

Briefing Notes on Euthanasia and Assisted Suicide: Minimum Age Restrictions

April 2016

The EFC absolutely rejects the idea that assisted death should be made available to minors.

- Assisted death cannot be undone, it is intended to kill, and thus it cannot be considered like any other type of medical treatment over which minors may have legal decision-making power.
- In Canada, the age of majority is the age at which a person is considered by law to be an adult. This age is either 18 or 19, depending on the province or territory.

The **Supreme Court of Canada** used the term “competent adult” repeatedly and deliberately in the *Carter* decision. The Court is fully aware that there are differing provincial standards and ages of competence for care, but nonetheless chose to restrict the exemption to “adults,” rather than “competent persons.”

The **Special Joint Committee on Physician-Assisted Dying** has recommended a two stage implementation that would extend assisted death to mature minors within three years.

With respect to children, the **Canadian Paediatric Society** argued that the committee should not go beyond the Supreme Court’s pronouncement. As Dr. Mary Shariff of the Canadian Paediatric Society told the committee on Feb. 3:

“...there is a massive ethical question as to whether children and adolescents should be able to qualify in the first instance for lethal injection. This ethical question was not considered in *Carter*, and to the best of my knowledge, it has not been fully considered by Canadians.”

The **Canadian Hospice Palliative Care Association** recommended to the special joint committee that adult be defined as someone who is at least 21.

Constitutional expert **Peter Hogg** told the committee on Jan. 25:

“The Supreme Court, in its order, spoke of a “competent adult person”. I don't think it would be open to you, for example, to have 16 as an age of consent for this purpose, because that would not be a competent adult person. Between 18 and 21, I would think you would have some leeway within the word “adult” to decide that.”

The committee asked Dr. Dawn Davies of the **Canadian Paediatric Society**, on Feb. 3, if there is any consensus in pediatrics of a minimum age at which there is no doubt in determining that a child cannot give free and informed consent. She replied:

“I don't think there is any consensus. Even across provincial jurisdictions, the age of consent varies greatly, from 14 to 18. I think capacity really comes down to the individual patient, with the individual question that's being asked of them. In general, the less weighty the outcome of the decision, the more we allow the minor to play a role in that decision.”

Dr. Davies of the **Canadian Paediatric Society** went on to say:

"While the provincial and territorial panel suggests that capacity is more relevant than age, they did not consult with pediatric health care providers, parents, or minors."

"In general, the less weighty the outcome of the decision, the more we allow the minor to play a role in that decision. For example, for a very young child, it may be asking which arm they would like their intravenous started in because the risk of harm is so low. However, a child not wanting potentially life-saving chemotherapy if they have a good prognosis or not wanting any further treatment if they have just suffered from a terrible car accident, for example, are the cases that are much more difficult to assess."

Dr. Mary Shariff of the **Canadian Paediatric Society** explained to the committee:

“ ... the argument is being made that the law has already allowed mature minors to make medical decisions even if doing so would result in their death. But let's think about that a little more closely. In those death cases, the decision is about rejection of treatment whereby if the child rejects treatment, the child runs the risk of dying. This is an entirely different consideration for children than is children being expected to consent to lethal injection.

... we also see from those cases in the Canadian case law that if the odds of survival are good with treatment, the court will override a minor's refusal. We know that *Carter* does not use the criteria of terminal illness, so how does one figure out the odds of survival for a child whose medical condition is a mental health issue or other form of disability?”

Michael Bach of the **Canadian Association of Community Living** told the committee on Feb. 4:

“We strongly urge that mature minors not be eligible. We don't deny the suffering of children and adolescents, but we believe that palliative care is the answer in those situations. This is a decision that children and adolescents and their families should not have to make. If you have to be majority age to vote in this country, surely this is a limit that we can impose.”

Children and youth should continue to receive the protection of a *Criminal Code* prohibition against euthanasia and assisted suicide.

Briefing Notes on Euthanasia and Assisted Suicide: Mental Health

April 2016

Mental illness and psychological suffering, in the absence of a terminal, degenerative illness, should be expressly excluded from the eligibility criteria for physician-hastened death.

The **Special Joint Committee on Physician-Assisted Dying** recommends that individuals with a psychiatric condition should be eligible for assisted death, even in the absence of a physical illness. It also recommends that psychological suffering – whether or not physical illness is also present – be recognized as a criterion for assisted death. Further, it does not require psychiatric assessment of patients with psychiatric conditions, or whose suffering is psychological.

These recommendations are contrary to testimony the committee heard from national associations such as the Canadian Psychiatric Association and the Canadian Association for Mental Health.

As Dr. Sonu Graind of the **Canadian Psychiatric Association** told the committee on Jan. 27:

Mental illnesses can affect cognition and impair insight and judgment. Symptoms of cognitive distortions common with clinical depression include negative expectations of the future; loss of hope; loss of expectation for improvement, even when there may be realistic hope for positive improvement; loss of cognitive flexibility; loss of future-oriented thought; and selective ruminations focused on the negative and minimizing or ignoring the positive. There are commonly distortions of a person's own sense of identity and role in the world, including feelings of excessive guilt and worthlessness or feeling like a burden to others.

Dr. Graind went on to say,

“I want to emphasize that none of this is to suggest that simply the presence of any mental illness alone impairs people's judgment and cognition, but in the PAD discussion, by definition, we are talking about the most severe situations, and in severe cases of mental illness, the risk of such cognitive distortion is, of course, higher. We think with our brains, not with our hearts or limbs.”

The **Canadian Psychiatric Association** recommended that when a person with a psychiatric illness requests physician-assisted death, that multiple assessments over time be carried out by those with suitable skill sets to ensure that nuanced issues that could affect decision-making are properly assessed, and to allow time for potential remediation of symptoms and/or psychosocial factors.

Dr. Tarek Rajji of the **Centre for Addiction and Mental Health** told the committee on Feb. 3:

“...there must be safeguards in place to ensure people with mental illness truly have the capacity to consent to PAD. ... When a person is experiencing an acute episode of their illness such as a major depressive episode, or an acute psychotic episode, or a manic episode, it's not uncommon for them to have severely distorted beliefs about themselves, the world, and their future. Sometimes the sense of helplessness, and worthlessness, and hopelessness continues even when the symptoms of the mental illness are better controlled.”

Dr. Rajji went on to say:

“I think it's critical to have a comprehensive capacity assessment for someone who has a mental illness but is suffering from a non-mental illness which could be the grievous and irremediable condition. ..., I think it would be critical to evaluate whether the request for PAD, for example, is being driven by the mental illness itself or the view of their physical illness as influenced by the mental illness.”

In the *Carter* case, the **Government of Canada** argued that sources of possible error and factors that can render someone “decisionally vulnerable” include depression and other mental illness (para 114).

The *Carter* decision did not address mental illness directly. In para 127 of the *Carter* decision the **Supreme Court** stated, “The scope of the declaration is intended to respond to the factual circumstances of this case.” The *Carter* case responded to the specific fact situations of individuals with terminal and degenerative physical conditions.

The Supreme Court reasoned that persons who might find themselves physically unable at some point to take their own lives might end their lives prematurely if no assistance would be available to them later. The court did not propose extending assistance to those who wished to end their lives and were capable of doing so. The focus of the Court was allowing assistance in suicide for those who would be physically incapable of taking their own life.

The trial Judge in *Carter* (all of whose factual conclusions were accepted by the Supreme Court of Canada) expressed particular doubts about compliance with the mental health referral requirement in Oregon State (para. 649), finding that “it is virtually impossible to guarantee that a person whose decisional capacity is affected by depression will not slip through the safeguards designed to reduce that risk” (para. 669) and that at least 3 depressed people appear to have done so (para. 670). This was of concern to the trial judge who acknowledged that major depression could vitiate the applicant’s consent to death.

As Michael Bach of the **Canadian Association for Community Living** told the committee on Feb. 4:

When the *Carter* case was first heard at the B.C. Supreme Court, Justice Smith knew enough of such cases to very carefully examine the extensive evidence before her about the types of safeguards that could be put in place, given the obligation to protect the right to life of vulnerable persons. She concluded her analysis with the following list: mandatory psychiatric evaluation to ensure capacity for informed consent; disqualification of major depressive disorder... Immediately following the presentation of that list, in her decision, the trial judge stated her conclusion, which was also quoted by the Supreme Court to justify its own decision:

...the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced.

Persons experiencing mental illness are particularly vulnerable to suicidal ideation, and the committee’s recommendations fail to offer any protection.

Briefing Notes on Euthanasia and Assisted Suicide: Conscience Protection for Medical Practitioners

April 2016

It is a violation of conscience to be compelled to take another person's life or to participate in the taking of a life. This right to conscience protection is fundamental.

Physicians and other medical practitioners must have the right to refuse to participate in physician-assisted suicide for reasons of conscience, either directly or indirectly, including the right not to have to provide a referral.

Providing a referral is, in effect, a professional recommendation for a course of treatment. In the case of physician-assisted suicide or euthanasia, it is a form of participation in an action that is destructive to the patient and is contrary to the deeply-held beliefs of many physicians.

The **Special Joint Parliamentary Committee on Physician-Assisted Dying** recommended that all physicians be required to provide a referral, in spite of hearing from numerous medical professional associations about the fundamental importance of conscience protection.

The **Canadian Medical Association's** Vice-President of Medical Professionalism told the committee, on Jan. 27:

“For other physicians, however, making a referral for assisted dying would be categorically, morally unacceptable. For these physicians, it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. In other words, being asked to make a referral for assisted dying respects the conscience of some physicians, but not of others.”

“The whole issue of connecting access with the right to conscientious objection is a false dichotomy. The two are not interrelated. In fact, we have a very small percentage of members who said they feel very conflicted about the obligation to refer; however, the entire rest of the profession says that even though they may not share that view, they will fight for the right of the others to not have mandatory referral.”

The Chair of the **Canadian Pharmacists Association** told the committee, on Jan. 27:

“Pharmacists overwhelmingly support the inclusion of a protection-of-conscience provision in legislation. Like other professions, pharmacists feel strongly that they should not be obligated to participate in assisted dying if it is against their moral or religious convictions.

The **Canadian Paediatric Society** brief to the Committee states:

“Given the rapid societal shift since the *Carter v Canada* decision, and short timeline to enacting legislation, **the CPS strongly enshrines the physician’s right to conscientiously object to being involved in Physician Assisted Death generally, but especially in the cases of children and adolescents.**”

Larry Worthen of the **Christian Medical and Dental Society of Canada** told the committee, on Feb.3:

“A referral is the recommendation or a handing over of care to another doctor on the advice of the referring physician. The requirement to refer forces our members to act against their moral conviction that assisted suicide or euthanasia will, in fact, harm their patients. ... Health care workers do not lose their right to moral integrity just because they choose a particular profession.”

The **Supreme Court** said in *Carter*, “Nothing in this declaration would compel physicians to provide assistance in dying.” The question of referral was not directly addressed in *Carter*. The Court immediately went on to say, “The Charter rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgment.” These statements taken together indicate a need to reconcile the rights of patients and physicians without compelling objecting physicians to provide assistance, directly or indirectly.

The CMA submission to the College of Physicians and Surgeons of Ontario in January 2016 argues:

“It is in fact in a patient’s best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, medical regulators ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience.”

The **College of Family Physicians of Canada’s** Executive Director said to the committee, on Feb. 1:

A central information system for patients would support this process and help a great deal to avoid feelings of abandonment and confusion. It would also improve the standardization of information available across Canada on this important issue. The objecting family physicians will provide continuity of care and transfer the patient’s medical record promptly and effectively if requested.

Options to provide conscience protection to healthcare practitioners

- Create a central agency to coordinate access, so patients can self-refer, as proposed by the Canadian Medical Association.
- Notify a third-party who will coordinate a referral, when a patient requests euthanasia or assisted suicide, similar to Quebec’s regime.
- A federal regulatory agency to licence medical practitioners who participate in euthanasia or assisted suicide. Only those who are licenced would be legally permitted to participate in assisted suicide.
- Enact a *Criminal Code* prohibition on coercing a medical practitioner to participate in assisted suicide or euthanasia, as recommended by the Coalition on HealthCARE and Conscience.

No other jurisdiction in the world requires mandatory referral.

The intention to end a life, rather than to alleviate pain, makes euthanasia and assisted suicide fundamentally different than end of life care.

Briefing Notes on Euthanasia and Assisted Suicide: Conscience Protection for Institutions

April 2016

Many faith-based institutions provide senior care, extended care and hospice care. The care they offer is an expression of the deeply held beliefs of the communities that provide the care.

- To compel institutions to facilitate or allow assisted death on their premises denies the beliefs that animate their compassion.
- Health care professionals, staff and the administrators of these facilities should not be compelled to participate in or facilitate assisted death.
- These facilities should be able to obtain an exemption if Parliament proceeds with legislation on euthanasia and assisted suicide.

The **Special Joint Committee on Physician-Assisted Dying** recommended that the government work with the provinces and territories to ensure that all publicly funded health care institutions provide medical aid in dying, in spite of hearing clearly expressed testimony on the need for conscience protection for institutions.

Cardinal Collins, Archbishop of the Archdiocese of Toronto, told the committee on Feb. 3:

“I think it's very true to say that institutions are not bricks and mortar..... They're not things; they're communities of people. They have values, and that's why people come to them. That's why they seek them out.”

“These institutions are funded by the government because they do immensely good work. ... If you undermine the institution for what it is, our society will be very much harmed. Our whole community would be a lot harsher, colder, crueller, without the witness given by communities of faith who are on the ground, on the street, day by day, caring for the most needy. I don't think they should be undermined or attacked.”

The **Salvation Army**'s brief to the committee states:

“Permitting some facilities to be exempt from providing physician-assisted death will not limit access in a meaningful way. Rather, allowing for institutions to be exempt will offer protection to the conscience, morality and beliefs of patients, health-care providers and organizations who do not wish to engage with physician assisted death. We note that several other jurisdictions such as Washington and Oregon offer health facilities or health care providers the option to decline from participating in physician assisted death.

Sharon Baxter, **Canadian Hospice Palliative Care Association**, told the committee on Feb. 2:

“The process in our residential hospices, of which there are 80 in this country, is not around hastening death. They're asking for a site exemption. Keep in mind that most of them don't receive much government funding. They are charitably funded, for the most part, and they want to make sure that they are actually following the wishes of the community that raises the money for residential hospices.”

Responding to the parliamentary committee recommendations, Cardinal Collins [wrote](#):

“It is unjust to force people to act against their conscience in order to be allowed to practice as a physician or, in the case of a health care facility, in order to qualify for government funding. It is not tolerant of religious diversity. It is religious discrimination that punishes those who so faithfully serve everyone who comes to them, and have done so since before Canada existed but who, in good conscience, cannot perform some procedures, such as helping to kill their patients.”

The **Supreme Court of Canada**'s 2015 decision in the Loyola case strongly affirmed the communal nature of religious practice. The majority decision stated:

“Religious freedom under the *Charter* must therefore account for the socially embedded nature of religious belief, and the deep linkages between this belief and its manifestation through communal institutions and traditions.”

In the minority decision, the remaining three judges stressed the communal nature of religion. They argued that the religious freedom of individuals requires that the religious freedom of religious organizations be protected.

“The individual and collective aspects of freedom of religion are indissolubly intertwined.”

“The communal character of religion means that protecting the religious freedom of individuals requires protecting the religious freedom of religious organizations...”

The majority of the Supreme Court, in the 2015 decision in *Mouvement laïque québécois v. Saguenay*, stated:

“A neutral public space free from coercion, pressure and judgment on the part of public authorities in matters of spirituality is intended to protect every person's freedom and dignity, and it helps preserve and promote the multicultural nature of Canadian society.”

In any regime allowing physician-hastened death, the conscientious objection of institutions must be protected.

A failure to respect the conscientious objection of institutions would violate fundamental conscience and religious beliefs. It would also put institutions offering much-needed services in the difficult position of choosing between violating their deeply-held beliefs or closing their doors.

Briefing Notes on Euthanasia and Assisted Suicide: Palliative Care

April 2016

Palliative care is best suited to provide comfort and care to patients and their families who are suffering and near death. We urge the government to establish a national strategy to address the availability of high quality palliative care.

It is lamentable that we as a country are contemplating the decriminalization of assisted suicide in response to suffering when most Canadians do not have access to high quality palliative care and related support systems.

Underlying arguments for assisted dying is the exercise of autonomy, the exercise of choice. To offer assisted suicide as an option when so many Canadians lack access to high quality palliative care, is to offer them a hollow choice at the end of life.

The report of the **External Panel on Options for a Legislative Response to *Carter v. Canada*** found that there is an urgent need for improved access to excellent palliative care across Canada. The External Panel notes that it “heard on many occasions that a request for physician-assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate a person’s suffering.” The report goes on to state:

“With the advent of physician-assisted death, it has become critically, even urgently, apparent that Canadian society must address its deficiencies in providing quality palliative care for individuals living with life threatening and life limiting conditions. Our country must rise to this challenge, as no Canadian approaching end of life should face the cruel choice between physician-assisted death and living with intolerable, enduring suffering in the absence of compassionate, comprehensive quality care.”

The **Special Joint Parliamentary Committee on Physician-assisted Death** heard from many witnesses about the need to expand the availability of quality palliative care. We support the committee’s recommendations on palliative care, however, more needs to be done.

The Canadian Cancer Society’s report, *Right to Care: Palliative care for all Canadians*, released in January, found serious gaps in palliative care across the country, with thousands of critically ill Canadians not receiving proper care.

As Dr. Harvey Chochinov writes in a recent [commentary](#):

“Only 15 to 30 percent of dying Canadians have access to or receive hospice palliative care or end-of life services, dedicated to addressing all forms of suffering -- physical, psychological and

existential -- affecting patients nearing death and their families. And yet, should the report's recommendation come to fruition, all healthcare facilities would be required to offer physician-hastened death, i.e., euthanasia and assisted suicide.”

Gabriel Miller of the **Canadian Cancer Society** told the committee on February 1:

“Any serious conversation about the needs of severely ill Canadians must include palliative care, and any responsible policy on assisted dying must guarantee access to quality palliative care for all Canadians.”

“Palliative care doesn't have the same complexity as assisted dying. It is simply the notion that people should be well cared for—as people—to minimize their suffering and maximize their enjoyment of life. The only enduring mystery is how Canada has failed for so long to fix its broken palliative care system.”

Sharon Baxter, Executive Director of the **Canadian Hospice Palliative Care Association**, Feb 2:

“Comprehensive hospice palliative care can help alleviate many of the factors that may cause people to consider physician-hastened death, particularly the burden on their loved ones, depression, and inadequate pain and symptom management.”

Baxter went on to say:

“Palliative care and physician-hastened and physician-assisted death are philosophically and clinically separate. Conflating them could result in confusion, making people who are already frightened of palliative care even more reticent to avail themselves of this vital and effective means of addressing suffering.”

The Canadian Hospice Palliative Care Association believes hospice palliative care does not include physician-hastened death. Hospice palliative care does not hasten or prolong death. Hospice palliative care strives to end suffering, not life.

Dr. France Lemire, **College of Family Physicians of Canada**, Feb 1:

“The college believes that Canadians should have access to quality palliative care in their communities.”

Suffering is a broader human question, involving emotional, psychological, spiritual, social dimensions, and is beyond the expertise of medicine alone to address. The solution proposed by the Court to the problem of suffering not only fails to address the suffering, but eliminates the one who suffers. Suffering is properly addressed by good quality palliative care that considers the whole person and includes a range of supports.

Without access to quality palliative care, people will be vulnerable to feelings of isolation, despair, to feeling like a burden to family or caregivers, and to the medical system. Assisted death must not be the only choice.

The intention to end a life, rather than to alleviate pain, makes euthanasia and assisted suicide fundamentally different than end of life care.

Briefing Notes on Euthanasia and Assisted Suicide:

Recent Articles

Canada's Health Facilities Cannot Handle Physician-Assisted Death

By Harvey Max Chochinov, Huffington Post, April 1, 2016

“What about the notion of forcing euthanasia and physician-assisted suicide into faith-based health-care organizations? Most are built on the foundation of inviolable moral, religious and ethical traditions. Failure to find a more nuanced solution that respects conscientious objection and safeguards patient autonomy will place faith-based facilities on a direct collision course with the federal government.”

http://www.huffingtonpost.ca/harvey-max-chochinov/canada-health-facilities-physician-assisted-death_b_9586040.html

Majority rejects assisted suicide for mentally ill, poll finds

By Sharon Kirkey, National Post, April 1, 2016

“An overwhelming majority of Canadians believes psychological suffering on its own should never be grounds for granting a doctor-assisted death. ... 78 per cent of those surveyed in the weeks after [the parliamentary committee’s report] its release said “psychological suffering” on its own should not meet criteria for a doctor-hastened death.”

<http://news.nationalpost.com/news/canada/majority-rejects-assisted-suicide-for-mentally-ill-poll-finds>

Doctor-assisted dying: Why religious conscience must be part of the debate

By Lorna Dueck, *Globe & Mail*, March 16, 2016

“If the recommendations from the parliamentary committee for new legislation are accepted and approved by the June 6 deadline, Canada would be by far the most liberal country in the world for medical assistance in dying. It would also become the most repressive on conscience rights, because the committee recommended that conscientious objectors refer death-seeking patients to another doctor or health-care facility – something that many people informed by a sense of duty to God and neighbour cannot do.”

<http://www.theglobeandmail.com/opinion/doctor-assisted-dying-why-religious-conscience-must-be-part-of-the-debate/article29252574/>

Help the mentally ill. Don't kill them

Sen. Denise Batters, National Post, March 14, 2016

“Delivering the means to suicide straight into the hands of mentally ill individuals directly contradicts the suicide prevention standard in the mental health field. How can we expect mental health caregivers to advocate suicide prevention on one hand, while signing the death warrant for a mentally ill patient with the other? The preservation of hope for mentally ill people is absolutely paramount. Those who endure psychological suffering need our support, our resources and our promise that we will never give up on them, even when they can see no other option but to give up on themselves.”

<http://news.nationalpost.com/full-comment/denise-batters-help-the-mentally-ill-dont-kill-them>

Should right-to-die law apply to mentally ill people?

Margaret Wente, *Globe & Mail*, March 1, 2016

“Obviously, psychiatric illness can produce grievous suffering. But it is not the same as terminal cancer. Psychiatrists’ practices are filled with people who want to die. Their decision making is frequently impaired by their illness. People who are suicidal often change their minds. And major mental illness, although often incurable, can often be relieved. So can the conditions that make it worse, such as social isolation, poverty and homelessness. You are not likely to find a mental health leader in Canada who has argued that the right to die would serve the greater good of psychiatric patients.”

<http://www.theglobeandmail.com/opinion/should-right-to-die-law-apply-to-mentally-ill-people/article28953328/>

On assisted dying, government should respect the beliefs of religious hospitals

Barry Bussey, *National Post*, March 8, 2016

“These Catholic hospitals are being accused of not respecting Canadians’ charter right to assisted death. The argument is that publicly funded institutions must accept public norms. According to this logic, these institutions lose all their rights to have religious beliefs when they are at least partially funded by taxpayers. It is further claimed that these organizations have no charter rights in and of themselves.

However, such views are contrary to the opinion expressed by Chief Justice Beverley McLachlin and Justice Michael J. Moldaver (both speaking for the minority opinion in the *Loyola High School* case in 2015), who accepted the charter’s protection of the “communal character of religion”: “The individual and collective aspects of freedom of religion are indissolubly intertwined. The freedom of religion of individuals cannot flourish without freedom of religion for the organizations through which those individuals express their religious practices and through which they transmit their faith.”

<http://news.nationalpost.com/full-comment/barry-w-bussey-on-assisted-dying-government-should-respect-the-beliefs-of-religious-hospitals>

Canada is making suicide a public service. Have we lost our way as a society?

Andrew Coyne, *Canada.com*, February 29, 2016

“Once you have normalized suicide, from a tragedy we should seek to prevent to a release from suffering we should seek to assist, it is logically incoherent — indeed, it is morally intolerable — to restrict its benefits to some, while condemning others to suffer interminably, merely on the grounds that they are incapable of giving consent. So it is that assisted suicide has gone, in the space of a year, from a crime, to something to be tolerated in exceptional circumstances, to a public service. Perhaps you see this as progress. But I cannot help feeling that a society that can contemplate putting children to death has somehow lost its way.”

<http://www.canada.com/news/national/andrew+coyne+canada+making+suicide+public+service+have+lost/11753244/story.html>

Anesthesiologists warn assisted death not simple: convulsions and ‘awakenings’ possible complications

By Sharon Kirkey, *National Post*, January 16, 2016

“Canada’s anesthesiologists, doctors who work every day with some of the drugs commonly used in euthanasia and assisted suicide, are warning hastened death may not always result in a peaceful exit. They say patients could experience convulsions, or a longer-than-expected “time to death,” or “awakenings” while the fatal cocktail of drugs take effect.”

<http://news.nationalpost.com/news/canada/death-not-simple>