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## The “Normalization” of Euthanasia in Canada: the Cautionary Tale Continues



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In June 2016, Canada legalized euthanasia and assisted suicide, which legislators referred to collectively as “Medical Assistance in Dying” (MAiD). In Sept 2018, an article

was published in this journal summarizing the early impacts of legalized euthanasia on Canadian medicine [1]. In October 2019, the World Medical Association (WMA)

reaffirmed its opposition to euthanasia and assisted suicide [2]. We propose in this article to update colleagues around the globe on consequences of the rapid expansion and

cultural normalization of the practice of intentional termination of life in Canada.

This paper will balance recent portrayals in the popular and medical media that imply only a positive impact as a result of the introduction of euthanasia into Canada's health system [3–4]. Evidence will be presented to demonstrate that there are significant negative and dangerous consequences of this radical shift for medicine, and particularly for palliative medicine. These include the widening and loosening of already ambiguous eligibility criteria, the lack of adequate and appropriate safeguards, the erosion of conscience protection for health care professionals, and the failure of adequate oversight, review and prosecution for non-compliance with the legislation. Indeed, what we have seen over the past four years is that “the slope has in fact proved every bit as slippery as the critics had warned” [5]. We also seek to reaffirm the vision of the physician's role “to cure sometimes, to relieve often and to comfort always.”

## How Many People Undergo Euthanasia in Canada?

In just under four years, the number of euthanasia deaths has rapidly increased in Canada. New statistics released by the federal government on February 24, 2020, show that 13,000 people have died by euthanasia since the legalization of the practice, which represents approximately 2% of all deaths in Canada. The government estimated that there were 5,444 deaths in 2019 and 4,438 deaths in 2018 from euthanasia [6]. In comparison, Statistics Canada reported 1,922 deaths in motor vehicle accidents for 2018, the latest year for which statistics are available [7]. Euthanasia proponents argue that the Canadian death rate should stabilize at a level comparable to other jurisdictions with equivalent legislation, such as the Netherlands where euthanasia now accounts for 4.9% of deaths [8]. However, it is troubling that Canada's rate has increased

more rapidly than other permissive jurisdictions over a similar initial time period, and that our rates are quickly approaching current rates in the Netherlands and Belgium, where euthanasia has been legal for almost 20 years.

## Expansion of Euthanasia Practice and Legislative Changes

In addition to the increasing numbers of cases, there is also an expanding range of indications approved for euthanasia. In four years, Canada has moved from approving euthanasia for so-called “exceptional” cases to euthanasia being treated as a normalized, almost routine, option for death.

Ongoing court challenges to legislative requirements for euthanasia have resulted in its approval for individuals with chronic illnesses such as osteoarthritis, dementia, and physical disability [9, 10, 11, 12]. Media reports point to less restrictive interpretations of eligibility criteria by assessors and providers of euthanasia without intervention from the courts [13, 14]. These precedent-setting cases have produced what euthanasia providers themselves call “not an expansion of our law” but “a maturing of the understanding of what we're doing” [12]. This, in turn, has led providers to approve cases they would not have previously approved due to earlier fears of criminal prosecution [15]. Although reports of criminal code and regulatory body violations have been well documented [16, 17], no charges have ever been laid.

In September 2019, a Quebec Superior Court ruling on the Truchon case [11] struck down a central euthanasia criterion for “reasonably foreseeable natural death” (RFND) which may soon open up euthanasia to those with chronic conditions, disabilities and mental health issues as a primary diagnosis. The Federal Government

is committed to expanding the legislation and, on February 24, 2020, tabled a new bill in Parliament to respond to the Truchon case ruling to remove the requirement for RFND [18]. In the near future, euthanasia in Canada will almost certainly be open to any person who feels their suffering cannot be addressed except through intentional termination of life. As mandated by the 2016 legislation, the Canadian government is continuing to explore the additional inclusion of those with mental health issues as a primary diagnosis, “mature minors” (i.e. children), and euthanasia by advance directive (for those who may lose decisional capacity at some point in the future) as part of a parliamentary review expected to begin by June 2020 [19].

Even those who support euthanasia in some circumstances are voicing concerns over the rapid expansion of the procedure in Canada, and a problematic lack of proper, robust analysis of its utilization [20]. Many who care for citizens with mental health issues are extremely concerned, not only that psychiatric conditions may be considered “irremediable” by some, but also that if psychiatric indications are permitted as the sole reason for euthanasia, these patients could possibly have euthanasia performed almost immediately, whereas the wait time can be years for specialized, life-saving psychiatric interventions and care [21]. The lack of access to psychiatric care in Canada is also putting patients who are facing an end of life diagnosis in an even more dire situation [22], given the high risk for suicide in this population [23, 24].

Euthanasia deaths are now serving as a growing source of organ and tissue donations in Canada [25]. Unlike other countries, Canada is the first jurisdiction to allow non-patient-initiated discussion of organ donation for those approved for euthanasia. In other jurisdictions where euthanasia is legalized, including the Netherlands and Belgium, only patient-initiated organ donation discussion is allowed, while in some

jurisdictions, including Switzerland and some U.S. states, subsequent organ donation is not possible following assisted suicide. Having the potential to alleviate the suffering of another person in need or to leave a legacy appears to be a powerful motivator in the decision for organ donation as part of death by euthanasia [25]. One individual who donated her organs after euthanasia stated, “I thought the knowledge of having full autonomy by way of MAiD was comforting, but, when the possibility of organ donation was added to it, the sense of elation is the only appropriate word for me.” [25]. Given that most requests for euthanasia are due to existential suffering, in particular feeling a burden to others and loss of meaning and purpose in life [26], the potential “good” of organ donation may be a persuasive incentive for some who may otherwise not have chosen to hasten their death.

Euthanasia providers are now making recommendations to add drugs (e.g., potassium chloride) to the existing regimen which will cause rapid cessation of cardiac activity and reduce the potential for ischemic damage to organs to be transplanted. The rationale for the change is that it “allows organs to be donated in the best condition possible” [27]. Questions are also being raised about starting organ procurement processes prior to death being determined which would also allow organs to be donated in “the best condition possible” [28]. There are a number of difficult issues that arise when considering organ donation in these circumstances, including conscientious objection of team members involved in transplantation, the “dead donor” rule, and informing potential recipients of the source of the organs to be transplanted.

More evidence of the normalization of euthanasia can be seen in the recent set of tips published on how to prepare children for a euthanasia death of a loved one. The author, Co-Chair of the Ontario College of Family Physicians Palliative/End of Life Care and MAiD Collaborative Mentoring Network,

recommends, “if the adults surrounding them normalize MAiD [sic], so will the children” [29]. Medical literature regarding children, death and grieving was used to extrapolate approaches to the euthanasia context. Tip #5 states that these conversations can easily be had with children as young as four years old. Tip #6 suggests that euthanasia providers should offer to show your equipment (syringes, stethoscope, IV supplies). For example: “I have a tray with the things I will use to help your loved one die. These include medications and syringes. I am going to leave them on the table and if you would like to take a look you can. I will stand beside the table and you can ask me any questions” [29].

### **Euthanasia Due to Lack of Access to Care or Lack of Perceived Quality of Life**

Examples are mounting of Canadians requesting euthanasia because of lack of access to care, such as long-term care or disability supports [30, 31]. A significant number of reports have documented cases in which individuals have been told by health care professionals and others to consider euthanasia as an “answer” to a perceived poor quality of life or a lack of health care resources to meet their needs. Motivation for these decisions and suggestions appears to include the cost of care or specialized supports [32, 33].

Following the Quebec Superior Court ruling on the Truchon case [11], over seventy Canadian disability allied organizations came together out of concern for the equality rights of vulnerable Canadians, and signed an open letter asking the federal government to appeal the court ruling to the Supreme Court of Canada [34]. A similar open letter [35], urging an appeal in the same case, was signed by over 350 physicians from all specialties across Canada. No appeal was made. These disability experts and physicians argued that the removal of

the end of life criterion (RFND) means that disability-related suffering, largely caused by lack of support and societal inequality, justifies the termination of a person’s life. When the legislation is amended, this will effectively enshrine in Canadian law the principle that a person’s life can be ended based on disability alone, further stigmatizing and devaluing the lives of those living with disabilities.

Disability advocates continue to express alarm at the evolving situation in Canada, and Catherine Frazee (former Human Rights Commissioner in Ontario and retired professor in Disability Studies) points to the hidden message being conveyed by government, that “expanding medically assisted death so that it is not only for those who are dying, but also, exclusively, for those who have some illness, disease or disability, makes us a ‘special case’ for ending a difficult life. This categorically sends one and only one message: we are not needed. Whatever gifts we bring to the world, gifts of mind and heart and body, are not of such value that Canada will fight for us to live” [36].

International attention was garnered last year when the UN’s Special Rapporteur on the Rights of Persons with Disabilities traveled to Canada in the spring of 2019. In her end-of-mission statement, Ms. Devandas-Aguilar stated that she is “extremely concerned about the implementation of the legislation on medical assistance in dying from a disability perspective...” and she urged Canada to do more to “...ensure that persons with disabilities do not request assistive [sic] dying simply because of the absence of community-based alternatives and palliative care” [37].

### **“Safeguards” for Euthanasia**

The Supreme Court of Canada, in the case of *Carter v. Canada* (2015), that originally led to the decriminalization and subsequent legalization of euthanasia, stated that a

“carefully designed and monitored system of safeguards” would limit risks to vulnerable persons [38]. The safeguards in the subsequent 2016 legislation [39] include a mandatory ten-day reflection period between the request and the euthanasia procedure, the independent nature of the two eligibility assessors, the requirement for decisional capacity of the patient at the time of the request and at the time of the procedure, protection against coercion by requiring two independent witnesses, and a rigorous system of monitoring and review.

Currently, the ten-day reflection period is often waived, and the newly proposed legislation would formally repeal this requirement [18]. In one cohort study of euthanasia deaths in Ontario, 26% of euthanasia deaths had the ten-day reflection period expedited [40]. In Quebec, it has been reported that 60% of euthanasia cases had the ten-day reflection period waived and, of these cases, 48% did not meet the criminal code criteria for removal (i.e., imminent risk of death or imminent loss of decisional capacity) and 26% had no documented reason for waiving the reflection period [41].

Compliance reports from Quebec have also documented concerns about the “independent nature” of assessors [17]. In our personal experience, the assessors are in reality not always independent. Assessors are often colleagues belonging to a small community of providers who practice euthanasia. The second assessor can see the first assessor’s report prior to seeing the patient or writing their own report. There are also no data about how often a second assessor disagrees with a first assessor, or how many different assessors an individual seeks out, since there is no limit to the number of assessments that can be obtained. An individual patient only needs two approved assessments. A study from Belgium, which deals with euthanasia for psychiatric reasons, suggested that 24% of cases involved disagreement amongst consultants, highlighting the challenge of discordant assessments [42]. Although the

current and proposed initial amendments to the euthanasia legislation in Canada (response to the Truchon case) do not permit euthanasia for psychiatric reasons alone, this indication is under formal review [19] and there is considerable public pressure for its legalization from those who wish to see this expansion [43].

We also note that it is difficult, even in person, to determine decisional capacity or possible coercion, especially if a case is complicated. In Canada, both telemedicine (video) and telephone (voice) are allowed to be used for euthanasia assessments. Determination of a person’s decisional capacity is not straightforward and may require advanced skills and tools [44], but there are no formal requirements for training to assess decisional capacity and no requirement for psychiatric consultation in complex cases. Many physician colleagues, ourselves included, report personal experiences with patients who, in their opinion, lacked decisional capacity at the time of the euthanasia assessment and/or at the time of the procedure, and still received euthanasia even though formal documented concerns had been raised with the euthanasia providers.

Monitoring requirements include only basic demographic information and are reviewed in retrospect [45]. Information about race, education, socioeconomic status, and language abilities is not collected, and there is no direct oversight or mechanism to stop the procedure if red flags are raised.

A group representing euthanasia providers, the Canadian Association of MAiD Assessors and Providers (CAMAP) has been calling for the abandonment of the requirement for two independent witnesses (established to ensure protection against coercion). They contend that this requirement is a bureaucratic frustration that blocks patient access. New legislation proposes to reduce the number of witnesses to one and would make it legal for that witness to be the patient’s paid personal care worker

or health care provider [18]. There is also a reasonable concern that the blanket misapplication of the so-called “duty to inform” may soon suggest to all physicians that they are required to offer euthanasia as an option in every serious illness. If this is the case, it will be impossible for physicians to avoid the appearance, if not the reality, of coercion for vulnerable patients who may already feel they are a burden to others. Even supporters of euthanasia have already acknowledged there is no reliable way to measure coercion [46].

Concerned Canadians continue to work together to address the issue of safety for vulnerable citizens. The Vulnerable Persons Standard (VPS), initially developed in response to the *Carter v. Canada* decision, is an internationally recognized evidence-based framework “that provides clear and comprehensive guidance to law-makers by identifying the safeguards necessary to protect vulnerable persons within a regulatory environment that permits medical-assistance in dying” [47]. The VPS was developed by a large body of advisors with expertise in medicine, ethics, law, public policy and the needs of vulnerable persons. Despite the fact that the VPS has received strong, broad-based, continuing support, it has been completely ignored by every level of government.

It is also important to note that, during the legalization process, access to palliative care was positioned as a “safeguard” for euthanasia. However, in reality, less than 30% of Canadians have access to any form of palliative care and less than 15% have access to specialized palliative care [48]. Many, including Shariff and Gingerich, have questioned if euthanasia can truly be an informed choice if there is no meaningful access to palliative care [49].

Although economic considerations may not currently be driving the normalization and expansion of euthanasia in Canada, it cannot be denied that the procedure is sig-

nificantly cheaper than rigorous, traditional palliative care. The financial savings of euthanasia for the health care system in Canada have already been reported [50] and with an aging demographic and diminishing fiscal resources, the option to save money in this way may become increasingly acceptable to health care decision makers.

## Confusion Between Palliative Care and Euthanasia

Another ongoing issue is the confusion and conflation of euthanasia with palliative care. The use of the euphemistic terminology of *Medical Assistance in Dying* to refer to euthanasia in Canada has exacerbated this confusion in both the public and health care spheres. Canadian palliative care organizations have argued against the use of such language, affirming that palliative care provides support or “assistance» in dying to help people live as fully as possible until their natural death, but does not intentionally hasten death [51]. This assertion is also supported by the longstanding World Health Organization definition of palliative care [52].

In spite of clear and repeated distinctions made by national palliative care organizations and the Canadian Medical Association [53–56], there are ongoing efforts by some euthanasia providers to incorporate euthanasia within the scope of practice of palliative care, and to co-opt palliative care language to describe their euthanasia practice, “as one of the many items in the palliative care basket” [57, 58]. Linking the two practices in this way misleads other health care professionals and the public regarding palliative care. The 2019 Canadian Guideline for Parkinson Disease is a recent example [59]. Palliative care was commendably presented as one of the five key recommendations for the approach to care for persons with Parkinson Disease. However, euthanasia (as “MAiD”) was listed directly under the banner of palliative care support and was the only specific measure listed!

National Canadian palliative care organizations have expressed concern that this confusion and conflation of euthanasia and palliative care perpetuates the myth that palliative care hastens death and that misconception may prevent patients from seeking timely palliative care interventions which improve quality of life and, in some cases, enable people to live longer [60]. The Canadian Society of Palliative Care Physicians has stated that “patients and families must be able to trust that the principles of palliative care remain focused on effective symptom management and psychological, social, and spiritual interventions to help people live as well as they can until their natural death.” [53].

Dr. Balfour Mount, the “father” of palliative care in Canada, recently stated that

Canadian legislation utilizes the euphemism ‘medical assistance in dying’ (MAiD) to define euthanasia/assisted suicide and that language has caused confusion concerning its distinction from Palliative Care. For over four decades, Palliative Care has been providing expert medical management to assist and support those who are dying without hastening death or administering a lethal dose of drugs to end life. The MAiD euphemism confuses and causes fear in our patients and the general public regarding the practice of Palliative Care and the nature of Palliative Medicine [61].

## Impact on Palliative Care

The 2016 Federal legislation positioned euthanasia (MAiD) as a health care right under the Canada Health Act, and so it must be publicly funded and accessible to all Canadians [39]. Palliative care, however, is not afforded such status and there is no similar requirement for it to be funded and accessible to Canadians. This is highly inequitable since almost 98% of deaths in Canada are not through euthanasia [6].

Euthanasia proponents continue to co-opt the vocabulary and tools of palliative care to create a new discipline of “end of life medicine” with a radically different philosophy, intention and approach that embraces hastened death as the “most beautiful death” [3]. Under this banner of “end of life care,” existing palliative care resources are being used in some jurisdictions to provide euthanasia, effectively reducing already limited resources for palliative care. This is the case in Ontario where, in some regions, the community Hospice Palliative Care Nurse Practitioners were given the additional role of providing euthanasia [62–63]. The assessment for and provision of euthanasia by physicians in Ontario are billed to the Ministry of Health using palliative care billing codes, despite the objections of palliative care physicians [64]. The very distinct and disparate goals and procedures followed by euthanasia teams and palliative care teams make it reasonable and advisable to separate the two practices. This separation should be accepted without acrimony or contention as it is in the best interests of patients, their families and the teams themselves.

The impact of normalized euthanasia on our day-to-day clinical work in palliative care has been profound. When someone expresses a desire to die or a desire for hastened death (for example, “I just want this to be over...”), there can now be a knee-jerk reaction to consult the euthanasia team as a first response and neglect what palliative care has to offer. Until now, the standard of care has been to engage the patient in serious dialogue, to try to understand the nature of their suffering and grief expression more fully, and to determine what supports might be helpful. In palliative care, it is universally accepted that expressing a desire to die and talking about hastening death are most often normal expressions of grief, loss and coming to terms with one’s mortality in the face of a life-threatening condition. Such expressions of distress need to be explored and supported with skilled palliative care interventions to better understand the nature of

the suffering and how to address this, and/or to accompany the person in their suffering. There are many holistic, dignity-conserving palliative care interventions such as Dignity Therapy [65], developed by renowned Canadian palliative care psychiatrist Dr. Harvey Chochinov, which are aimed at restoring purpose, meaning, and reframing hope in the face of the losses that accompany life-threatening illnesses. Such therapies help a person and their loved ones to focus on living, even while dying, and provide support to accompany people on their journey, so they do not feel abandoned or alone.

There is no mandatory palliative care consultation prior to euthanasia. The only requirement is that a patient is aware of all options for care (informed of all means to relieve suffering, including palliative care). Awareness is not the same thing as meaningful access, and what a person understands palliative care to be may influence the person's understanding of what palliative care has to offer. The Chief Coroner of Ontario, who receives all reports of euthanasia cases in the province, has identified that it is very difficult to evaluate the quality/suitability of the palliative care being offered to patients who receive euthanasia [66]. Our own personal experience is that many patients and health care professionals, including some euthanasia providers, do not fully understand palliative care and its extensive array of therapeutic interventions.

It is also our experience that, although palliative care teams offer to provide ongoing palliative care for patients who request a euthanasia death, a number of these patients reject palliative care involvement. These patients often refuse many of the medications offered for optimizing symptom management, citing fear that the medications will cause them to lose decisional capacity and therefore their eligibility to receive euthanasia. Tragically and paradoxically, this may result in the last days of life awaiting a euthanasia death being more highly symptomatic, and patients may have eu-

thanasia without ever having a proper trial of excellent palliative care, even where it is available. A Quebec study found that in patients requesting euthanasia, 32% of those who received a palliative care consultation had it requested less than seven days before euthanasia provision and another 25% of palliative care consults were requested the day of or the day after the euthanasia request [41]. With the removal of the ten-day reflection period from euthanasia request to delivery of the procedure in the proposed revision for euthanasia legislation [18], the reality of a meaningful palliative care consultation seems even less likely.

Downar et al (2020) state that 74% of euthanasia cases in Ontario had palliative care involved, however, the reporting measures used during the study period do not allow for a detailed evaluation of the quality of medical care provided, including palliative care, as it is not within the legislated requirements for oversight by the Office of the Chief Coroner to review or collect this information [66]. It is thus not possible to delineate or evaluate either the quality or quantity of palliative care involvement, when it occurred in relation to the request for euthanasia (the study only documented that there was involvement at the time of request), which palliative care team member provided it (e.g. physician, nurse, or social worker, etc.) or whether there was any meaningful involvement by a specialist palliative care team. A number of detailed responses outlining the significant problems with the conclusions made in this paper have already been published online [40].

Strong lobbies are pushing for euthanasia to be available in every palliative care unit and hospice in the country [67]. In many areas, euthanasia is required to be provided in all settings of care in order to avoid the withdrawal of public funding. Hospice societies who fundraise to build the buildings and co-support the day-to-day costs of specialized hospice care are also being mandated to provide euthanasia on site or face closure.

Hospices and faith-based institutions are criticized for “blocking access” to euthanasia, even where access is documented to be excellent [68].

## Protection of Conscience for Physicians

Participation in euthanasia is also a great concern for physicians who are professionally and/or morally opposed to it. Some physician regulatory bodies require participation via a mandatory referral for euthanasia by physicians unwilling to provide the procedure themselves. For some physicians, such an obligation makes them complicit in an act they find not clinically indicated, unethical, or immoral. This happens in Ontario, Canada's largest province, where the College of Physicians and Surgeons of Ontario has mandated such an “effective referral” requirement [69]. Physicians who decline to do this could face disciplinary action such as the loss of the license to practice medicine. The Ontario courts have agreed that the requirement for referral violates the conscience/religious rights of physicians (which are protected under the Canadian Charter of Rights and Freedoms) but justifies the referral requirement to “ensure access» to euthanasia for patients, despite no documented lack of access in Ontario [70]. This is the very first time in Canada that the burden of ensuring access to other parts of the health care system has rested on the individual physician.

As previously discussed, euthanasia proponents are now suggesting that doctors must introduce euthanasia as an option to all potentially eligible patients as a so-called “duty to inform” [71]. However, in no other clinical situations are physicians required to discuss all potential options and procedures if they determine that those options are not medically indicated [72–74].

Some euthanasia providers are now refusing to become the “Most Responsible



Physician” (MRP) via a transfer of care prior to or during the euthanasia procedure. One of the authors on this paper has directly experienced this at their local hospital. Personal written communications have also reported this practice happening at other hospitals across Canada. In addition, some euthanasia providers are refusing to accept patient transfers from palliative care units and hospices. These strategies profoundly damage collegiality and may force physicians unwilling to collaborate in euthanasia (professionally or morally) into an ethical crisis, compelling them either to remain the MRP, formally approving euthanasia and responsible for all aspects of care for the patient and family, or to refuse to approve it and face contrived accusations of having obstructed patient access.

Palliative care clinicians have a high level of burnout [75–76], and the perceived lack of control over the scope of practice and forced participation in something that goes against their convictions about the very core of their vocation may be contributing to increasing moral distress and moral injury. This is reflected in colleagues who come to us on a daily basis to share experiences of repeated distress from euthanasia cases. Even colleagues who support euthanasia in some circumstances have reported experiencing this serious distress at times. Moral distress and moral injury manifest as early retirements, leaves of absence, and career changes by physicians who will no longer provide palliative care due to the expectation that euthanasia is included in the scope of practice. Additional moral distress is experienced by some palliative care leaders when health region administrators arbitrarily put euthanasia administration and oversight into the “end of life care” portfolio. The probable loss of palliative care physicians from the workforce at a time when even more clinicians are needed is in part a direct consequence of such stressful situations and heavy-handed measures.

Proponents of euthanasia use the phrase “my life, my death, my choice,” which calls

solely on the principle of autonomy as justification for euthanasia [77]. But, in Canada, the delivery of euthanasia is anything but an autonomous act. By design, it involves one or more other individuals. Many individuals and health care and community services commonly participate in each death, sometimes against their better judgment and possibly even against their will.

While palliative care has so far been on the forefront of the euthanasia experience, the coming expansion of the legislation that will allow euthanasia for suffering due to any illness, condition or disability, will have a much broader impact on physicians from all medical disciplines, as well as on other health care professionals. There will be very few areas of medicine that euthanasia does not touch.

In less than four years since the legalization of euthanasia in Canada we have witnessed

- rapid increase in rate of death by euthanasia (now estimated to be 2% of all deaths and expected to rise further) – a rate of growth over 3 years that has surpassed all other permissive jurisdictions
- the loosening of eligibility criteria by assessors and courts and the weakening of safeguard mechanisms in existing legislation
- the imminent expansion of euthanasia through legislative revision, despite strong opposition from citizens in the disability community, mental health professionals, palliative care clinicians and public policy leaders
- the failure of federal and provincial governments to designate palliative care as a right and to provide access to palliative care that is at least as robust as access to euthanasia
- the confusion and conflation of palliative care with euthanasia; and
- the erosion of conscience protection for physicians and other health care professionals leading to coerced participation and demoralization.

These formidable challenges faced by physicians and patients in our difficult Canadian

experience should not lead to discouragement but should instead inspire a reaffirmation of the commitment to traditional, whole-person medicine. Patients, loved ones, clinicians, and even society in general are all deeply enriched when palliative teams use our expertise to show compassion through excellent clinical care in an on-going, committed relationship with each patient, no matter how difficult the circumstances or how complicated the issues. Suffering — pain, fear, loss of control, sense of burden—is not solved by hastened death, but by this excellent care, delivered in a community and a society that honours and protects our most vulnerable citizens at the most difficult times in their lives. Euthanasia is not the panacea that proponents promise. Its legalization and subsequent rapid normalization have had serious negative effects on Canadian medicine and on Canadian society as a whole. We urge the WMA and our colleagues around the world to look beyond the simplistic media reports and to monitor developments in Canada carefully and wisely before making any changes in their own country’s legal framework for medical practice.

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