Controversial Policies and the Usefulness of Nonprofit, Private, and Public Sector Partnerships: Introducing an Assisted Suicide Service in Ontario

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Abstract

This article addresses whether a partnership between the public, non-profit, and private sectors represents a feasible solution for dealing with contentious and symbolic public policy issues in the provision of assisted suicide service in Ontario. The first section outlines key characteristics of mature and integrated relationships among the three sectors. The second determines the parameters of acceptable policy by exploring the intersection between economic drivers and public opinion on assisted suicide:the Ontario government is intent on reducing health care expenditures, while public opinion increasingly favours end-of-life options but is wary of state pressure upon individuals to choose an early death in order to save on costly medical interventions. The third section demonstrates how a trisectoral partnership could build a model of an assisted suicide policy and service in Ontario by incorporating design elements from the Dignitas Clinic in Switzerland. This model would reduce the intensity of public opposition and gain public confidence by providing citizens with robust end-of-life options and the assurances they require. Finally, the paper argues that trisectoral policy partnerships are an appealing means for dealing with controversial policies imbued with symbolic meaning.

Résumé

Cet article analyse la faisabilité d'un partenariat réunissant les secteurs public, sans but lucratif et privé dans le but de gérer les questions controversées et symboliques que soulève la mise en place d'un service de suicide assisté en Ontario. Dans un premier temps, nous présentons les principales caractéristiques des relations solides et intégrées qui existent entre ces trois secteurs. Puis, nous définissons les paramètres d'une politique acceptable. Pour cela, nous examinons le point de convergence entre les moteurs de l'économie et l'opinion publique sur le suicide assisté : le gouvernement de l'Ontario est résolu à réduire les dépenses de santé, tandis que l'opinion publique se montre de plus en plus favorable aux options de fin de vie, mais craint que l'État ne fasse pression sur les malades pour les inciter à choisir une mort prématurée et ainsi éviter des interventions médicales coûteuses. Nous nous appuyons ensuite sur la structure de l'établissement suisse Dignitas pour démontrer comment un partenariat entre les trois secteurs pourrait servir de modèle en vue d'une politique et d'un service de suicide assisté en Ontario. Un tel modèle permettrait d'atténuer l'opposition du public et d'accroître la confiance des citoyens, grâce à des options de fin de vie fiables assorties des garanties requises. Pour conclure, nous avançons que les partenariats entre les trois secteurs constituent un moyen intéressant de gérer les politiques à forte charge litigieuse et symbolique.

Introduction

Assisted suicide is a controversial and sensitive public policy issue because of its moral overtones.[1] Many groups approach the discussion of moral issues in the policy realm as a means of legitimising their own religious, ethical, or moral behaviour. They believe their view is correct and that they are helping others if they induce them to accept their standards. As a result, these areas of public policy are vested with symbolic importance. The danger of symbolic policy issues is that public opinion becomes polarised and entrenched, thereby making any movement on policy treacherous. Groups react vigorously if the proposed change is perceived to challenge or replace one set of values or way of life with another (Gusfield, 1970). If policy change is desired for practical reasons or because a majority desires it, then the issue must be transformed from symbolic to quiescent. This can be achieved by subjecting the issue to observation and systematic study, thus rendering it more instrumental and less contentious. At this point, perceptions of the nature of the issue and the means of handling it converge (Cobb & Elder, 1973; Edelman, 1980). Although hardline groups may still oppose any change, if the policy answer explicitly addresses their concerns this opposition will increasingly lie outside the public consensus and be less compelling to others. While this transformative policy process was originally observed to be effective in changing attitudes towards liquor consumption and prohibition, it applies equally well to moral issues like abortion, Sabbath laws, GLBT (gay, lesbian, bisexual and transsexual) rights and, most importantly here, assisted suicide. Groups with strong religious or ethical values and beliefs in the sanctity of life may have increasing reservations about the introduction of an assisted suicide policy, particularly at a time when secular values are seen as progressively governing policy choices.

This paper argues that a partnership among the public, non-profit, and private sectors in Ontario could offer a model for a policy on assisted suicide, transforming the currently symbolic and highly charged issue into a quiescent one. Public opinion on this issue is currently polarised but, as shown below, a majority of the population increasingly favours this policy change. However, as both Edelman (1980) and Gusfield (1970) have observed, when controversial policy issues are at stake, the state still lacks the legitimacy to act alone in introducing new policy, regardless of public opinion. If the state introduced an assisted suicide policy and service, for instance, it could be criticized for endorsing one set of values, or to be in conflict of interest with its mandate to protect life and provide a reasonably high standard of care for its citizens. The private sector cannot be given the lead on the issue given the general public antipathy to profiteering from death.[2] Although the nonprofit sector may be more trusted than the other two sectors, acting alone on the privatization of a key policy related to health and the symbolic nature of assisted suicide would be unacceptable. A partnership in obtaining the public policy goal of end-of-life treatment seems the most feasible means of transforming the issue from symbolic to quiescent, instrumental one provided that the partnership is subject to systematic scrutiny and public accountability, public fears and opposition are addressed in the operation of the partnership, the interests of each sector are acknowledged and constrained in the working

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[1] The author thanks Robert Young, Ian Gemmill, David Walker, Hugh Winsor, Sue Bedell, Chris and Ian Hendrie and the reviewers and editors of this journal for their astute comments on earlier versions of this article.

[2] While some private companies and individuals provide legitimate services involving death, the objection is to private companies or individuals deriving profits from causing someone's death directly. This is why laws in many jurisdictions prohibit euthanasia or murderers making profits from their actions by selling books, for example.

alliance, and the alliance is circumscribed by the parameters established by public opinion and tolerance.

Through three steps, this paper explores the feasibility of a trisectoral alliance in delivering end-of-life policy in Ontario and, by extension, other contentious or sensitive policy issues. In the first section, the nature of partnerships among nonprofit, public and private sector actors are explored in order to distill the critical ingredients of a successful joint policy initiative. The second examines the intersection of economic drivers and public opinion on assisted suicide to determine the parameters required for policy action involving end-of-life care. Based on the findings in these first two sections, the third proposes a possible model for delivering assisted suicide in Ontario through a trisectoral partnership. Although this model is original in design by advocating a trisectoral arrangement, some of the operational principles of such a clinic are derived from the Dignitas Clinic in Switzerland, which provides an assisted suicide service. Other jurisdictions including The Netherlands and Oregon have legislation allowing the practice of euthanasia and assisted suicide which may provide alternate models for an assisted suicide service and policy in Ontario; however, this paper presents a trisectoral partnership for the practice of assisted suicide as a means of meeting the parameters of an acceptable policy as determined by the state of public opinion in Canada and Ontario. The paper ends with reflections on the appropriateness of partnerships for resolving contentious policy problems, concluding that when a policy area is imbued with symbolic meaning then a partnership among the public, non-profit, and private sectors may be a means of allaying public concerns, thus optimising success for policy change.

Currently, assisted suicide is illegal in Canada but the legal barriers are beginning to fall. Sections 14 and 241 of the *Criminal Code of Canada* (1985) prohibit individuals from consenting "to have death inflicted" upon them, even with that person's consent and counselling (241(a)), aiding and abetting (241(b) a suicide whether the act succeeds or not. The penalty is imprisonment of up to 14 years. Other sections of the Criminal Code govern the act of assisted suicide indirectly. For example, section 245 states that anyone found administering or causing to be administered a noxious or destructive thing to another person with the intent to endanger the life of that person may be sentenced up to a maximum of 14 years imprisonment. A doctor prescribing drugs for the purpose of assisted suicide could be charged under this section even if the person desiring suicide took the final step of administering the drugs. On 15 June 2012, in a decision regarding a plaintiff's request for assisted suicide, Justice Lynn Smith of the British Columbia Supreme Court held that section 241 was overbroad in its absolute prohibition of assisted suicide under Sections 15 and 7 of the *Canadian Charter of Rights and Freedoms* on equality rights and the right to life, liberty, and security of person. Although Section 1 of the Charter allows reasonable limits to those rights, Justice Smith ruled that the Criminal Code provisions could not be saved and gave the federal government one year to change the Criminal Code. However, she did allow the plaintiff and her physician a constitutional exemption during that year, granting a doctor-assisted suicide under specified conditions. Justice Smith suggested that "a stringently limited, carefully monitored system of exceptions" to the prohibition of assisted suicide would suffice to remedy the law (Carter v. Canada (Attorney General) 2012). As Justice Smith indicated in that case, the Criminal Code would need to be amended if the policy of assisted suicide recommended here were to be adopted.

The legal and ethical issues involved in a policy of assisted suicide or euthanasia would need to be understood and resolved before the methodology outlined here could be adopted. The next stage in my research will be to address the legal question and, in a manner similar to Justice Smith, recommend that the federal government retain the Criminal Code prohibitions outlined above but add an exemption to those clauses that would permit legally sanctioned clinics to provide the service.[3] This solution would help ensure that the practice is carefully circumscribed and less subject to abuse than if these clauses were eliminated or substantially amended. Furthermore, with clinics as the service delivery vehicle, governments would be less directly seen as sanctioning and providing for suicide, and physicians outside this clinical system would not be under pressure to provide the service. The legal questions, like the ethics, of assisted suicide have been extensively debated elsewhere and will not be examined here (Downie, 2004, 2007; Somerville, 2001). Instead, this paper focuses on the practicality of using a trisectoral alliance to implement an assisted suicide policy.[4] For clarity, assisted suicide involves the intentional act of killing oneself with the help of another person, in contrast to euthanasia that is a deliberate act of ending another person's life (Tiedemann & Valiquet, 2008).

The Nature of Partnerships

State and non-state (such as organizations in the private and nonprofit sectors) relationships may assume a variety of forms, depending on the function that each might serve: financial arrangements, history, political culture, and social context. Relationships that are integrated and functional will result in the three sectors sharing decision-making authority and responsibility (Gidron, Kramer & Salamon, 1992; Phillips & Graham, 2000). These partnerships are characterised by consensual relations established between the three organizations to attain a shared policy objective that could not have been achieved through the activities of one sector acting alone (Amirkhanyan, 2008; Babiak & Thibault, 2009; Bryson, Crosby & Stone, 2006; Ferguson, 2004; Gazley, 2008).

Five key characteristics render these relationships viable and productive over the longer term. First, the partners must be relatively autonomous and respect each other. Each must bring its own strengths and interests to the relationship, including its own operating basis and values. The nonprofit sector should have an independent source of revenue to ensure it is not compromised or dependent (Brock & Webb, 2006). The different values and interests of independent partners lead to a creative tension, where each player serves as a "watchdog" or "check and balance" on the others. With three interdependent and reputable partners, the opportunities for collusion and privileging interests of the triumvirate over the public good are reduced; this in contract to dual partnerships where collusion is more likely to occur (Webb, 2005). Mutual respect helps avoid behaviours that undermine the alliance or its policy objectives (Babiak & Thibault, 2009; Gazley, 2008; Ghobadian, Gallear, O'Regan, & Viney, 2004).

Second, collective and individual lines of responsibility and accountability are well-defined and maintained in mature and integrated alliances. These relationships will involve multiple centres of authority to be responsible for individual and joint actions, as predetermined by mutually defined institutional arrangements, rules, and procedures. The state does not abdicate authority or responsibility to less accountable or democratic institutions (Amirkhanyan, 2008; Webb, 2005). Instead, it shares authority and responsibility based on the respective strengths of the partners while extending principles of accountability, transparency, and democratic governance to those actors (Ferguson, 2004; Gazley & Brudney, 2007). Similarly,

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[3] At the time of publication, the proposed paper addressing the legal aspect of assisted suicide is being written and will be submitted to another journal.

[4] The recommendations here could apply to an euthanasia policy as well.

the private and nonprofit actors are liable for their own actions. Collectively, however, the partners share responsibility for the overall functioning of the alliance. Systematic, not random, efforts guide the principled collaboration.

Ultimately, policy-based relationships forged among state, non-profit, and private organizations are sustainable when each accepts responsibility for its role but where each may also pursue its own interests modified by those of the others. By heeding their role as representative of the public interest, nonprofit partners must guard against over-commercialization which would erode their legitimacy, alienate donors and volunteers, and neglect the needs of clients. Private sector actors cannot elevate social concerns over profits without risking losses to shareholders and customers and thus threatening their own existence (Sagawa & Segal, 2000). Governments develop better policy based on the feedback from partners and achieve more efficient service delivery in the interest of the public good (Gazley & Brudney, 2007). Only by identifying their self-interests and primary obligations and then finding a means of pursuing those interests in common pursuit of a policy goal, can the three sectors form sustainable alliances that serve the public.

Fourth, partnerships must promote a common interest that serves the partners and the public good. This involves defining the objectives of the partnership and communicating these goals to their organizations and beyond. Partners will continue to seek new opportunities and value in the relationship, contribute to and benefit from the partnership in appropriate ways, identify internal champions of the relationship, and subject their activities to periodic reviews, termination, or renewal, as needed (Sagawa & Segal, 2000). Regular performance-based measurement that clearly articulates the "public purpose" inherent in the relationship is important (Amirkhanyan, 2008; Bryson et al., 2006; Scott, 2002).

Finally, leadership is paramount to stable partnerships. In recent years, leaders within the three sectors have moved to a more transactional style where the modus operandi is positioning one's organization, obtaining maximum benefits, and terminating relationships not immediately serving one's interests. This style of leadership can prevent organizations from engaging in alliances that may incur short-term costs only to maximize longer-term benefits (Reich, 2001). Partnerships are best served by leaders who share a vision that facilitates public policy objectives, work cooperatively and compromise to achieve the objectives, appreciate the strengths and limitations of the partners in the alliance, and communicate decisions effectively. Insecure, jealous, or inarticulate leaders will fail to build the trust and understanding that mature and integrated partnerships require.

In sum, successful relationships among the three sectors require strong leaders, mutual respect among autonomous partners, cooperation and compromise, and clearly articulated public policy objectives that build upon the interests and strengths of the partners. Partners must contribute to and benefit from the shared activity and actively accept responsibility for both their role in the alliance and the shared functioning and outcomes of the alliance. Regular review of the relationship and outcomes will ensure the partnership stays the course. These features of partnerships are useful for understanding how an alliance among the public, private, and nonprofit sectors can be an effective means of handling contentious policy issues like assisted suicide.

Determining the Policy Parameters for Assisted Suicide in Ontario

There are three main drivers for the introduction of an assisted suicide policy and service in Ontario. First, the Ontario government is struggling to constrain its growing deficits, and debt and public healthcare costs are a rising portion of the provincial GDP. The current model of healthcare delivery that is primarily publicly funded is increasingly being questioned. At the same time, the option of intersectoral partnerships to deliver services is being considered more seriously. Second, under the current healthcare model, the aging demographic in Ontario is driving healthcare costs to unsustainable levels, where the majority of these costs are incurred during the last year of life. Third, Canadian public opinion is shifting, indicating a greater receptivity to the idea of assisted suicide under certain conditions.

This section discusses public opinion on assisted suicide in relation to healthcare costs. The next section goes on to demonstrate how an intersectoral partnership embodying the values of integrated relationships provides a practical means for successfully introducing this contentious policy in Ontario, while meeting the constraints imposed by public opinion and the economic realities of healthcare.

Two arguments are particularly important when considering the rising healthcare cost structure in relation to the question of assisted suicide. First, the proposition that aging populations will cause publicly funded healthcare costs to reach unsustainable levels in Canada and Ontario like most western democracies, is generally accepted but misleading. Seshamani and Gray (2004b, 2004) demonstrate that age is a much less significant determinant of healthcare expenditures than proximity to death. Owing to healthier life style choices and better health management practices than previous generations, the aging baby boomer population is unlikely to cause costs to rise at the rates projected based on the choices and practices of previous generations, and the difference in expenditures between age groups is likely to decline. They observe that in the population aged 65 and older, 5% of patients in the last year of life generate approximately 50% of hospital stays for that group. Furthermore, findings for 2002 indicated that although people in the last year of life comprised 1% of the population, they consumed 28.9% of hospital expenditures. Like Seshamani and Gray, the Canadian Institute of Health Information (CIHI) study on *Health Care Cost Drivers* (2011) concludes that seniors are a diverse population, with those over 80 years old consuming a higher portion of the healthcare dollar because they are more likely to be in their final months and prone to chronic conditions. Research comparing end-of-life health care costs in Canada and the US documents that about a third of healthcare resources are expended in the last year of life and are not levelling off (Harding, 2010). These findings are replicated in a study of 22 OECD countries (Palangkaraya & Yong, 2009).

Thus, aging alone does not pose a problem to health care costs; rather, proximity to death is a more telling indicator of health care cost drivers. Patients with terminal illnesses or chronic health conditions in the last year, or even more noticeably, in the last six months of life, will consume a higher portion of health care resources, driving overall costs up. It follows that if individuals were given the freedom to choose their appointed time of death when diagnosed with a chronic or life-ending condition, they would be inclined to exercise that choice before reaching the maximum pain and discomfort levels requiring the most intensive and costliest medical and technological interventions. The associated reductions in required medical, palliative, or hospice care could result in savings in the publicly funded health care system.

A second driver of health care costs is controversial: suicide. A 2001 US study estimated 300,000 Americans per year survive suicide attempts, with the majority requiring emergency room treatment, 116,000 needing hospitalisation, and most being discharged alive after an average hospital stay of 10 days costing $15,000. The 17% of survivors who are permanently disabled cost approximately $127,000 per person per year (Stone, 2001). The World Health Organization (2008) estimates that the rate of suicide in Canada is slightly higher than in the US: 11.6 versus 11.1 for

every 100, 000 people in 2005. The 2008 CIHI and Ontario Trauma Registry Comparative Data Set (OTR CDS) estimated that 10% of in-patient costs in acute care facilities are due to injury. While the cost of a hospital stay averages $7,000 per day, the mean cost for injury victims averages $9,400.
The 2011 OTR CDS study of personal injury cases in 11 lead trauma centres in 14 Ontario communities in Ontario found that in 2009-10 of the 4,235 injury cases admitted to these centres, 89 (2.1%) were suicide or self-inflicted injuries requiring a 21 day mean length of stay. These incidents averaged 26 on the Injury Severity Scale (ISS) ranging from 1 (minor) to 75 (fatal) (CIHI, 2011b). Thus, these 89 self-inflicted injuries cost approximately $17,568,600 (89 x $9,400 x 21). The Canadian Mental Health Centre Alberta (2011) estimated the cost of a suicidal death to be between $433,000 and $4,131,000 per individual depending on age, income, and effects on family; and the cost of attempted suicides between $33,000 and $308,000 per person depending on hospital treatments, rehabilitation, and support required and family disruption. During the 2011 debate on Bill C-300 An Act Respecting a Federal Framework for Suicide Prevention in the Parliament of Canada, Parliamentary Secretary (to the Minister of International Cooperation) Lois Brown estimated the economic cost for Canada at of approximately 3,600 suicides per year at $2.4 billion (Hansard, 2011). Although all of these figures must be taken with some scepticism since they are difficult to verify with precision, they do point to one simple fact: suicide and attempted suicides are costly in economic terms as well as personal and emotional ones.

An end-of-life clinic could potentially reduce the costs of suicide in two ways. First, in a brief to the United Kingdom Parliament, officials from the Swiss Dignitas clinic that provides an assisted suicide service argued that even “a slight reduction” in suicide attempts “would bring considerable relief” to the public economy as well as to first responders and families (Dignitas, 2004, p. 4). A more controlled and regulated avenue of exit in Canada would similarly provide this measure of relief to the publicly-funded healthcare economy. The second argument is even more compelling. From 1998 to 2010, Dignitas provided its assisted suicide services to 1,060 people but, more remarkably, over 80% of Dignitas members approved for an assisted suicide did not exercise the option. Why? Dignitas believes that by taking these requests for assisted suicide seriously, providing medical options and counselling specific to the individuals, and imparting the knowledge that they could end their lives humanely and with assistance, provided these individuals sufficient comfort to “allow the wish for death to recede” (Dignitas, 2010, p. 1). Assisted and attempted suicides are reduced simply by providing a safe and effective place for afflicted individuals to discuss their desire to end their lives without the stigma of mental illness, and by giving them back a measure of control over their lives. An assisted suicide clinic in Ontario could provide the same compassionate relief; reduce associated costs to the individuals, families, emergency workers, and the health care system; and offer some assurance to clinic opponents by encouraging the life option over suicide in a majority of cases.

Reduced expenditures on end of life care or suicide-related incidents could help offset rising healthcare costs to a moderate degree. Total spending on healthcare in Canada is projected at $200 billion in 2011. Over the past decade the public sector accounted for approximately 70% of this bill. Between 1998 and 2008, public sector spending on healthcare rose at a rate of 7.4%. Although this rate is slowing, the general trajectory is outstripping economic growth and is not sustainable. In 2009 health care spending peaked at 8.5% of GDP. It is currently forecast at 8.1% of GDP in 2011 (CIHI, 2011). Healthcare expenditures are not a problem if taxes increase, or if a larger portion of the public dollar is diverted from other areas such as education, social assistance, economic and cultural development, or if the private sector assumes a larger role in health care provision. Polls over the past decade have tended to show that while 66% of Canadians are amenable to new models of healthcare financing if a better level of health care results, less than half would favour increasing taxes to pay for health reforms including greater private sector involvement (Crowley, 2004). These constraints mean relief has to be found within the system and greater private sector involvement would need to be subject to strict public sector control.

Public attitudes are not inconsistent with the introduction of a policy of assisted suicide that would alleviate pressure on healthcare costs and involve the private sector. Between 15 and 22 September 2010, the Environics Research Group conducted a telephone survey of 2,025 adult Canadian yielding results with a margin of error of 2.2 percentage points, 19 out of 20 times. According to the survey results:

- After being told that euthanasia is illegal in Canada, over half strongly (21%) or somewhat (36%) support legalizing euthanasia while one–third are strongly (20%) or somewhat (13%) opposed;
- Approximately 60% strongly (22%) or somewhat (37%) support permitting a doctor or caregiver to euthanize a consenting person while one-third are strongly (20%) or somewhat (13%) opposed.

Respondents were more cautious when the question of healthcare costs was introduced:

- Almost two-thirds of Canadians are very (33%) or somewhat (30%) concerned that elderly people might feel pressured to agree to euthanasia to reduce health care costs if it were legalised while many are not very (16%) or not at all (19%) concerned. A majority of respondents in every region of Canada expressed concern.
- Almost 80% of Canadians are very (46%) or somewhat (32%) concerned that the sick, disabled, or elderly would be euthanized without their consent.
- Almost three-quarters of Canadians favour government investment in more and better palliative and hospice care (71%) over legalizing euthanasia (19%) for the terminally ill.

Similarly, an Angus Reid poll of 1,003 Canadians conducted in February 2010 with a margin of error of 3.1% found that 63% favour legalizing euthanasia, 81% believe euthanasia would give people an option for easing pain or suffering, and 72% believe legalization would provide doctors with clearer guidelines for end-of-life decisions. In contrast to the Environics results, less than half (42%) thought euthanasia would leave vulnerable people without sufficient legal protection for their lives and 33% thought it would imply that the lives of sick and vulnerable people are less valuable than of the healthy (Angus Reid, 2010, 2010b). In short, Canadians favour assisted suicide, provided that individual consent is freely given and not driven by economic costs and individuals have a real choice that does not impugn the quality of life of differently-abled people through the improvement of palliative and hospice care.

Another mirror of public opinion, neither measurable nor systematically documented, is that physician assisted suicide occurs in Canada every day. Patients refuse treatment or food and water to end to their lives which can result in a painful, drawn-out death. Family members make decisions to end treatment for a loved one. Physicians decide or consult family members on whether to remove life support and increase medication to the point that a loved one dies. Although these actions are illegal, few charges are ever laid (D'Orazio, 2010). While there are sensational legal cases where people have been charged or are petitioning for the right to end or sustain life, like the Robert Latimer, Sue Rodriguez, or more current Hassan Rasouli cases, most incidents of assisted suicide or euthanasia occur without legal action. Both practices are tolerated in Ontario and Canada but are without clear and consistent policy guidelines or regulations.

Therefore, while a clear majority of Canadians are receptive to legalizing euthanasia or assisted suicide for consenting adults, they are opposed to health care costs being used to facilitate or coerce consent from people. Rising health care costs may be a factor in the decision to legalise assisted suicide but it should not be a factor in individual decisions: that is, decreased pressure on health care costs may be an incidental benefit of legalizing direct or indirect suicide but no one should feel pressured into making a decision in order to save on publicly funded health care costs. A strong majority of Canadians desire improved palliative and hospice care as an alternative to early death but Canadians also want the option of ending their lives under certain conditions. Taken together, these opinions yield the result that Canadians favour clear and viable options for free and uncoerced end-of-life decisions. This support is contingent upon a system that not only protects but is also seen to protect individual choice. Further, opposition to assisted suicide is entrenched in moral grounds requiring careful policy action that diffuses the issue.

In sum, an assisted suicide service would need to ensure that: (1) individuals were not under pressure at any time to choose an early death; (2) the state interest in healthcare savings did not influence medical decisions to help a person in an early death; (3) individuals made their final choice by taking the final step themselves; (4) the other options for end-of-life care were strengthened for people not choosing assisted suicide; (5) the guidelines for any medical decisions leading to assisted suicide were clearly established and regularised; (6) the practice was clearly circumscribed by state laws with assisted suicide remaining illegal under conditions that had not been medically approved according to state defined criteria; (7) the state must be seen as neutral and providing multiple options to people nearing death; and, (8) counselling was available to anyone desiring an assisted suicide at the outset to determine if an alternative treatment might work instead. While some people might remain opposed to the policy and service, their views could be modified if an orderly and strictly regulated service that gives preference to other choices than suicide were introduced. Overall, in order to transform this controversial issue into one on which policy action is possible all the above conditions must be met. An assisted suicide policy based on a mature and integrated trisectoral partnership can achieve these objectives.

Partnering to Provide an Assisted Suicide Service in Ontario

This article began by explaining that if a service were to be provided by government or quasi-government agencies or within the publicly funded system of hospitals, the data showed that Canadians worry that public servants and medical practitioners might be influenced by economic and cost considerations to encourage patients to consent to an early death. Even if legal protections for patients existed, the perception that coercion, driven by health costs, might occur is damaging to the system and service provision. State interests especially in times of deficit reduction would be or appear to be in conflict with the general public interest. Further, the fundamental public policy function of providing for the safety and security of citizens clashes with direct state provision of an assisted suicide service. The state cannot risk being seen as the instrument of death but needs to be seen as an impartial regulator of the service. Second, the private sector cannot provide the service given public distaste for and legal sanctions against individuals and corporations profiting from early death, but can be instrumental in ensuring the service is provided in an efficient and cost-effective manner. Third, the nonprofit sector has more legitimacy than the state and private sector in acting altruistically and as the conscience in a partnership, but the perception lingers that one organization providing the service alone could be compromised by financial considerations. Even where strict guidelines and public scrutiny are in place, such as in Switzerland, allegations of financial impropriety and illegal actions of staff, although unproven, have impacted the Dignitas Clinic's reputation (Bingham, 2009; Dignitas, 2010; Sawer, 2009). The Clinic's independence from the state has also caused difficulties when changes to the guidelines and procedures have been made without adequate input from the service providers, again affecting the Clinic's reputation (Dignitas, 2010).[5] A well-structured trisectoral partnership could be used to avoid these problems of legitimacy and service provision that Dignitas has encountered and meet the public's concerns.

The discussion of mature and integrated partnerships among the three sectors emphasized the need for equality, respect, and clear lines of communication among the partners. To establish this relationship, the state should act in tandem with nonprofit and private sector actors in providing an assisted suicide service. At the apex would be a governing body comprising representatives from the government department with primary authority for the service (most likely Health) and the office of the Attorney General or Justice Department to handle legal questions, the nonprofit organization(s) mandated to provide the service, the medical and legal community who are not involved in provision of the service, the commercial interests involved in provision of the service, and the general public with identified expertise but who are not stakeholders or representatives of organised interests. This governing body would jointly recommend policy and procedural guidelines to the government, establish and review a fee schedule for the service, monitor operations including finances, and review any complaints arising, among other things. It would not be an investigative or policing authority but would have the power to review and refer complaints to the proper authorities for investigation. One of its primary functions would be to provide a forum where the policy and service provision could be discussed and any changes debated and informed by representatives from the different sectors to ensure evidence-based policy recommendations to the state are developed and practised. Conversely, partners would be responsible for ensuring that any changes in government policy or regulations were understood within their organization(s). This would provide for enlightened communication vertically and horizontally among the partners, avoiding policy confusion and service delivery problems. Publication of an annual report with statistics on the service including the financial operations would encourage transparency and buttress public support.

Well-functioning partnerships include clear lines of responsibility according to the roles, interests, and mandates of each partner. The state would retain authority for passing legislation and regulations governing the service, but one or more nonprofit(s) acting together with commercial interests would provide the actual service. Following a procedure similar to the one used by Dignitas, [6] the clinic staff (preferably screened volunteers) would receive and interview clients, ensure they meet any legally mandated requirements, refer them to medical and other experts specialising in their area of discomfort to determine if less drastic means could be found to alleviate the discomfort, make appointments with two physicians to assess medical eligibility, and oversee the process leading to the assisted suicide. To ensure consent, the last step would involve the patient administering the final act under medical supervision by pressing a button if physically able or by signalling for the button to be pressed if physically unable. As in the Dignitas model, all assisted suicides would be video-recorded with the video transferred to the police to ensure the procedure was consensual. Private sector organizations would supply pharmaceutical and other supplies, provide

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[5] In 2008, the Zurich cantonal physician mandated in 2008 that the drug NaP could not be prescribed after one physician consultation as had been the practice in assisted suicides but provided no rationale and no guidelines. After Dignitas responded by using helium in four cases with disturbing results, it began using NaP again but after consultations with two physicians to meet state concerns This lack of communication must be avoided here.

[6] For a detailed description of the process and procedures used by Dignitas, see Dignitas, 2004 and 2010 as well as the Dignitas website at www.Dignitas.ch. Accessed October and November 2011.

services such as body transportation, video production, funeral arrangements and cremation at set costs, and conduct the independent annual audit required by the governing body as part of the annual report. Primary responsibility for each activity would rest with the partner concerned who would be answerable to the governing body.

To maximise public trust and legitimacy in a partnership, the partners must be sufficiently empowered and independent to serve as mutual checks on the self-interest of each other. Self-interest can be partly maintained through well-structured financial arrangements in addition to good governance. Like Dignitas, the nonprofit organization(s) could collect a membership fee as well as a service fee, but with the difference being that both would be set and regularly reviewed by the joint governing body. The membership fee would help sustain the organization and provide it with an independent financial basis, but it would not be sufficient to cover its full operating costs.[7] Service fee rates should be set high enough for those who can afford the service to cover the operational costs including the contracted private sector services and to generate a surplus as a proportion of the actual costs. The surplus funds could be channelled in two directions: to subsidise those desiring the service but who are unable to afford it; and, to subsidise both palliative and hospice care. The former use of funds upholds the principle of accessibility enshrined in our public healthcare system and the principle of equality entrenched in the *Canadian Charter of Rights and Freedoms, 1982*. The latter addresses one of the key considerations raised by Canadians when polled on end-of-life options: that every individual has a genuine choice for which end-of-life care is personally preferred whether assisted suicide, palliative care, or hospice care. By directing these funds from within the partnership to the other two policy areas, the flow of funds is clearly traceable in a way that they would not be if the state were to act alone or if it were to tax a privately-provided service.[8] It also has the ancillary effect of signalling to the public that the state values life until natural death, thus providing government a buffer against criticisms from opponents to assisted suicide. Representation of each partner in the governing body and joint responsibility for policy recommendations combined with individual responsibility for service delivery means each partner has a vested interest in guarding against any ill-advised or illegitimate actions by the other partners. Healthy competition and cooperation is the result.

Strong leadership and clear expectations are critical to the partnership. In Switzerland, the state sets out policy criteria and guidelines but, unlike The Netherlands, allows the clinics latitude in applying them. Dignitas has developed standardised procedures. A critical component of its operation is that no one is obligated at any point to proceed with the service unless fully and freely desiring early death. The initial counselling and referral service is provided to anyone contacting the organization with no fee or obligation to become a member. At each stage in the process, consent is confirmed. If staff detects any coercion or indecision, then the process is halted. Once the two consulting physicians have approved the person for an assisted suicide, the person is given a provisional "green light" for an assisted suicide and all legal procedures are followed with the proper documents being secured and filed but the member is under no obligation to go through with the act. According to the Dignitas records, over 70% of members who request an assisted suicide and receive approval never contact the organization again and only 13% made final arrangements (Dignitas, 2004, 2010). Similar statistics would be maintained and publicised in the Ontario case to educate the

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[7] In the case of Dignitas, members who are clients pay a joining fee and an annual subscription fee as well as a service fee that can run between 7,000 and 10,000 British pounds (Exit, 2011).

[8] If the state were to act alone, perceptions could exist that state support for palliative and hospice care might be reduced by the amount of the subsidy from the assisted suicide service. A partnership renders visible funds obtained from the assisted suicide service and funds obtained from state coffers.

public about the life-saving benefits of the assisted suicide clinics and to promote acceptance of the service. Strong direction provided by the governing body would ensure that consent is provided at each stage of the service, individuals understand their options, and service providers follow procedures. The end result would be enhanced legitimacy and public trust in both the actors and the process attending assisted suicide in Ontario.

Conclusion

With the legal barriers to assisted suicide beginning to fall, there is an opportunity to begin thinking about innovative policy solutions. There is public support for introducing an assisted suicide service in Ontario and Canada. As the population ages and as medical technology to prolong life improves, the desire for more individual choice over end-of-life options will most likely continue to grow, especially given the baby boomer penchant for control in their lives. These choices include palliative and hospice care and assisted suicide. Public acceptance is likely to remain contingent upon the choice being genuine and uncoerced, the state not imposing one choice in the interests of cost-savings, no one profiteering from death, and clear guidelines and procedures being established to guide practitioners rather than the current ad hoc procedures. A trisectoral alliance under defined and well-regulated circumstance, as has been shown, can most meet these criteria for a service desired by the public.

Partnerships provide a means of navigating through contentious or sensitive policy issues as this model demonstrates, by offering clear guidelines, procedures, lines of accountability, and public scrutiny. The public interest is served by obtaining both a high-quality service that is monitored and reviewed by a governing body accountable to the public and more robust hospice and palliative care. The interests of the three sector partners are checked to ensure that serving the public good remains the primary focus. The state interest in controlling publicly funded health care costs is served by reduced expenditures of costly and futile treatments and on suicide attempts, introduction of an efficient service, and by the flow of funds from the service to other areas of end-of-life care while its incentive to encourage assisted suicide is curbed. Policy decisions, a responsibility the state retains, would be evidence-based and grounded on recommendations from the well-informed governing body. The nonprofit sector enhances its image by providing an increasingly desired service at arm's length from the state but also by engaging in a policy development role. The private sector profits responsibly from its role but contributes to the smooth functioning of the service. While there always will be strong opponents of euthanasia or assisted suicide, the recommended partnership and procedures offer clear safeguards, especially uncoerced consent, and guidelines for the service to secure the support of the majority of Canadians and to abate opposition. The key to sustaining a partnership on contentious policy issues is to ensure that realistic expectations are set and met and that all interests are served and contained at the same time. The model developed here for a trisectoral partnership for an assisted suicide policy and service achieves these objectives.

The key to successful implementation of policy issues imbued with moral and symbolic meaning is to transform them into quiescent ones. The first step is to ensure that public fears are confronted and minimised. A partnership can help in this capacity by ensuring the state acts on good information in making its decisions through communication with the partners; is seen as aloof and independent from, but attuned to the actual service, and thus able to correct any problems; is not perceived as serving its own interests, while remaining responsible. A carefully constructed alliance can ensure that the public knows that the policy and service are being monitored and clear guidelines are set. As Edelman cautioned, public opinion on contentious and symbolic policy issues becomes polarised and hardened if the population feels threatened, but moderated if the threat is clearly observable, subject to systematic study, and its handling addresses the main objections and fits with public preferences (1980; Cobb & Elder, 1973). A partnership that embraces the values of transparency (through regular reporting and annual public reports), strong leadership (through the tripartite body), and mutual respect and deterrents against abuse in the interest of the public good, can maximise the potential for success. A partnership like the one outlined here not only serves as a model for introduction of an assisted suicide policy and service in Ontario by addressing public desires and fears, it also offers a model for policy partnering successfully on contentious issues. By meeting public concerns over assisted suicide with a carefully constructed partnership with nonprofit and private actors, and maintaining strict legal and regulatory guidelines over the alliance, tensions surrounding the issue can be eased, thereby providing the state with room to act on a contentious issue. Partnerships can indeed provide the missing ingredient of legitimacy to act on contentious policy issues.

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