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Canadian Journal of Bioethics
Revue canadienne de bioéthique

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

The Moral Dissociation Curve, Blind Spots and Prescribing Death in Canada

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Volume 7, Number 4, 2024

URI: https://id.erudit.org/iderudit/1114969ar
DOI: https://doi.org/10.7202/1114969ar

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Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

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Cite this document

Sams II, R. W. (2024). The Moral Dissociation Curve, Blind Spots and Prescribing Death in Canada. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *7*(4), 125–130. https://doi.org/10.7202/1114969ar

Article abstract

Provider assisted death is becoming a leading cause of death in Canada since the passage of Medical Assistance in Dying (MAiD) legislation in 2016. What was to be exceptional has now become common; some are calling for it to be expected. Increasing numbers of patients with chronic, non-terminal conditions are being euthanized. Healthcare personnel are now approving and offering MAiD to vulnerable patients who are depressed, disabled, chronically ill or impoverished. This paper presents a rationale from a transcendent moral law perspective, traditionally called natural law, for why Canada now has the most liberal euthanasia regime in the world. The act of euthanasia requires the provider to willfully end the life of the patient by administering a lethal substance. This violates the transcendent moral law, do not kill. Once a culture willfully rejects this fundamental law and embraces a utilitarian ethic devoid of any principle except the notion of autonomy, it is inevitable that the practice will lead to ethical ambiguity and uncertainty. As the practice persists and becomes the norm, moral blindness develops which leads to gross abuses to human beings. I present an ethical diagram, the Moral Dissociation Curve, that depicts the reason for the trends unfolding in Canada. The Canadian healthcare system must re-affirm the principles of the Hippocratic Ethic and the inherent dignity of their patients. Those in healthcare need to prioritize high quality, compassionate, palliative care and say “no” to willfully ending the lives of suffering patients. In so doing, moral clarity will be re-gained, and society’s most vulnerable will be protected.

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Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

RW Sams II. *Can J Bioeth / Rev Can Bioeth.* 2024;7(4):125-130

TÉMOIGNAGE / PERSPECTIVE

The Moral Dissociation Curve, Blind Spots and Prescribing Death in Canada

Richard W Sams II[a,b]

Résumé

La mort assistée par un prestataire est en passe de devenir l'une des principales causes de décès au Canada depuis l'adoption de la loi sur l'aide médicale à mourir (AMM) en 2016. Ce qui devait être exceptionnel est devenu courant; certains demandent qu'on s'y attende. De plus en plus de patients atteints de maladies chroniques non terminales sont euthanasiés. Le personnel de santé approuve et propose désormais des MAiD aux patients vulnérables qui sont dépressifs, handicapés, atteints d'une maladie chronique ou appauvris. Cet article présente une justification du point de vue de la loi morale transcendante, traditionnellement appelée loi naturelle, pour expliquer pourquoi le Canada a maintenant le régime d'euthanasie le plus libéral au monde. L'acte d'euthanasie exige que le prestataire mette délibérément fin à la vie du patient en lui administrant une substance mortelle. Cette pratique est contraire à la loi morale transcendante : ne pas tuer. Dès lors qu'une culture rejette délibérément cette loi fondamentale et adopte une éthique utilitaire dépourvue de tout principe, à l'exception de la notion d'autonomie, il est inévitable que cette pratique entraîne une ambiguïté et une incertitude éthique. Au fur et à mesure que la pratique persiste et devient la norme, l'aveuglement moral se développe et conduit à des abus flagrants sur les êtres humains. Je présente un diagramme éthique, la courbe de dissociation morale, qui illustre la raison des tendances observées au Canada. Le système de santé canadien doit réaffirmer les principes de l'éthique hippocratique et la dignité inhérente de ses patients. Les professionnels de la santé doivent donner la priorité aux soins palliatifs de haute qualité, empreints de compassion, et dire « non » à l'idée de mettre délibérément fin à la vie de patients souffrants. Ce faisant, la clarté morale sera retrouvée et les plus vulnérables de la société seront protégés.

Mots-clés

assistance médicale à mourir, suicide assisté, euthanasie, éthique, soins palliatifs, loi morale transcendante

Abstract

Provider assisted death is becoming a leading cause of death in Canada since the passage of Medical Assistance in Dying (MAiD) legislation in 2016. What was to be exceptional has now become common; some are calling for it to be expected. Increasing numbers of patients with chronic, non-terminal conditions are being euthanized. Healthcare personnel are now approving and offering MAiD to vulnerable patients who are depressed, disabled, chronically ill or impoverished. This paper presents a rationale from a transcendent moral law perspective, traditionally called natural law, for why Canada now has the most liberal euthanasia regime in the world. The act of euthanasia requires the provider to willfully end the life of the patient by administering a lethal substance. This violates the transcendent moral law, do not kill. Once a culture willfully rejects this fundamental law and embraces a utilitarian ethic devoid of any principle except the notion of autonomy, it is inevitable that the practice will lead to ethical ambiguity and uncertainty. As the practice persists and becomes the norm, moral blindness develops which leads to gross abuses to human beings. I present an ethical diagram, the Moral Dissociation Curve, that depicts the reason for the trends unfolding in Canada. The Canadian healthcare system must re-affirm the principles of the Hippocratic Ethic and the inherent dignity of their patients. Those in healthcare need to prioritize high quality, compassionate, palliative care and say "no" to willfully ending the lives of suffering patients. In so doing, moral clarity will be re-gained, and society's most vulnerable will be protected.

Keywords

medical assistance in dying, assisted suicide, euthanasia, ethics, palliative care, transcendent moral law

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Have you ever experienced a moral blind spot in your life? Most humans who have lived long enough to make serious relational mistakes will admit the same. We violate some basic law of human decency like fairness, kindness, or honesty; we ignore the virtue of fidelity; we trample on the vulnerable for selfish gain; or we cheat to get ahead. Someone points out our error, and we vigorously defend ourselves, only later to discover we were going in the wrong direction. Entire cultures can develop ethical blind spots (1). For example, in the United States, white Americans violated the inherent dignity of entire groups of people with black or brown skin for hundreds of years. The cultural pathos of white supremacy resulted in the horrors of slavery for millions of Africans, and a destructive civil war. For one hundred years following the civil war, pernicious laws stripped basic rights and freedoms from people of color and perpetrated death and oppression upon thousands of blacks through lynching and other acts of violence. It took the non-violent protests of the civil rights movement in the 1950's and 1960's lead by Dr. Martin Luther King Jr. to raise the consciousness of the US to begin to regain moral clarity. These blind spots still persist among some in our country, and they are blind spots we still regularly think, write, and make movies about (2,3).

A blind spot is developing in some Western nations, including parts of the US, and it recently has enveloped Canada. Provider assisted death in the form of assisted suicide or euthanasia was considered morally illicit for more than 2,400 years in medicine but is now becoming acceptable by some (4). As a family physician who has practiced for 29 years, I care for suffering patients daily. As one who cares for the aged, chronically ill, and infirm, and who teaches geriatrics, ethics, palliative and end of life

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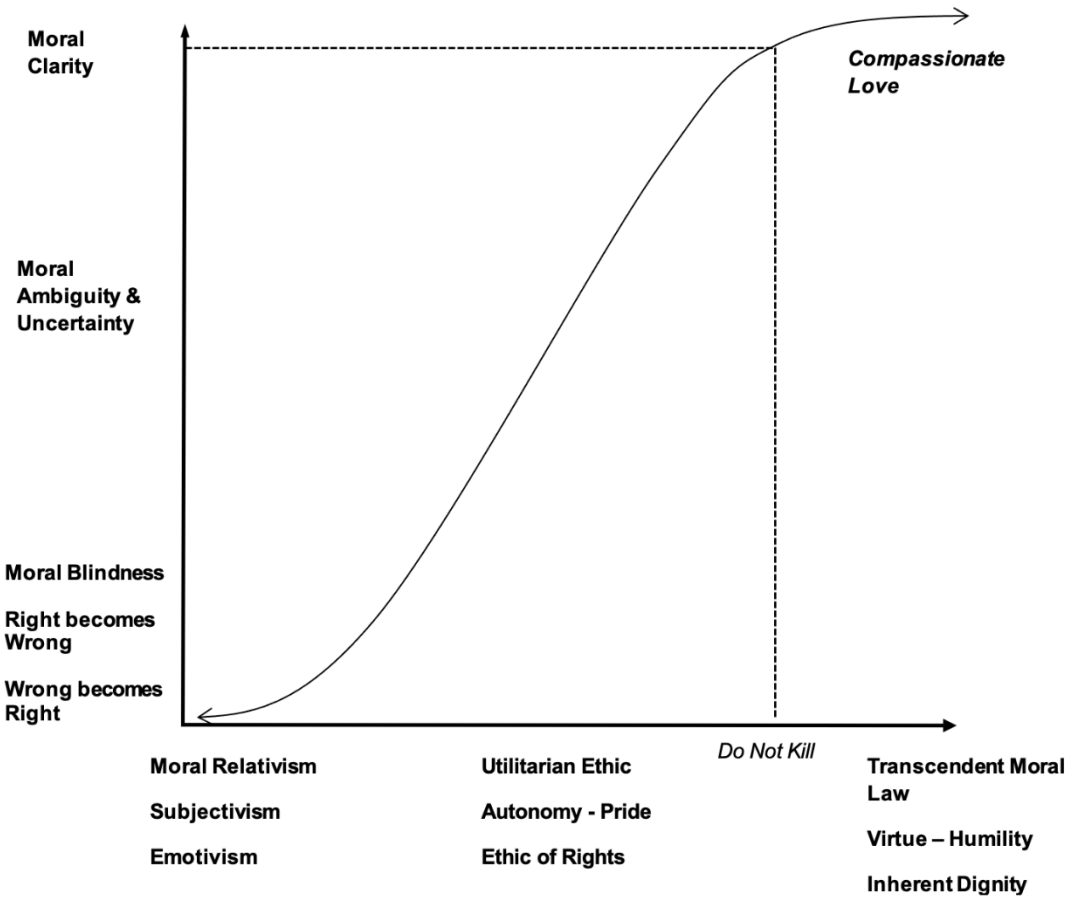
ISSN 2561-4665

care, I believe the West is at a crossroads as to how we will care for the aging and infirm populations of our graying nations. Canada has decidedly gone in a particular direction, fully embracing euthanasia as a means of dealing with human suffering under the rubric of autonomy. Since the passage of Medical Assistance in Dying (MAiD) legislation in 2016, 99.9% of all cases of assisted death in Canada occur by euthanasia: the provider administers a lethal substance to the patient resulting in death (4). In the US, we remain ambivalent. Provider assisted death is illegal in 80% of the states, and where it is legal, it is only for those with a terminal illness and the provider writes a prescription, traditionally known as assisted suicide (5).

I will provide a reflection on what is unfolding from a transcendent moral law perspective, historically described as natural law (6-9). I believe we are violating a fundamental moral law when, as providers, we willfully terminate our patients' lives. I contend that when so doing, we descend what I call the moral dissociation curve and wrongly justify unethical behaviors. If left unchecked and wholly embraced, the practice negatively affects the whole society. Ultimately if continued, the society will descend into moral confusion then moral blindness, resulting in gross abuses to human beings. See Figure 1.

Figure 1. Moral Dissociation Curve



The moral dissociation curve (MDC) serves as a bridge between meta-ethical theory, applied ethics, and their relationship to moral clarity on a given issue. It reflects an *a priori* commitment to the presence of transcendent moral law (TML) to include universal moral laws and virtues. CS Lewis provided the best-known defense of TML in his book *The Abolition of Man.* He calls TML the *Tao* and demonstrates that consistent fundamental moral values, virtues, and laws have been present in independent civilizations throughout human history (9). The TML relevant to the present issue is *do not kill.* The corollary moral principle for physicians and other healthcare providers is, do not intentionally end patients' lives (10). The Hippocratic Ethic first recognized this principle over 2,400 years ago. It sprang from the metaphysical commitments of the Pythagoreans (8). Such a commitment is contingent upon the humble recognition that there are universal moral laws in the universe that are not devised by humans. I am not the final source of the moral law. We are not the final word, nor is the state. Such laws are recognized by intuition with the eyes of our hearts. In the words of Maritain, they are connatural (7). Some argue that they are not universal because all people at all times have not recognized them. Maritain retorts that just because someone does not understand that 2+2 = 4 does not negate its universal truth (7). This is evident because certain actions in certain times have been legal in the eyes of human law, such as slavery or restricting women's right to vote, but were later intuited as unethical. Such laws violated the fundamental moral law that all humans are equal in the eyes of God and therefore deserve equal rights. TML is analogous to the physical law of gravity which is always present in all places. It is not something we devised. If people choose to violate this physical law, they do so at their own peril. From a transcendent moral law perspective, if a culture willfully violates or rejects a particular TML, it eventually does so at the culture's peril, and most commonly at the cost of the vulnerable.

The MDC reflects that if we reject this universal moral law and become “our own legislators,” in the words of Kant, and set up autonomy (*auto* = self, *nomos* = law) as the first principle, moral ambiguity develops (11). Typically, those who emphasize autonomy as the principal guide in ethical reflection hearken back to moral principles derived from TML yet deny their transcendent nature. A utilitarian ethic is used to justify what was once thought to be morally reprehensible. The further we depart from universal moral laws and virtues, the more we lose moral clarity. Any “rights” devised by persons or the state not contingent upon universal moral laws are nothing more than the whims of those declaring these rights. As the eyes of our hearts turn away from TML, our moral vision dims. If as a culture we descend into nihilism and completely reject universal moral law or any of its corollary principles, we are left with right and wrong determined by the loudest voice, the majority vote or the strongest arm. What is right or good becomes purely subjective, guided only by emotion and impulse. In such a state of affairs, we should not be surprised when we become numb to other abuses such as torture, human trafficking, infanticide and genocide. In the case of provider assisted death, we begin to see the disabled, mentally ill, and the vulnerable as expendable.

In the seven years since Canada legalized MAiD, there has been a dramatic acceptance of the practice by many providers and patients. Canada’s 4th Annual Report for the year 2022 reported there were over 13,000 patients euthanized, accounting for 4% of all deaths in Canada (4). The Head of the Commission for Medical Aid in Dying in the province of Quebec reported in November 2023 that his province was on track for 7% of all deaths to be the result of euthanasia (12). This would make euthanasia the third leading cause of death in Canada with the highest incidence of any type of provider assisted death in the world. Recent projections anticipate this will increase to 10.5% (13). Without any type of concrete terminal diagnostic criteria, providers are euthanizing an increasing number of patients with chronic, non-terminal conditions (5). For example, one of the more common conditions in those requesting MAiD whose death is not in the “foreseeable future” is fibromyalgia, a functional disorder without evident pathology, tightly associated with mood disorders and adverse childhood experiences (14). The government was poised to officially open the door to euthanasia for patients suffering from mental illness. There was tremendous backlash from disability and indigenous groups that resulted in a delay until 2027. In response, the government did not declare “Perhaps we were mistaken,” but simply, “We’re not ready.” (15)

In the words of Quebec’s commissioner, euthanasia is no longer “an exceptional treatment but a treatment that has become very frequent.” He declared, “more and more of the cases are approaching limits of the law.” (12) Indeed, there are documented cases of patients suffering from depression, the despair of poverty or homelessness, or the lack of access to health services who are offered MAiD and euthanized. Disabled patients trying to access disability services are being offered MAiD instead of assistance in gaining necessary services (16-18). Recently, a Canadian in her twenties with no serious chronic disease except mild autism was granted a MAiD request with the help of a “MAID navigator.” Her father attempted to block the approval, but the Supreme Court declared inviolable the decision between a provider and their patient (19). Some bioethicists argue that it is more harmful to deny MAiD to citizens suffering from difficult socioeconomic issues than to allow it (20). Health policy experts and the Canadian government, using a calculating utilitarian ethic, are reporting that MAiD can save the cash-strapped Canadian health system over $100 million annually (21,22). An award-winning columnist brazenly argued that the aged and infirm should access MAiD to step out of the way for the younger generation (23).

How is it that physicians and society can construe euthanasia as therapy, a “treatment” where the doctor willfully takes the life of the patient with years or even decades of life remaining? The entrenched euphemism, MAiD, obscures the reality that people who are not dying in the proper sense of the word are being routinely euthanized (24). This euphemism, along with the advocacy group’s euphemistic name, Dying with Dignity, cloak the fact that its proponents are suggesting killing you, and they are encouraging you to take this course of action by vigorous government-lead advocacy for the process (25-27). How have we reached the point of choosing to end the lives of the vulnerable, the poor, the downtrodden and the chronically ill instead of trying to improve them? How is it that the “right to die” movement birthed by autonomy-based liberalism has morphed into a pragmatic duty to die for the unfit, aged and infirm (28)? When a government worker declares to a Veteran and a Paralympian seeking help that the requested assistance is not available, but she can offer MAiD, she is saying “We can’t help you, but we can kill you if you like.” (29) What was once considered a dystopian society in fictional literature is now considered the way things must be by some in Canada (30).

Legalization – even on a federal level – does not make assisted death right or ethical. In the words of Martin Luther King Jr., “there are two types of laws: there are just laws, and there are unjust laws. I would agree with St. Augustine that, ‘An unjust law is no law at all.’” (31) I contend that based on the transcendent moral law, do not kill, assisted death laws are unjust. The Hippocratic Ethic, which stood as inviolable for more than 2,400 years, drew a clear line in the sand that doctors must not kill. This Ethic protected vulnerable patients who already felt like a burden and were suffering under emotional and physical symptoms. This Ethic protected patients from an abuse of power in the setting of an asymmetric doctor-patient relationship. This Ethic declared never to suggest such an act to patients, intuitively recognizing that it implied to patients *their lives were not worth living* (8,32). When a woman who is depressed and already feeling bad about herself goes to get help and is offered MAID, it sends a clear message to the person that “You are not valued, and your life is not worth saving or helping.” (33) The fundamental moral principle that healthcare providers must not kill has been willfully rejected by those in government and in healthcare, those people traditionally charged with protection of the vulnerable. The continued widening of the criteria and the encouragement by some MAiD proponents for the suffering to accept MAID as their fate is similar in nature to the evolution of euthanasia in Germany in the early 1900’s, prior to the rise of National Socialism.

German physicians and legislators who were proponents of euthanasia at the end of the 19th and the beginning of the 20th centuries used the same language of compassion for unbearable suffering as justification for euthanizing of the infirm, the mentally ill, and the aged. The discourse was initially cloaked in the language of the patient wishing to die from unbearable suffering, consent of the sufferer, and an unmitigated right to die as the ruler of your own life (34). Once euthanasia was sanctioned by the state, a hard utilitarian ethic based on the functional value of the infirm and their cost to society broadened the scope and practice of the euthanasia regime, which was then embraced by the National Socialist Party. In the wake of German physicians killing their own citizens, Dr. Leo Alexander, a psychiatrist who worked with the prosecuting counsel of the Nuremburg trials declared,

> Whatever proportions these [medical] crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic to the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick (35).

By willfully rejecting the moral principle that providers must not kill, Canada has fully embraced a utilitarian ethic and decidedly crossed the line in the sand (10). Under the guise of patient choice, MAiD providers are deciding certain lives are not worth living and prescribing death as “therapy,” to cure human suffering. The MAiD assessors and providers declare that they are simply fulfilling the wishes of their autonomous patients who have a legal right to end their lives. Cofounder of the Canadian Association of MAiD Assessors and Providers (CAMAP), family physician Stefanie Green, stated that “I don’t see assisted dying as ending someone’s life; the underlying illness and suffering are doing that. I understand it more as facilitating someone’s wishes” (36). In reality, the assessor and providers must decide, is this patient suffering unbearably? Is their condition irremediable? It is evident from the literature and from some of the proponents’ own writings that there are no qualms authorizing a request or even suggesting MAiD for functional disorders such as fibromyalgia that historically would not be considered irremediable with unbearable suffering. Fibromyalgia is a condition that requires a therapeutic relationship with a skilled provider over time, addressing prior trauma and mood disorders and instituting a comprehensive treatment plan (14,37,38). Fibromyalgia sufferers do not need a facile MAiD assessment; they need a competent and compassionate physician. Also concerning is that many of the same physicians and practitioners who are the governing board of CAMAP are the leaders for the national advocacy group for MAiD (25,26). The providers vigorously advocating for MAiD are the same ones assessing patients and euthanizing patients. These are not physicians typically with a long-term relationship with the patient. These providers have a vested interest in supporting a request and even encouraging MAiD to suffering patients. The patient may make a request, but it is these same providers who ultimately decide if the patient lives or dies.

These rapidly unfolding events at a cultural level are a direct reflection of a descent down the MDC. Once a culture willfully and systemically violates a fundamental moral law, it is only a matter of time that it will descend the curve; first causing ambiguity and uncertainty of the consequences; then descending into moral confusion; and finally, comfortably justifying the illicit acts. A gaping ethical blind spot develops to acts once thought unthinkable which now occur before our very eyes (1). This is exactly what is happening in Canada. Leaders in healthcare and government have normalized the taking of life, justified by an autonomy-rights based ethic. What started as something to be an exceptional act has become common and is now becoming expected. Some MAiD providers believe it is their deontological obligation to provide MAiD to suffering patients. If the TML, do not kill, is true and not meant to be violated in healthcare, segments of Canadian culture have reached a point where right becomes wrong and wrong becomes right.

Sadly, family physicians are leading the charge, accounting for 68% of all providers euthanizing patients (5). Seven of the 19 clinician advisors at Dying with Dignity and 3 of the 13 of the leaders at CAMAP are family physicians (25,26). Family Medicine residencies offer MAiD training to their physician residents (39). One family physician who spent a career performing abortions has now turned her attention to the infirm and has personally euthanized over 400 patients, declaring it is the most rewarding thing she has done (40). Imagine that, vulnerable patient: killing patients is the most rewarding act your doctor believes they are doing. Imagine how such a physician views you, when you go to see them, feeling depressed, in pain or having trouble with your daily activities. Am I worthy to be helped or will the physician suggest MAiD? (33)

How can a culture turn back from what is quickly becoming the dark ages of healthcare, where the grave mistakes of history are being repeated? Sometimes if we desire progress, the first thing we must do is recognize that we have turned down the wrong road. In this case, the quickest way for true progress is to turn around, go back to the crossroads and go down the right road. It requires a humble recognition that “We are not all autonomous islands floating in a sea of humanity; we are highly influenced by each other and by cultural norms.” (41) Our autonomous choice to end our lives on our own terms sends ripple effects through our families and society. In the words of King, “In a real sense all of life is interrelated. All men are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.” (42) If my neighbor made the courageous decision to be euthanized, should I? (43) Perhaps I am too much a burden on others or society and I’m better off dead (29). Our participation in ending someone’s life negatively impacts how we as society view one another. Patients are no longer persons with inestimable worth and inherent dignity; the value of their lives

becomes inextricably tied to their functional status. We need to recognize the moral injunction, do not kill, stands as a safeguard for all of humanity against these base temptations (10). It keeps us on the high end of the moral dissociation curve.

Our suffering patients do not need physicians willing to take their lives. They don't simply need physicians who say no to provider assisted death. They need virtuous physicians, nurses and others in healthcare who are willing to walk alongside them in their suffering – the true meaning of compassion. If unable to cure, we seek to relieve symptoms and to care for the dying to the point of natural death. We cease the hubris of keeping patients alive beyond a timely death when they are "overmastered by their diseases, realizing that in such cases medicine is powerless," but allow nature to take its course and provide high quality palliative care to the patient and the family along the journey (44,45).

The virtues of medical care – presence, empathy, fidelity to the person, courage, wisdom, temperance, humility, and bedside grace – should guide and shape our actions to our suffering patients. These are tied together by compassionate love, which seeks the highest good for the patient (46-48). When a multidisciplinary team dedicated to person-centered care delivers this type of health care, patients and their families are genuinely grateful. In the words of Dame Cicely Saunders, founder of the hospice movement, and a staunch opponent to assisted suicide and euthanasia, we say to our patients "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die." (45)

Providers must re-affirm the Hippocratic Ethic in healthcare. As a profession we should stand firm in protecting the vulnerable through all stages of life, seeking the ultimate good for the patient with compassion and moral integrity, and say "No" to willfully ending our patients' lives (32). We should embrace high quality palliative care that lives out the vision "Where there is hope, there is life. It fills us with fresh courage and makes us strong again." (49,50) Let's support increasing healthcare dollars spent on access and implementation of palliative care, not assisted death, helping patients die at home and not in the hospital. This saves healthcare dollars and affirms life simultaneously (51,52). Colleagues, let us desist from prescribing death to our suffering patients. Let us instead strive to care for our patients in their time of suffering, seeking ways to assuage their struggles in life, and thereby re-ascend the moral dissociation curve and regain our moral clarity. Let us commit to injecting hope into their lives by providing high quality healthcare – not lethal substances.

Reçu/Received: 2/5/2024
Publié/Published: 2/12/2024

Remerciements
Mes patients souffrants qui sont mes plus grands professeurs.

Acknowledgements
My suffering patients who are my greatest teachers.

Conflits d'intérêts
Aucun à déclarer

Conflicts of Interest
None to declare

Édition/Editors: Hazar Haidar & Aliya Affdal

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