



Perspectives

The deVeber Institute for Bioethics and Social Research

2017

Research and Scholarship for an Informed Social Response to Human Life Questions



A Reflection BY A YOUNG INDIGENOUS WOMAN

It is startling to know that the Government has now drawn a very thin line separating life and death with the implementation of ‘Medical assistance in dying’ (MAiD), considering the fact that many people today are suffering from mental illnesses that make them question their will to live. “For the First Nations population, suicide rates are twice the national average and show no signs of decreasing.”¹ At 6 to 11 times the Canadian average, suicide rates among Inuit are even higher than among First Nations communities.² In Nunavut, rates are so high that 27% of all deaths since 1999 have been suicides.² In addition, these rates are rising over time.² Given this, imagine the impact this law will have on Canada’s First Nations population.

Coming from an Indigenous background (Ojibwe First Nations), our people face many difficult obstacles throughout our lives. The same obstacles faced by our ancestors are now passed down to today’s society. The legalization of euthanasia has now enabled death to be so easily accessible for those who do not see a point in living; a reality I feel is truly disappointing.

Winnipeg Centre, MP Robert-Falcon Ouellette commented about this issue surrounding euthanasia and the Indigenous community: **“I’m concerned that we haven’t thought out the complete ramifications that a decision like this might have on Indigenous communities that seem to be suffering greatly.”** He continued, **“this will be a right that will become entrenched and the impacts on vulnerable groups will become entrenched and it’s very hard to stop.”**³

My people believe that God has brought us into this world, and that we should wait until our time has come and die naturally. We need to protect not only them but all individuals young and old who suffer from mental illnesses against the pressures to commit suicide. On the contrary, we need to encourage Indigenous communities, especially their most vulnerable members, not to question their reason for living. Palliative care is a proven way to treat a suffering patient without killing them. The government should support what works, not what is harmful and places more vulnerable people at risk.



Jade Meawasige is a current grade 11 student attending York Memorial Collegiate Institute. Her future career is in journalism.

Working with the deVeber Institute this year has allowed her to focus on her interests, as well as gather experience for her future job saying,

“The deVeber Institute is a wonderful organization that I think many more people should be aware of in terms of what they research, as they are very controversial yet important issues.”

* Image drawn by David Devine, OUHSD Title VII Indian Education, California.

1. Government of Canada. (2006). Aboriginal mental health and well-being. In The human face of mental health and mental illness in Canada (Chapter 12). Ottawa: Minister of Public Works and Government Services Canada. www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php.

2. Jack Hicks. Statistics on deaths by suicide in Nunavut, 1975-2003 [Presentation]. Nunavut Bureau of Statistics; January, 2004.

3. Hoffman, Kristy. “Robert-Falcon Ouellette questions impact of doctor-assisted dying on Canada’s Indigenous Peoples.” CBC News [Manitoba] April 15, 2016. <http://www.cbc.ca/news/canada/manitoba/robert-falcon-ouellette-doctor-assisted-dying-indigenous-communities-canada-1.3537217>

On Saying “No”: The Ethics of Conscientious Objection in Healthcare



Dr. Ewan Goligher

Key points as presented by **Dr. Ewan Goligher** during the deVeber Institute’s public lecture in October of 2016 at Wycliffe College, at the University of Toronto.

The conscientious objector’s concerns are properly located in a desire to be faithful to the goals and virtues of medicine.

Medical practice is an innately and unavoidably moral activity because of its regard for the patient’s intrinsic and incalculable value and because of the covenant of trust into which physicians enter with their patients.

“Forcing doctors to knowingly send their patient to another doctor willing to cause the patient’s death will seriously compromise the moral integrity of conscientiously objecting doctors and risks undermining the quality of patient care.”

– Dr Ewan Goligher, *National Post*, April 14, 2016

Patient Autonomy and Physician Autonomy:

“Patient autonomy is becoming absolutized to the extent that the right to refuse treatment has become the right to demand treatment. There is now need to be concerned about violations of the physician’s autonomy, that is to protect the integrity of the physician’s values as a person and a moral being, and to protect the integrity of the enterprise of medical ethics itself.”¹

– Edmund Pellegrino

The vision of patient autonomy presented by the opponents of conscientious objection would coerce the physician to be subject to the patient’s foundational beliefs simply by virtue of the fact that she offers to help the sick.

It seems strange to claim that one’s health and wellbeing can be advanced by nonexistence.

How does one quantify the wellbeing or lack thereof attached to being dead?

Consider the claim that a patient may decide that it is in his interest to no longer be alive, this necessarily presupposes some knowledge of what it’s like to be dead. Yet medicine has no empirical observational knowledge of what it’s like to be dead. Doctors cannot speak with any authority on the question of the existence and nature of the afterlife.

1. Edmund Pellegrino, CMAJ, 1994.



The Hidden Professions of Conscientious Objection

Federal legislation permitting the killing of people who meet the criteria for Medical assistance in dying (MAiD) has challenged most healthcare professionals to carefully consider where they morally stand on causing someone's death. While many healthcare providers may feel it is against their values to participate in euthanasia, we have all been asked or will be asked at some point about euthanasia by a patient or their family.

With the passing of legislation allowing euthanasia, physicians, nurses, pharmacists, social workers and other healthcare providers who provide direct care have generally been protected if they have stated their opposition to causing death. They have been protected in law and in the policies of their organizations. **It is important to note that euthanasia is occurring within institutions as well as in community.**

In general, frontline conscientious objectors have been respected and accommodated. **But, what about those behind the scenes?** For example, for healthcare in a multicultural and multi-linguistic setting to work we must rely on quality interpreters to ensure that effective communication has

taken place. As a principle of good practice when we are working with a person who does not speak English we must ensure that we use proper interpretation. Consequently when interpretation services are formally requested to process a euthanasia request, we must ensure that the interpreter knows why they are being asked so they can have the opportunity to exercise their conscience and object to participating. Like frontline staff they too may feel morally compromised if their services contribute to a death.

Another behind the scenes group who are integral to modern healthcare are staff involved in clinical informatics. These are professionals who design, implement and oversee our electronic health records and our organization's websites. This is the case with documentation for MAiD especially as the coroner reviews all cases to ensure participants receive the exception from criminal law. Within this group of healthcare professionals, they too have had conscientious objection to MAiD and did not want to participate. Fortunately those who opposed euthanasia had their conscientious objection respected.



Bob Parke, Toronto Bioethicist

While interpreters and clinical informatics team members may be asked to participate in euthanasia their right to conscientious objection is not recognized as it is for doctors, nurses, pharmacists and other frontline staff. As such, they need to be considered and supported in organizational policies addressing MAiD.

I further want to encourage us to consider who and where are the other hidden professions of conscientious objection who need our support.

Hospice to Provide Safe Haven from Euthanasia for Patients, Staff and Healthcare Professionals

(Adapted from a Catholic Register article.)

“We will help you live until you die (...) you’re not alone in your journey”¹

Bob Parke, professional bioethicist and member of the Clinical Advisory Committee for the Ontario Palliative Care Network, wants to create a hospice that would not permit assisted death. The hospice would be a place to support life until the person dies naturally, providing care to alleviate suffering, meals, social comfort and excellent hospice palliative care. The safe haven hospice’s staff would not hasten death and would address a person’s total pain including physical, psychological, social and spiritual.

One of the biggest hurdles in launching this initiative is that the hospice will need private funding. “Some of my colleagues were saying if you take government money, then you must provide medical aid in

dying,” Parke said. While we would like to accept government money, we want to ensure that institutional conscientious objection would be respected. Otherwise, we might be entirely dependent on donors for our funding. While the cost of medications, as well as physician fees, will in most cases be covered by government-funded insurance plans, he said the hospice is going to require a lot of help to get off the ground.

Ron Forbes, a partner of the safe haven hospice project and former CEO of the Juvenile Diabetes Research Foundation, said avoiding government funding will be challenging. He expects it will take about \$10 million to bring the hospice to life for a stand-alone facility.



“You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.”

– Dame Cicely Saunders, nurse, physician and writer, and founder of the modern hospice movement (1918 – 2005).

For further information about the Safe Haven Hospice contact:
hospice@scainternational.org

1. Boudreau, Evan. “Hospice to provide safe haven from euthanasia for patients and doctors.” The Catholic Register, article issued March 24th 2016.

We wish to thank the following individuals for their help and assistance in the production of this newsletter edition:

Philip Sung Design, Jade Meawasige, Dr Ewan Goligher, Bob Parke, SCA International, Tiffany Tran, Elaine Drake, Katie Pfaff, and Martha Crean.



The deVeber Institute for Bioethics and Social Research

Founded in 1982

415 Oakdale Rd., Suite #215,
Toronto, Ontario M3N 1W7

Tel. 416-256-0555
Fax. 416-256-0611
bioethics@deveber.org
www.deveber.org

Executive Director
Kathy Matusiak Costa, BSc
Charitable Business Number
11896 4915 RR 001