Barbara Kay: Let’s not become Belgium when it comes to assisted suicide
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In February, the archbishop of Edmonton announced that in the event of legalized euthanasia, physicians and other health-care workers of Covenant Health Hospital would not be participating in the active termination of patients’ lives.

In response last month, Alberta’s associate health minister Brandy Payne stated that Covenant Health’s conscientious objection would be respected, and that patients requesting life termination there would be transferred. That seems reasonable. After all, when conscripted soldiers refuse to go to war for reasons of conscience, they are not asked to provide their own combat replacement.

In Quebec, by contrast, where euthanasia is already in effect, any Christian institution that refuses to comply with the legislation will be shut down. (Imagine the dubious distinction of being the first hospital in human history to be closed for refusing to kill patients in its care.)

Ethics-based tension in the medical community is but one of many concerns we must acknowledge to be inherent in Bill C-14. Last week, for example, Andrew Coyne focused on the issue of “consent.” He asked how even two doctors evaluating a case can be “sure that the decision was ‘not made as a result of external pressure’ or that a request was ‘voluntary.’” Coyne referenced the dubious record on consent in Belgium and the Netherlands, where life termination for all kinds of reasons, including depression and being “tired of life” at any age, is so common that in 2013 a single Dutch clinic helped kill nine able-bodied psychiatric patients, and safeguards are often flagrantly ignored. He cited as his source a newly published book, It’s Not That Simple: Euthanasia and Assisted Suicide Today, by palliative-care researchers Ian Gentles and Jean Echlin.

Anyone with strong opinion on this subject, whether pro or anti, should read this slim volume. The skeptics will find their opinion bolstered. Those in the pro camp will struggle to find reasons why Canada should be immune from the slippery-slope perils outlined in its pages.

In research commissioned by the Dutch government, for example, Gentles and Echlin found that in 27 per cent of euthanasia cases in the Netherlands, “the decision was not discussed with the fully competent patient;” in close to 20 per cent of cases, general practitioners did not consult a colleague before proceeding; and in almost three quarters of cases, death certificates cited natural causes as the cause of death, even though legislation defines euthanasia as “unnatural.” (No Belgian or Dutch doctor has ever been punished for such violations of protocol.)

Regarding the last: in its clinical-practice guidelines, Quebec’s College of Physicians recommends that doctors falsify death certificates of euthanized patients by listing the underlying illness as the cause of death. Such duplicity will make data collection impossible: not just in terms of numbers, but whether euthanasias are performed on legitimate grounds, with consent properly obtained and legal safeguards observed.

So great is the unease in critical circles in the Netherlands and Belgium that ethics professor Theo Boer, who was responsible for drafting the initial Dutch legislation, said in 2014, regarding the “explosive increase” in the numbers of the euthanized, that “we were wrong — terribly wrong, in fact.” He wondered aloud if “the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort.”

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The question of whether euthanasia is now seen “as a normality” seems already to have been answered in Belgium. Of all the shocking statistics I read in this book, two seemed particularly poignant. In all Belgium, there are only 70 palliative-

care beds; and in 2001-07 palliative caregivers were only involved in an average of 13 per cent of cases. That tells the story for me. Britain (whose parliament, by the way, has debated and issued a resounding no to euthanasia and assisted suicide), although only four times bigger than Belgium, has thousands of palliative-care beds.

It's Not That Simple particularly resonates with me because it concentrates on the untapped potential of palliative care to provide a better alternative to euthanasia for most people. Palliative care is only available in Canada to urban cancer sufferers, which means 70 to 80 per cent of Canadians have no access. We know from studies that it isn't present pain that dictates most people's positive view of euthanasia; rather they fear severe pain, abandonment and/or incapacity in the future. If they knew they would have a choice between euthanasia and a humane, pain-free transition under compassionate care, most would choose the latter.

Most, but not all. I wouldn't deny those bent on a controlled, precisely determined death their right to seek it. I agree with Gentles and Echlin, though, that assisting suicide and active killing should be a stand-alone, regulated profession. Palliative care is normal medicine. Euthanasia is something else. Let's not be Belgium.

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