

Canada's immoral solution to spiralling health-care costs – kill the patients

by Conrad Black



Last week I touched upon the fact that while the health-care system is essentially intended to preserve and extend life, it is so inadequately funded, and set up in a manner that is so impossible to operate satisfactorily without incurring unsustainable costs, that assisted death has now been tightly integrated into the system. Since wait lists are notorious and health care is in fact already rationed, and the greatest single challenge to our health-care budget and personnel are the elderly, the economics of socialized medicine has created intense pressure for elderly people and their families to acquiesce, under the theory that assisted dying is death with dignity.

In this view, the way to provide the highest-quality health care for the largest possible number of people is to evangelize the elderly and infirm on the virtues of an early passage to the hereafter, in order to free up space and personnel for patients with a greater useful life expectancy. Because of the extreme delicacy of this subject, it is impossible to know to what extent the elderly receiving care are hastened into palliative care and then accelerated into the assisted achievement of mortal dignity. The rationalization of this informal practice is that it enables the health-care system to conform more closely with its budget, to achieve more positive outcomes by focusing on patients with a more hopeful future and the whole transfer of attention is papered over with ever more elaborate laudations of the virtues of an expedited precipitation into eternity.

Some of the views expressed in this column are, with the author's permission, derived from an extremely well-researched paper on the subject by Susan K. Riggs of the University of Toronto. She makes the point that in 2020, around 80 per cent of Canadian COVID deaths were of senior citizens living in long-term care homes, compared to around 30 per cent in the United States. She also argues that socialized medicine focuses greater attention on basic care and reduced commitments to medical research, with the result that Canada has a very limited ability to devise new treatments and to manufacture its own vaccines. This problem was severely compounded in the COVID-19 emergency by our early attempt to partner with China in the development of a coronavirus vaccine. The gradual infiltration of induced death into a supposedly legitimate function of health care is largely the work of the federal government's medical assistance in dying law, which is aided and abetted by an extensive alliance of organizations that promote euthanasia. And it was precipitated by the evolution of Canada's official judicial attitude toward assisted dying.

In its 1993 decision in the case of *Rodriguez v. British Columbia*, the Supreme Court of Canada upheld the prohibition against assisted dying; but in 2014, in *Carter v. Canada*, a case on essentially the same subject, Riggs explains that the Supreme Court "reconfigured" its reasoning in the *Rodriguez* case by declining to allow a "pro-life majority to oppress a pro-death minority." Where in 1993 the court had recognized that a patient who wished to die was being legally restricted by the defined public good, this was now deemed to be an "overbreadth." The court said there had been "changes in the social and factual landscape over the past 20 years," and declared that the *Rodriguez* decision "did not address the right to life." This was unrigorous because that was precisely what the court had addressed.

The court invoked the assisted death law in Oregon without pointing out that Oregon required that for someone to be eligible for assisted death, that person had to suffer from a terminal illness that was professionally expected to bring death within six months. Yet our Supreme Court ultimately ruled that the Criminal Code prohibitions on assisted dying, "insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering," were unconstitutional. The court pitched the previous Canadian concern about a "slippery slope," the gradual dilution of any notion of the sanctity of life into the facilitation of induced accelerated death: the retreat of palliative care into a notion of humanitarian homicide. In an extraordinary act of casuistry, the Supreme Court found the right to die was implicitly included in the Canadian Charter of Rights and Freedoms' guarantee of the right to "life, liberty and security of person." To round out this acrobatic reasoning, the court maintained that disallowing physician-assisted killing would be a deprivation of life because the individual in question might otherwise do away with himself earlier, and unassisted.

n 2014, the Toronto Star published an investigation into Ontario's Consent and Capacity Board, a quasi-judicial board with the authority to make life-or-death decisions on the fate of incapacitated patients, at that time mainly whether to keep them on life support, even over the objections of families. It took these matters away from the courts and acted on request of the doctors, and the Star found that it sided with the physicians in 84 per cent of cases. The Supreme Court explicitly upheld this authority and this method of determining such life-and-death questions.

In 2005, in *Chaoulli v. Quebec*, the Supreme Court purported to require "timely health care" and made the useful point that "access to a waiting list is not access to health care." This was a commendable insight, but the result of this case was to create chaos in the Quebec health-care system. In the 2014 Carter case, the Supreme Court did a complete back flip by finding that when the state approved killing a patient, it saves the patient the chore of killing himself earlier and attempted to make something out of the theory that whether by assisted or unassisted suicide or natural death, the "right to life ... was only engaged by the threat of death," and that the state's refusal to kill patients represents a threat to life: "It is therefore established that the prohibition of assisted physician death deprives some individuals of life." Riggs aptly writes: "Smoothly running health-care systems do not spontaneously pole-vault across the Rubicon to divest of excessive patient population."

The latest step in this sequence was Bill C-7, passed in March of this year, which removes the 10-day wait period for those whose death is reasonably foreseeable and allows those with a much broader range of ailments, who are not facing an immediate risk of death, to access the service.

Space does not allow remotely adequate discussion of the many issues this subject raises. But when a health-care system is insolvent and inadequate, that fact should be admitted and

addressed by comprehensive reforms. Encouraging large numbers of people to consent to die prematurely will neither save the health-care system, nor seriously address the profound philosophical and practical implications of vastly increasing the number of unnatural deaths. I believe that assisted dying is sometimes appropriate and a right of the individual involved. But the ennobling and promotion of a vast increase in the numbers of suicides in the guise of health-care reform is a fraud, a secular and ecclesiastical heresy and, in many cases, arguably a crime.

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