Submission to the Standing Committee on Justice and Human Rights re: Bill C-7

MAID for Mental Illness: The Sanitization of Suicide

When did it become morally acceptable to ask another human being to kill me?

Why did it become acceptable for a government to authorize and pay one citizen to kill another citizen?

When did suicide become a good medical treatment outcome?

How is it logical to say that because doctors assess decisional capacity for physical diseases that it is the same thing as assessing capacity for certain brain diseases that impair judgement, cause cognitive impairment, and induce hopelessness and suicidal thinking?

How does it make sense to say that a doctor has to kill me because I am unwilling to kill myself even though I am quite capable of doing so?

Why is it better for me get a doctor to kill me because I am having to wait months or years for proper psychiatric care to be funded and available?

Why do some politicians in Canada claim the moral authority to override two thousand years of medical ethics, the conscience rights of individual doctors, and the denunciation of the World Medical Association and the world's major religions (1, 2)?

When did legislators get a crystal ball that shows some people with mental illness can't get better when the majority of psychiatrists say that it is impossible to know whether a particular person will have relief of suffering when established treatments are available and tried?

How does it make any logical or evidence-based sense to extrapolate from short-term clinical trials, or limited epidemiological sampling, to the conclusion that certain percentages of patients will never get better? What if they are ultimately treated properly and with clinical sagacity?

Why does someone's claim that they will never get better stand up as justification for state support of their suicide when they have been refusing treatments that might help?

How is it acceptable to transform Canada into the most suicide-enabling country in the world?

Since when did false mercy, the sham triumphalism of legal rights over moral practice, and the devaluing of human life and dignity become the aspiration of a Canadian society that purports to protect the most vulnerable?

EUPHEMISMS AND DISSEMBLING

A patient earnestly said to me: *"If a doctor kills me, it is not suicide."* What is it then?

The term "Medical Assistance in Dying" (MAID) was originally coined as an alternative to the value-laden terms "euthanasia" (the doctor injecting the lethal poison) and "assisted suicide" (someone helping you kill yourself, like a friend shooting you or a doctor giving you a prescription for a lethal drug). "MAID" was initially only applicable to persons who were terminally ill. Now its media and social use has been broadened to include anyone wanting to die.

Using the term "MAID" was, and is, a euphemistic attempt to soften, mitigate, legitimize, put the "medical seal of approval" upon, and help people assuage their consciences so they no longer feel like they are choosing suicide. It is an attempt to separate "suicide" from its value-laden meaning and thousands of years of moral reflection. To quote Orwell, "If thought can corrupt language, then language can corrupt thought."

The U.S. Centers for Disease Control and Prevention, which is tasked with keeping American suicide statistics, defines suicide simply as "death caused by self-directed behaviour with an intent to die." So let's be clear. If I kill myself it is called "suicide". If I kill myself with a gun or by hanging or overdose it is called "suicide". If I hire a hitman to kill me it is called "assisted suicide". If I ask my spouse or brother to kill me it is "assisted suicide". And if I hire a doctor to kill me it is still "assisted suicide".

BACKGROUND

I have argued elsewhere that assisted suicide for mental illness as the sole underlying condition is misguided and that proposed legislative safeguards for limiting its use will not work (3,4). If we open the door, even a crack, abuse of process will emerge under the weight of particular "enlightened" judges' or doctors' values and sense of righteousness. And because safeguards will not work, it must not be allowed to happen at all. But it is going to happen unless politicians and judges understand what is at stake (5).

Bill C-14 (June 17, 2016) allows for medical assistance in dying (MAID) for patients who have intolerable physical or psychological suffering that occurs in the context of a reasonably foreseeable death. The "death being reasonably foreseeable" requirement was declared unconstitutional last fall by one judge in a Quebec court ("Truchon decision") and not by the Supreme Court of Canada.

I have psychiatrist colleagues saying the Quebec court's Truchon decision was a complete surprise to them. Politicians make the law. Courts interpret the law. In Truchon the tail was wagging the dog and the dog let it happen. Why didn't the Quebec or Federal governments appeal the Truchon decision? Apparently because some politicians in the

ruling parties supported the change. How does this show respect for the majority will of parliaments on a social policy matter as significant as deciding which citizens we kill? Legal colleagues tell me this is an example of judicial overreach, of a judge saying what the law should be rather than interpreting what it actually is. The judge did not respect legislators' intent to have the law they crafted and voted on apply only in cases of terminal illness.

Bill C-7 [currently before federal parliament (6)], an act to amend Bill C-14, specifies in its Summary that, "persons whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying". Despite this necessary protection of vulnerable citizens who are not dying and have treatable illnesses, it is certain that court challenges will be brought forward on the grounds of psychological suffering alone.

The current language of the bill must be amended to specifically define psychological suffering alone, when mental illness is the sole underlying condition, as a circumstance in which MAID is absolutely prohibited.

The inevitable court challenges to Bill C-7 by MAID advocates will be rooted in Charter rights and autonomy arguments, and unless parliament stands fast with unambiguous legislation, judges will again unilaterally change our moral landscape with law modifying precedents. Now is the time to make the language and limits on assisted suicide clear, strong, and unassailable.

A CRITICAL SOCIAL CROSSROAD

We are considering offering our fellow Canadians with mental illness state-sanctioned, funded, and assisted suicide…something impossible to even imagine 30 years ago. What happened to "Zero Suicides" as the most important of all mental health care goals?

Why would we as a society ever want to make suicide easier for people who are mentally ill? Where is the deterrence value in that? How does that give people the message that help and recovery are possible? Do we really want to help people kill themselves with a 100% rate of "success" when 70% of people who have attempted suicide never try again, 23% try again but then choose to live, and only 7% ultimately complete suicide (7)?

The list of sociological, legalistic, and ethical reasons that bring us to this discussion point is long: secularization, liberalization, euphemisms, misinformation, medical consumerism, lay misinterpretation of medical literature, biased media, suicide interest groups, the MAID bandwagon, leadership failure of professional associations, inadequate psychiatric care, an amplified and over-valued legal rights based paradigm, lack of properly funded mental health care, stigma… and compassion rooted in ignorance of options for reducing suffering.

MAID advocates speak of the terrible pain and suffering that attend having to kill yourself without support around you. But realistically and tragically, no matter how suicide is accomplished it can be devastating for families and loved ones (8).

Horrific personal and media stories fuel our abhorrence and shock over “messy” suicides. In a recent CBC Opinion piece (9) the author claimed that, “When a Canadian is compelled to take their life through violent, unpredictable, and dangerous means, because the government refuses to allow them the control and choice of a medically assisted death, it is a violation of those Charter guarantees.” I want to know who or what exactly is “compelling” anyone to take their life through “violent, unpredictable, and dangerous means”?

As a Canadian I am free to kill myself. I can Google how to have a pain-free suicide and have the method laid out for me in seconds. Simple how-to suicide guides have been available for decades. There are literally hundreds of how-to manuals online and, perversely, there is even one published by Dutch doctors (10).

I believe all suicide is tragic and that effective help is available. That said, the disturbing pragmatic reality is that following a suicide guidebook can make how you do it painless, clean, well-organized, and easier for first responders and police investigators. And it is not complicated. Capable people can plan for body discovery and video record their suicide (like in Switzerland) so police can make an easy “cause of death” determination.

MAID advocates can’t have it both ways…if you are rational and capable and autonomous then you can carefully and thoughtfully kill yourself on your own. If you are not rational, or not decisionally capable, then you would not qualify for MAID anyway.

By banning physician-assisted suicide, we are not denying anyone the opportunity to plan and complete their own suicide outside of a medical context. Why make it a legal right and force its operationalization upon physicians when it is already a social freedom? There is a true absurdity to this debate that is obscured by the smoke of angry distress and legal flag-waving. “Let’s give people a legal right to kill themselves even though they already have the legal freedom to kill themselves!”

There are many ways we let ourselves off the hook for very questionable moral choices. Fabian Stahle highlights the unsettling use of “exonerative comparisons”:

> An example of exonerative comparison is when it is emphasized that the alternative to euthanasia/PAS (physician-assisted suicide) is a dying process filled with torment and anguish. By use of this contrast effect, participating in the premature death of a fellow human being then appears as an act of the utmost goodwill. Another example of exonerative comparison is when the advocates claim that if we do not legalize euthanasia/PAS, sick people will in their desperation take their own lives, using much less safe methods, and that the consequence of that will then be greater suffering. It was precisely this disengaging maneuver that the Supreme Court of Canada resorted to for the purpose of removing legislation prohibiting assisted suicide. The court’s obscure reasoning included the argument that suicide assisted by a physician cannot be

> prohibited on the grounds that: "… the prohibition deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable." The court was unable, or rather unwilling, to realize the ironic consequence of its decision – that such legalization has the exact opposite effect, as it will most likely cause a far greater number of individuals to take their lives prematurely with the help of doctors, than the number that would have done so completely independently in the same situation. When you use this exonerative comparison, it is also a denial of the fact that a wish to die most often is an expression of depression that can be treated with far better methods than a lethal prescription (11).

IRREMEDIABILITY AND TREATMENT RESISTANCE

Much writing and argument about assisted suicide has conflated or misapplied notions of disease irremediability, treatment resistance, and the burden of psychosocial distress.

The unfortunate current language in the MAID law has narrowed the focus onto the legal term of "irremediability" (impossible to cure). Of course many diseases cannot be cured but are treatable and well-managed (e.g. diabetes). "Mental illness" is not a monolith of one disease, but hundreds. There are spectra of severity and progression. Alzheimer's is a neurodegenerative brain disease that currently has no cure, but we work at slowing progression. Drug addiction is a disease we manage. Schizophrenia is a brain disease where we slow, mitigate, or permanently disrupt progression. Depression and anxiety disorders are diseases we manage and most often cure.

If by "irremediability" you mean only "unable to be fully cured of their brain disease", then absolutely a great deal of mental illness is irremediable. If by "remedy" you mean the reduction of suffering, then I stand by my claim that all persons with mental illness can experience reduced suffering. Mental health clinicians use a biopsychosocial, recovery-focussed model that helps with housing, safety, poverty, social isolation/loneliness, developmental scaffolding, psychotherapy, medication, brain treatments (e.g. rTMS), and fosters a community of natural support and family connections.

Treatment studies only show results of very specific interventions over a limited timeframe for a limited and controlled sample. When MAID advocates say studies show that a certain percentage of people do not ever get better, they are making a claim unsupported by evidence because these study subjects are not subsequently followed through all available treatment options.

When any person claims they have an irremediable mental illness, have they received good quality treatment, care, and support delivered by skilled clinicians? A person may subjectively believe their suffering is untreatable, even when this is impossible to prove at any given time point because it is a claim about a future and unknowable subjective state. With mental illness, the past never definitively predicts the future; it can only inform

it to varying degrees. The reality is that every mental illness is potentially treatable and/or well-managed.

And surely psychiatrist experience and clinical acumen must be considered. There is professional skill and knowledge that is accumulated over time that absolutely makes a difference for treatment outcomes. “Treatment-resistant” illness may need the care and skillset of psychiatrists with very specialized knowledge. Sub-specialists are the norm in all areas of medicine, and psychiatry is no exception.

Many doctors do not use adequate medication dosing, many people suffering from mental illness choose not get help, and many people have no access to help (12). We know the systemic barriers are significant and grossly discriminatory. The obvious point is that systemic barriers to good care do not justify the support of suicide.

SUFFERING

People usually kill themselves to relieve suffering and not because they want to die.

It is an age old existential question. Does suffering serve any moral, spiritual, or human purpose? Either suffering has meaning for you personally or it doesn’t. If it doesn’t, then suicide or helping someone complete suicide, where the relief of suffering is weighted as the most significant action-determining value, will make sense. But of course the values involved in real life situations are myriad and interlaced in complex configurations. And we live in communities where our individual actions can have profound impacts and ripple effects.

All suicide is about how a person bears his or her suffering. Is suffering with no end in sight bearable? Is meaningless suffering an even greater burden than meaningful suffering? If so, then helping people find meaning and purpose in their suffering is thereby mitigating to some degree. Psychiatrists help people find meaning and purpose.

Roy Bonisteel (host of CBC’s “Man Alive” for decades) often spoke of the importance of humans being a burden on each other, and how this is a key part of what gives life meaning and purpose…helping others and being vulnerable ourselves.

Are we on the road to making suffering people feel they should die because we can’t bear their suffering even if they themselves can?

DECISIONAL CAPACITY

Much has already been written about the very significant problems with assisted suicide capacity assessments and poor interrater reliability in the context of mental illness and the dangers of killing people who would have gotten better and lived for decades longer. I wish to add a comment about just one fallacious point that I have heard repeated. The Supreme Court said capacity for MAID could be assessed like any other medical procedure: patients will be given information, assess risk, and provide informed consent.

That is not correct. MAID is unlike any other medical act or procedure. Before the advent of MAID, physicians have never asked any patient in any circumstance if they want a procedure that causes 100% guaranteed death. The process of “informed consent” involves considering what consequences might be anticipated due to the procedure and its potential impact on your quality of life and subsequent functioning. The only consequence in the assisted suicide scenario is death.

Risk of death is not at all the same as absolute certain death. This is a critical conceptual distinction that goes to the heart of what the practice of medicine is. Assisted suicide is not a medical procedure; you need no medical training to give someone lethal poison.

AUTONOMY ABOVE ALL ELSE

Suicide prevention is about fostering hope, restoring autonomy, and preventing impulsive or irrational decisions.

There is an academic and legal push of the principle of autonomy to the fore in an overvalued way with a focus on cognitive autonomy at the expense of emotional autonomy. Emotion drives action and emotional states can be impaired. Since all mental illnesses have the potential to impair the brain’s emotional processing systems, it is not enough to assess capacity through a narrow cognitive lens. The idealized, rational, Vulcan-like human model that the law uses when framing capacity legislation is far removed from the extraordinarily messy and complicated reality of human beings’ inner worlds.

A colleague recently wrote to me asking, “Where did this fetish of absolute autonomy come from?” Short answers: from the political privileging of legal rights based discourse over medical/social ethics discourse; from simplistic reductionism (“we must relieve suffering in any way possible”) overshadowing the complex discussion necessary to understand what becoming a suicide enabling country actually means in terms of broader harms to vulnerable and disabled people over the long term.

MEDIA IMPACT

The media gives a false impression of the rapid normalization, if not glorification, of MAID for terminal illness. For example, headlines say things like, “He died a dignified death thanks to MAID”, as if a natural death (or a medical team supported death on a palliative care unit) is not dignified.

This debate has been over-simplified with distorting emotional narratives circulated on social media. Being compassionate towards people who are suffering and have terminal illness is an easy sell. Specious extrapolation to being legally, morally, and emotionally supportive of suicide is far more complicated.

Some suffering people claim it is impossible for them to ever get better. They “have tried everything”. Social media and news outlets tell these personal stories as though they are

the whole story. Respectfully, they are not. Every news story I have read that listed treatments someone has tried had obvious and glaring omissions of treatment options. But the reading public does not know this.

The media stories of families who are happy that their suffering loved one is “finally free” (an exonerative comparison) perversely slant the bias towards a simplistic solution and away from truly effective treatment paths. Those families would be much happier with their loved one alive and effectively treated.

We are well aware of the evidence demonstrating the “Werther effect” (media-induced suicide contagion). There is good reason to be concerned that media reports of physician assisted suicide may contagiously spread the desire to copy the suicidal behaviour (13). This represents an insidious and profound social shift towards the social permission and expectation that people will kill themselves whenever they wish and making it virtuous to do so.

Part of the problem is we are all driven by strong emotional responses. A well-told story carries more impact than dry analysis. But politicians, judges, and clinicians have a moral obligation to weigh the moral analyses as dispassionately as possible.

Some MAID advocates are very passionate and absolutely certain of the righteousness of their cause. Their silencing certainty demands a strong response because otherwise there is a bandwagon effect and the public conversation becomes dominated by the affective narrative (individual cases of terrible suffering that provide no detail or explanation about why the person didn’t get effective treatment) over and against the reasoned narrative. The risk of zealotry is that it succeeds in making the killer seem virtuous.

FAITH-BASED VALUES

Psychiatrists practice their craft with a secular posture that is respectful of all belief systems in our pluralistic society. And they are open to discussion of whatever matters to a patient, including, of course, their religious/spiritual beliefs.

Spiritual experiences are self-validating and have profound impacts on life choices and meaning making. Throughout my medical career (25 years) I have had many patients tell me that they won’t kill themselves for religious reasons or because they fear going to hell. They have believed: *Life is a gift from God with intrinsic value. Human life is sacred. Suffering has purpose and meaning in God’s plan. Suicide is self-murder. Suicide is a sin.* Discussions about these beliefs have been important, if not critical, factors in the therapeutic relationship and the healing trajectories.

Such beliefs have been held and argued for thousands of years but in our secularized and pluralistic society the media, politicians, and academia often relegate them to the sidelines in the forum of public debate. The disparagement of religious/faith-based

perspectives is ironic given that 70% of Canadians report holding faith- or spiritual-based values (14). Many publicly mask what they privately hold.

The judge who ruled in the Ontario case about physicians having to make "effective MAID referrals" despite their personal conscientious objection made reference to such objections being rooted in religious beliefs (15). To be clear, some are and some aren't. And even if they are, that does not somehow render them invalid or less worthy than beliefs rooted in other equally faith-based positions (e.g. humanism, atheism).

When heretofore sacrosanct physician conscience rights are dismissed as simply religiously-driven beliefs, the critics betray there ignorance of the substantive moral reasoning that girds not just the particular suicide prevention positions but also the socio-political context itself. All arguments for human dignity and mutual respect are primarily rooted in the religious narratives that shaped Canadian law and values. MAID advocates who dismiss objections to their position as being held by "religious people who can't tell me or society what to do" have profoundly misunderstood and devalued the breadth of serious ethical analysis that underpins traditional religious stances and attendant social structures.

Conscience rights are actually rooted in what informs our conscience: deep moral intuitions born of faith in something. Many good ethical arguments against suicide are rooted not in faith-based or deontological claims but in relational, utilitarian, virtue, and professional ethics. There are many lenses through which we can find common ground and we must have a thoughtful and open discussion of what assisted suicide means for us as ethical (religious or non-religious) persons jointly forging caring societies.

PSYCHIATRISTS' PERSPECTIVES

I have been told, *"Doctors must compassionately and non-judgementally support people wherever their journey takes them".* Must we? I wouldn't help a patient who said he wanted to kill his partner? Why help him kill himself? Because he is suffering? I took an oath to relieve suffering with treatment, not killing.

We have only one dated sample of 528 Canadian psychiatrists (out of 4700) in 2016 that showed 75% against MAID for mental illness. I suspect that percentage across the entire group is actually higher as psychiatrists have the dawning realization of what assisted suicide would actually mean in our daily work when our primary professional obligation is the prevention of suicide (16).

> This (2016) study found that most psychiatrists do not support the legalisation of MAID for mental illness…Objections seemed to be based upon concern for vulnerable patients, personal moral objections, and concern for the effect it would have on the therapeutic alliance…57% of the sample reported having patients who recovered from a mental illness who may have received physician-assisted death if it were available at the time.

Whence the Canadian Psychiatric Association? The CPA website says*:* "The Canadian Psychiatric Association is the national voice for Canada's 4700 psychiatrists." In truth, only 46% of Canadian psychiatrists are members of the CPA.

The latest CPA position statement (17) was developed by just a few psychiatrists without consultation with the larger membership. It says the CPA will *"not take a position on the legality or morality of MAID as this is a decision reflecting current Canadian ethical, cultural and moral views"*. This is an extreme and disappointing abrogation of moral responsibility and leadership. Where is the protection of the vulnerable and the expression of the values and knowledge that we as psychiatrists have accumulated from our unique clinical vantage point? Dr. Sonu Gaind, the past president of the CPA, has rightly excoriated the CPA position paper for failing to provide any evidence-based guidance regarding MAID and mental illness (*18).* The problem with neutrality is it supports nothing and everything.

Contrast the disturbingly unclear and ambiguous CPA statement with the clear position of the American Psychiatric Association: *"The APA, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death" (2016).*

MEDICAL SCHOOL & MEDICAL CULTURE

What we teach the next generation changes everything for decades to come, if not indefinitely.

A lot has happened since 2016. I remain shocked by how quickly MAID was normalized in medical education. We are systematically training a new generation of doctors to violate the current Hippocratic Oath, all while the World Medical Association continues to condemn all euthanasia and views Canada as a bizarre moral outlier.

A Canadian ethicist recently argued that medical schools should only accept medical students who support abortion and MAID (19). Would we really want to exclude students who do not support MAID when in fact such a position is consistent with an almost complete majority of medical associations the world over? Such exclusion would be tantamount to a hegemony of liberalism over justice and professional ethics. It would, in fact, be patently discriminatory.

When someone's judgement is impaired by brain disease do we really want the tipping point to be a MAID-biased doctor who values autonomy rights over the work of healing?

CONCLUSION

Have you ever had someone suggest you should consider killing yourself? If my brain is not working properly because of a brain disease, offering me a suicide option when I am

vulnerable in this way is an abrogation of the duty to protect me from catastrophic decisions when I myself am unable to adjudge them as such.

Offering MAID as an option is tantamount to encouraging or endorsing suicide, and telling someone you don't believe their life is worth living. Are MAID advocates so focussed on particular individuals' autonomy rights that they have lost sight of the broader implications of suicide validation for society and the impact on its most vulnerable citizens? If so, I would call this a disturbing bias masquerading as social progress.

Is killing even one human being who could have gotten better morally acceptable? What about ten, or a hundred, or thousands? MAID advocates think this is an acceptable risk for the sake of giving suicidal people a "legal right" to a medically assisted suicide. If reduction of suffering is the primary goal, then why are they not simultaneously demanding better availability and funding of effective mental health services. Making suicide easier for an already poorly treated and vulnerable group of people is frankly perverse.

For the last 17 years of my professional life all I have done is treat people with so-called treatment-resistant disease. Given what I know about successful clinical treatment options for this group of people, I have to ask, "Are they getting adequate or correct treatment?"

If an impaired person comes to you as their doctor because they need help and can't heal themselves, what they need is your skill and acumen and hope… if you don't know what to do, refer on to a specialist or team with more skill. Assisted suicide is easier than the hard work of real comfort. But it is false mercy.

Respectfully submitted,

John Maher MD FRCPC
Psychiatrist
President, Ontario Association for ACT & FACT
Editor-in-Chief, Journal of Ethics in Mental Health

Nov 21, 2020

References

1. https://www.ieb-eib.org/en/news/end-of-life/euthanasia-and-assisted-suicide/position-of-the-world-medical-association-wma-on-euthanasia-and-physician-assisted-suicide-chronological-overview-1987-2019-1711.html?backto=cat
2. https://www.cccb.ca/wp-content/uploads/2020/10/MAID_Religious-Leaders-in-Canada-oppose-Bill-C-7_EN_FINAL.pdf
3. https://www.cbc.ca/news/opinion/dr-john-maher-1.5454009
4. https://impactethics.ca/2020/03/16/maid-for-mental-illness-why-safeguards-wont-work/
5. https://nationalpost.com/opinion/k-sonu-gaind-theres-a-price-to-pay-for-providing-maid-to-those-with-mental-illness
6. https://www.parl.ca/DocumentViewer/en/43-1/bill/C-7/first-reading
7. https://www.hsph.harvard.edu/means-matter/means-matter/survival/
8. https://www.ieb-eib.org/en/news/end-of-life/mental-health/death-by-request-in-switzerland-post-traumatic-stress-disorder-and-complicated-grief-after-witnessing-assisted-suicide-1627.html
9. https://www.cbc.ca/news/opinion/opinion-assisted-dying-maid-legislation-1.5488169
10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2432148/
11. https://jemh.ca/issues/v9/documents/JEMH%20article%20Stahle%20final%20proof%20-%20copy-edited.pdf
12. https://www.mentalhealthcommission.ca/English
13. https://www.cmaj.ca/content/190/30/E900
14. https://www.pewresearch.org/fact-tank/2019/07/01/5-facts-about-religion-in-canada/
15. https://www.jccf.ca/conscience-rights-for-medical-practitioners-thwarted-by-the-ontario-court-of-appeal/
16. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5697624/
17. .https://www.cpa-apc.org/wp-content/uploads/2020-CPA-Position-Statement-MAID-EN-web-Final.pdf
18. CanadianHealthcareNetwork.ca March 22, 2020
19. https://globalnews.ca/news/6183548/medical-school-applicants-abortion-assisted-death-conscientious-objectors/