to allow for eligibility of any candidates at this time.

2. **Processes and procedures** (e.g. mechanism of a request, oversight, privacy considerations):

   Response: It is clear that the risks including errors of diagnosis and prognosis, depression, discrimination of those with chronic conditions, the disabled, lack of health care services including access to lifesaving medicines, home care, hospice and palliative care services (cf above) place our citizens at too great a risk to enlist processes and procedures at this time.

3. **Roles and regulation of healthcare practitioners** (e.g. who should do what, rights of conscience, discipline and penalties):

   Response: It is clear that the risks to patients of euthanasia and physician assisted suicide outlined above are too great to allow for euthanasia and physician assisted suicide to be implemented. Therefore, it is too premature for Rules and regulation of healthcare practitioners to be considered at this time. Implementing euthanasia or physician assisted suicide goes against sound good scientific standard and best medical care of patients entrusted to physicians.
   In Quebec at this time, where the provisions of euthanasia of the Quebec law were being challenged (32), there is the clear infringement on the constitutional rights and freedoms of physicians. It obliges physicians, who refuse to administer euthanasia by reason of their medical code of conduct and medical conscience of best medical practice and best interest of their patients, to nevertheless participate by way of referral. Physicians are compelled to report to the medical director of the establishment that they have received a request of medical aid in dying even if they consider this not the best medical scientifically proven way to provide medical care and least harmful way to provide care. (32)