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NEWSLETTER OF THE NATIONAL ADVISORY COUNCIL ON AGING

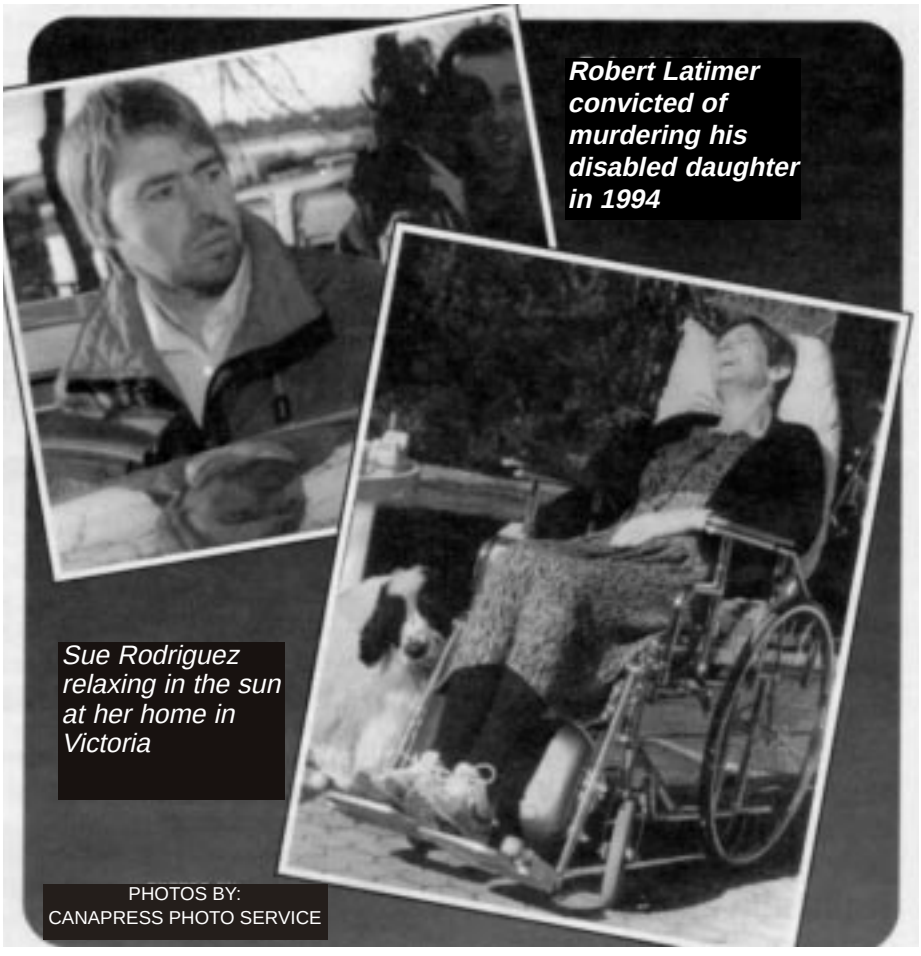
Member's Editorial

Choosing When and How to Die

Sue Rodriguez. Nancy B. Jack Kevorkian. These names evoke the strong emotions and ethical dilemmas brought to light when individual decisions about the time and manner of death become the subject of public debate. Tom Perry. Peter Graff. Scott Mataya. These names are much less familiar, but they too are part of history of Canada's response to the issues surrounding assisted suicide and euthanasia.

Against a background of long-standing ethical and legal arguments, public debate about individual rights, medical ethics and societal responsibility in matters of death and dying was intensified by Sue Rodriguez' court case and, after the Supreme Court of Canada decided against her request in a 5-4 ruling, by her physician-assisted death February 1994.

The issue could be decided ed by a free vote in the House of Commons- promised by Prime Minister Chrétien shortly after Sue Rodriguez' death possibly early in 1995. The content of a bill may be suggested by a Senate special committee now holding



Robert Latimer convicted of murdering his disabled daughter in 1994

Sue Rodriguez relaxing in the sun at her home in Victoria

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Canada

hearings on euthanasia and assisted suicide; its report is expected in early 1995.

These issues hold special significance for seniors. Although the most highly publicized cases in Canada to date have involved relatively young people, the fact remains that most people die at a later age. Do seniors with incurable diseases want the right to request a quick and painless end to suffering at the time and place of their choosing? Will the availability of euthanasia or assisted suicide create pressure on people with terminal illnesses to end their lives, perhaps to avoid burdening family or caregivers?

The National Advisory Council on Aging (NACA) has always upheld seniors' right to self determination and dignity until death. One of NACA's foremost concerns is that seniors have access to appropriate health care, including preventive, curative and palliative care, as warranted by the individual's condition and desires. NACA believes that no one should be subject to extraordinary life-saving measures against their will and that dying should occur with dignity and in the absence of pain. But owing to the complex and sensitive nature of the issues, NACA does not feel the debate has provided evidence sufficiently conclusive to recognize an individual's ethical or legal right to medically assisted suicide.

NACA's aim in this issue of *Expression* is to illuminate some of the issues surrounding euthanasia and assisted suicide, with the goal of encouraging reflection and informing personal positions in this highly charged debate.

Mary Ellen Torobin NACA Member Ontario

Euthanasia and Assisted Suicide: What They Mean

• **Euthanasia,** sometimes referred to as mercy killing, comes from Greek; its literal meaning is 'good death.' A distinction is often drawn between 'passive' and 'active' euthanasia:

• **Passive euthanasia** means withholding or ceasing treatment of someone who is ill or injured and not expected to recover, e.g., turning off life support systems and allowing a person to die 'naturally'.

• **Active euthanasia** means intervening actively to end a person's life, e.g., administering a lethal dose of sedatives to someone with a terminal illness. If performed with the consent of the person concerned, this is called 'voluntary euthanasia'.

• **Assisted suicide** involves providing the means for someone to commit suicide (e.g., prescription drugs), with or without direct participation in the event.

An important dimension in the decision to end life is that of consent. Those who favour legalizing active euthanasia or assisted suicide emphasize the importance of the patient's consent to any medical procedure and point to the need for safeguards to

ensure that consent is fully informed and freely given. The issue of consent also raises the question of how to protect against pressure—whether overt or subtle—from family, caregivers or society generally. Determining consent also becomes difficult in cases where the giving of consent is prevented by deterioration of a person's physical or intellectual faculties. In this instance, it has been suggested that advance medical directives or 'living wills' (written instructions specifying how intensively doctors should intervene in certain life threatening conditions) could be used as evidence of consent to life-terminating measures. However, issues such as the time elapsed since the directive was prepared or other extenuating circumstances make it difficult to ascertain consent for such an irreversible act.

A second dimension relates to whether and how the conditions for active euthanasia or assisted suicide should be established: should it be available to anyone at any time, or only in cases of terminal illness when death is imminent? What about terminal illness when death is not imminent? What about cases of chronic, debilitating diseases that, although they are not life threatening, do significantly diminish a person's quality of life? Should physical illness be the only justification, or should mental/emotional distress be considered? And who should take part in the decision?

Why the Controversy? Why Now?

Demographic change, advances in medicine, changes in societal values and the influence of advocacy groups—all have contributed to shifts in public opinion about whether individuals have the right to choose the time and manner of death.

People are living longer, multiplying their chances of seeing their quality of life eroded by frailty and disease as they age. At the same time, high-tech medicine offers the possibility of prolonging life-without necessarily improving the quality of life, and sometimes against the wishes of the person involved. For some, this raises questions about freedom of choice, personal autonomy and self-determination, values that have gained considerable currency in recent years. Similarly, many of those who have come to believe that the quality of life is at least as important as the length of life question the value or the morality of keeping people alive who would have died a 'natural death' in the absence of technology.

For others, using medical technology to prolong life raises difficult questions about whether the cost of treating long-lived but incurable conditions is justified, given that life-lengthening treatment does not always improve the quality of life and given the many other demands on our health care system.

Resolution of these issues has not been rendered any easier by social trends such as the decline in the influence of traditional religious values. In a society where virtually everyone shared the belief that only God gives life and only God can take it away, it would no doubt be easier to reach consensus. But such moral absolutism rarely holds sway in a country like Canada, where pluralism and diversity often call for lengthy public discussion, protracted negotiation and workable compromises in matters of public policy, particularly where an issue gives rise to strong opinions along a broad spectrum of views.

Reflecting changes in public attitudes several decades ago, suicide was decriminalized in Canada in 1972. Aiding and abetting a suicide remains a crime, leading some to ask whether it makes sense for society to allow suicide while prohibiting anyone from assisting in this perfectly legal act. Others point out that the time has come to review the law again in light of changes in medical practice having been passed before many of the current life-sustaining technologies were available and when palliative care was either unknown or in its infancy, the law no longer fits the medical reality.

Also instrumental in the formation of public attitudes toward euthanasia and assisted suicide have been the growth of death with dignity and right to die groups, court challenges by individuals seeking a death of their own choosing, and media accounts of the experience in other countries, notably the Netherlands. The advent of AIDS and publicity surrounding the assisted deaths of AIDS patients have been further factors in bringing euthanasia and assisted suicide to the top of the public agenda.

Health Professionals and the Law

The coroner and the B.C. college of physicians and surgeons conducted separate investigations of two cases involving Dr. Peter Graff, an intensive care physician, in which patients died after multiple injections of a painkiller and a sedative. Both investigations found that the doses greatly exceeded what was necessary to relieve the patients' pain and discomfort. The college found cause for serious criticism of the doctor 's actions, but it decided not to discipline him formally. The RCMP, which also investigated the deaths, decided against laying charges, primarily because both families refused to press charges and praised Graff for his compassionate care.

What Society Thinks

The tools available for measuring public attitudes about euthanasia and assisted suicide—mainly public opinion polls—offer only a crude idea of how this issue is affecting Canadian society. We do know that public opinion appears to have shifted in the past 20 years: 45% of Canadians surveyed in 1968 approved legalized mercy killing, while in 1992, 77% of those surveyed favoured voluntary euthanasia for terminally ill patients. The second survey also showed, however, that seniors were less inclined to favour voluntary euthanasia; 58% of those aged 65+ were in favour, compared to 78% of those in the 18-29 age group.

We do not know, however, what these figures really mean - do they reflect growing tolerance of something once considered taboo, greater value being attached to self-determination and personal autonomy, growing concern with the quality rather than the length of life, or increasing fear of losing control at the end of one's life in the face of invasive medical technology? Nor have we any way to compare these general attitudes with the attitudes of those actually facing a situation where euthanasia might be considered.

Information on the prevalence of euthanasia and assisted suicide is no more helpful. With only a handful of confirmed cases, the evidence is largely anecdotal. Given the current law prohibiting these acts, physicians and others (for example, family members) are understandably reluctant to speak publicly about their involvement in the death of a terminally ill patient or relative.

A 1993 survey of Canadian Medical Association (CMA) members—who constitute about 80% of the medical profession showed that just over 60% of doctors favour amending the *Criminal Code* to eliminate the provisions prohibiting physician assisted suicide. But in August 1994, CMA members voted by a margin of 93-74 to ban doctors' participation in euthanasia and physician-assisted suicide, despite a report from the CMA's ethics committee recommending that this remain a matter of conscience for individual doctors and proposing guidelines for practice should physician assisted suicide be legalized. The lack of unanimity within the profession parallels the lack of consensus in society.

Health Professionals and the Law

Scott Mataya, a Toronto nurse, was charged with first-degree murder following the death of a patient who was in an irreversible coma. The patient's wife had consented to discontinuing artificial life support, but when the ventilator was disconnected, the patient began to convulse and vomit. Mataya administered a lethal injection, without a doctor's authorization, and the patient died minutes later. Mataya was convicted of the lesser charge of administering a noxious substance, received a suspended sentence and was prohibited from ever practising nursing again.

What the Law Says... What Lawmakers are Thinking

The current debate is taking place against a background of ambiguity; the law is clear, but given the history of prosecutions, the law as it now stands may not be enforceable. Several cases where health professionals have contributed to hastening the death of terminally ill patients have become public knowledge in Canada (see boxes), but there have been no convictions on charges of aiding or abetting a suicide or other related provisions of the *Criminal Code.*

Suicide is not a crime, and competent individuals have the right to refuse life-sustaining medical treatment or to have that treatment stopped. The *Criminal Code* clearly prohibits euthanasia and assisted suicide, however, and the highest court in the land decided in September 1993 that Sue Rodriguez' right to life, liberty and security of the person did not include the right to choose when that life would end or to have a doctor help her exercise that

choice. The decision split the court 5-4, however, reflecting social divisions about how to reconcile the strongly held values of self determination and the sanctity of life.

At the same time, despite several opportunities, no Canadian health care worker has ever been prosecuted successfully under the euthanasia or assisted suicide provisions of the law (see boxes). Nor have there been any murder convictions for causing death by giving death-hastening painkillers or by terminating therapeutically useless treatment for a dying patient. This situation, along with mounting public debate on the issue, has prompted lawmakers to take another look at the law, which was last amended in 1972.

Among the earliest systematic studies was that of the Law Reform Commission in 1983, which recommended against decriminalizing euthanasia but proposed that palliative treatment intended to relieve suffering, even if it incidentally hastened death, be exempt from Criminal Code provisions on murder, negligent homicide, manslaughter and furthering suicide. More recently, the British Columbia Royal Commission on Health Care and Costs (1991) recommended changes in the *Criminal Code* to

- recognize the competent patient's right to refuse medical treatment or demand its cessation, either directly or through an appointed proxy
- remove a physician's legal obligation to administer therapeutically useless treatment when consent cannot be obtained
- allow terminally ill patients to request and receive fatal doses of pain medication and
- decriminalize aiding the suicide of a terminally ill person.

A House of Commons subcommittee has asked the minister of Justice to review the legal and philosophical issues surrounding assisted suicide, and several private members' bills have proposed amendments to the *Criminal Code* similar to those recommended by the Law Reform Commission and the B.C. Royal Commission. Those bills were defeated or died on the order paper, however, and no government legislation has been introduced, although the Prime Minister has promised a free vote on the issue. That opportunity may come sometime in 1995, after a Senate committee now studying the legal, social and ethical questions surrounding euthanasia and assisted suicide submits its report.

Health Professionals and the Law

The April 1993 edition of the *Canadian Medical Association Journal* recounts the case of Dr. Tom Perry Sr., a medical scientist who was in the final stages of a 9-year battle with prostate cancer. Choosing to remain at home, he had been cared for by his children—three doctors and two nurses—who took turns looking after him 24 hours a day. His family physician had prescribed morphine for pain, which the family administered.

Dr. Perry died shortly after his son, Dr. Tom Perry Jr., administered a shot of morphine. Discussing the event later with a journalist, Tom Perry Jr., then a member of the B.C. legislature, said, "If you asked me did it hasten the time of death, the answer is yes, it may have." Perry continued, "Or, alternatively, would the person have lived longer, the answer is yes, possibly, but [he] would have been in serious pain."

Following an uproar in the media and the legislature, an investigation by B.C.'s chief coroner found that Perry had done nothing wrong, and the provincial college of physicians and surgeons (the self regulating body for doctors) commended him for the care he provided.

Assisted Suicide: The Arguments For and Against

Advocates and opponents of decriminalizing assisted suicide offer moral, legal and practical reasons for their positions.

Public opinion favours decriminalizing assisted suicide, proponents argue. This is not a sufficient reason to change the law, opponents say; this fundamental issue must be decided on the basis of valid moral arguments, regardless of public opinion. Killing is always wrong, they say, and the sanctity of life is a higher-order moral principle than individual autonomy.

Advocates argue that respecting the wishes of a dying person is the right moral choice. The *Canadian Charter of Rights and Freedoms* protects liberty of choice and self-determination (despite the Supreme Court decision in the Rodriguez case). "If a person is of competent mind why shouldn't she have the right to choose the manner of her death?" Dr. Scott Wallace asks. "In the last few decades we have made some really dramatic strides in human rights, yet when a dying person wants some help from the medical

profession to ease the last days or weeks of ... life, this is denied by law." *[Canadian Medical Association* Journal *148:8 (1993), pp. 1363-66.]*

Opponents point out that improving a dying person's quality of life by meeting their physical, psychological, social and spiritual needs is the most appropriate way of showing compassion. Dr. Robert Twycross sees voluntary euthanasia and assisted suicide as "an extreme solution to a situation that demands a far more comprehensive and compassionate approach. The need is not for a change in the law but for a change of emphasis in medical education ... a greater realization by doctors of what can be done... to enable those with [terminal illnesses] to live better with their disease." *[Lecture to an International Conference on Voluntary Euthanasia and Suicide, 1980.]*

Others assert that compassion lies in complying with the wishes of someone who has asked for help in dying. As Russel Ogden has argued, "How one dies is part of life itself, and one should be able to exercise choice regarding this aspect of life. Often the knowledge that one has control of one's death leads to a greater feeling of control of one's life. A sense of control is essential to quality of life, especially when one is confronting death." *[Canadian Public Policy 20:1 (1994), p. 15.]*

Advocating a middle way between these views are Dr. Gabor Maté, a palliative care specialist, and Margaret Somerville, a biomedical ethicist. In his experience, Maté says, "a great deal of the desire to end one's life comes from a fear and anxiety about suffering. The fact is that the vast majority of patients don't have to suffer. The desire to hasten death expresses a fear of being out of control." *[Canadian Medical Association Journal 148:8 (1993), p. 1368.]*

Somerville adds that "Leaving people in pain is not only a human tragedy and contrary to the most fundamental concepts of human rights, it should be treated as at least legally actionable medical malpractice and possibly as a crime. Certainly to provide necessary pain relief treatment, even that which could shorten life, must not be seen as criminal .... Those who oppose euthanasia, but fail to take steps to ensure that adequate pain relief treatment is provided (or even worse, oppose this, if it could shorten life) do much to promote the case for euthanasia." [*Journal of Contemporary Health Law and Policy 9:1 (1993), pp. 13-14.1]*

Opponents of any change in the law often caution against creating a 'slippery slope', arguing that permitting assisted suicide will lead eventually to involuntary euthanasia. Testifying before the Senate committee, Winnipeg nurse Leona Chalmers said, "Human wisdom and integrity are not great enough to give us the right to decide when life should end. Death as a solution to pain and suffering slides very easily into the... ethic where certain people may feel obligated to opt for it because they feel a burden or less than human." In other words, those who are vulnerable emotionally fragile or socially marginalised people, for example, including seniors - may be pressured to request euthanasia against their will, and those who cannot express their wishes may see their fate decided by others. Advocates counter that adherence to strict guidelines can prevent abuses; examples would include the need for a court order giving permission for an assisted suicide, certification from a physician and a psychiatrist that the decision is free and voluntary, the presence of a physician at the suicide, and a requirement that the act causing death be that of the person seeking to die.

Proponents of decriminalization also argue that slippery slope arguments, while plausible, are not supported by the experience in the Netherlands, where voluntary euthanasia and assisted suicide are very infrequent (according to a report by the Dutch attorney general), despite official tolerance. Opponents argue that involuntary euthanasia is occurring in the Netherlands, however, pointing to other figures in the same report showing that half of all decisions to withhold or withdraw treatment were taken without the patient's consent; most of these cases involved elderly people.

Other arguments relate to the difficulty of enforcing the present law. Advocates of decriminalization are concerned that without the assisted suicide option, people may try to take their own lives by violent means in dehumanizing circumstances or may botch the attempt, leaving them worse off than before. In addition, assisted suicide would continue to occur, as it does now, in secret. Dr. Ted Boadway, a physician who opposed the CMA resolution, says that "The practice will be kept underground... and that doesn't serve anybody well." [*Toronto Star, August 17,*

1994, p. A3.] Recognizing that it exists and setting strict guidelines gives society more opportunities to control the practice and prevent abuse. Opponents argue, however, that the persistence of a crime is no reason for society to condone it any more than we condone other actions prohibited by the *Criminal Code.*

Suicide is legal, proponents of assisted suicide point out, and it does not make sense to make it illegal to help someone perform a legal act. Moreover, the constitutional right to life, liberty and security of the person includes the right to end one's own life. Suicide is not a right, opponents counter; removing suicide from the *Criminal Code* does not mean that society condones it, but that society recognizes that the law is not the appropriate vehicle for dealing with suicide or attempted suicide. Law enforcement agencies still intervene when they can to prevent people from harming themselves.

Advocates of change in the *Criminal Code* provisions on assisted suicide also contend that the law is discriminatory, in that people with disabilities face legal prohibitions on ending their own lives while able-bodied people do not. This aspect of the issue was exemplified by the Sue Rodriguez case. Opponents point out, however, that it is the disability, not the law, that prevents such a person from committing suicide.

Finally, advocates on both sides of the debate foresee profound implications for the doctor/patient relationship. Opponents of legalizing assisted suicide fear that the relationship between patients and health professionals could be poisoned if the professional comes to be seen as both healer and potential executioner.

"When the doctor comes to their bedside to give them a needle for their pain," says Dr. Robert Pankratz, patients won't know "whether it is to relieve their suffering or permanently put them out of their misery." [*Canadian Medical Association Journal* 148:8 (1993), p. 1366.] Another fear is that people in need of medical care, particularly seniors and people with disabilities, may become reluctant to seek medical help.

On the contrary, say the proponents, the relationship would be strengthened by the patient's knowledge that the professional is always acting as an advocate for the patient and that the patient retains the right to make the ultimate decision. After the vote on the CMA resolution Dr. Boadway observed, "The patient has primacy, but this resolution is saying that despite what the patient wants, doctors should not participate." [*Globe and Mail*, August 17, 1994, p. A3.] In addition, even if the law were changed, doctors would remain free to act according to their own conscience, not taking part in assisted suicide if they oppose it on moral or any other grounds.

What Are Society's Options?

Given the nature of the arguments for and against decriminalizing assisted suicide and the strong positions taken in the debate, the answer for society and its lawmakers may lie somewhere in the middle. There is no simple solution trying to implement one may lead to unwanted consequences. What options are available, then, and what might the results be?

Keeping the current provisions in the Criminal Code would affirm support for the sanctity of life as a higher principle than individual autonomy and would meet concerns about protecting the interests of the socially vulnerable, especially seniors. This position also accords with the position of a majority of Canadian seniors, as revealed by public opinion polling.

However, this approach would perpetuate the current situation the practice would continue covertly, to the potential detriment of patients, physicians and the patient/ physician relationship. In addition, given Canadians' attitudes, we may find that juries are reluctant to convict people charged with these offences or are willing to convict them only of lesser offences. This concern has already been borne out by the Kevorkian case (Michigan, 1994) and by the Scott Mataya case in Canada (see box).

Decriminalization or, as in the Netherlands, keeping the criminal provisions but refraining from prosecutions if strict guidelines are followed, would respect the principle of autonomy and self-determination and would assist in societal

control of the practice by bringing it more into the open. Many fear, however, that it could also lead to abuse the so-called slippery slope between voluntary euthanasia and compulsory euthanasia for society's weakest and most vulnerable.

Another approach would be to maintain assisted suicide in the *Criminal Code,* but make it a less serious offence than murder. This would allow recognition of the sanctity of life as a fundamental social principle while also acknowledging the principle of self-determination and the compassionate motives of physicians or others who, on request, help someone die. This approach may be unacceptable, however, to advocates on both sides of the debate, who would see it as either too lenient or too restrictive. And as long as any penalty is attached to the practice, the problem of secrecy and therefore lack of social control may persist.

Clearly, there is no single satisfactory solution to this debate. The personal fears that fuel support for euthanasia and assisted suicide might abate somewhat, however, if, as Margaret Somerville has suggested, adequate recognition were given to

- the right to adequate treatment for the relief of pain and other symptoms of serious physical distress
- the right to refuse treatment, and
- the absence of obligation on the part of physicians to provide futile treatment.

[*Journal of Contemporary Health Law and Policy 9:1 (1993)*, p. 15.]

If this or a similar approach is indeed the one Canadians want and lawmakers choose, is the Criminal Code the best vehicle for translating it into action? Or might other options—a separate federal law, individual provincial laws, provincial or professional guidelines or directives for health care professionals—be more appropriate?

Given the complexity of this profoundly difficult issue, NACA urges all Canadians to give serious thought to their own positions and to make their views known to their members of Parliament, who will likely vote on the matter in 1995.

For Further Reading...

Please refer to your library for a copy of these publications.

Russel, Ogden. "The right to die: A policy proposal for euthanasia and aid in dying." *Canadian Public Policy,* 20:1, (March 1994), pp. 1-25.

Somerville, Margaret. "The song of death: The lyrics of euthanasia." *Journal of Contemporary Health Law and Policy*, 9:1, (1993), pp. 1-17.

Scott, John. "Lamentation and euthanasia." *Humane Medicine,* 8:2, (April 1992), pp. 116-121.

Tada, Joni Eareckson. *When is it right to die? Suicide, euthanasia, suffering, mercy.* Zondervan Publishing House, Michigan: 1992. 189 p.

Humphry, Derek. *Final exit: The practicalities of self-deliverance and assisted suicide for the dying*. The Hemlock Society, Oregon: 1991. 192 p.

Law Reform Commission of Canada. *Report 20: Euthanasia, aiding suicide and cessation of treatment*. Ottawa: Supply and Services Canada, 1983. 35 p.

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Research: Louise Plouffe
Production: Francine Beauregard