

Introduction

In June 2005, a private member's bill (Bill C-407) was introduced in the federal parliament to legalize euthanasia and assisted-suicide. That bill died on the order paper, but was re-introduced as Bill C-562 in June 2008, and again as Bill C-384 in May 2009. This bill would amend the Criminal Code to "allow a medical practitioner subject to certain conditions, to aid a person who is experiencing severe or mental pain without any prospect of relief or is suffering from a terminal illness to die with dignity once the person has expressed his or her free and informed consent to die". While the bill seems unlikely to pass, it has stimulated public discussion about the issue, and there will no doubt be other attempts in the future to pass euthanasia and physician-assisted suicide legislation. This is a highly contentious issue, with concerns regarding mercy, uncontrolled suffering, patient autonomy, care provider autonomy, concern for the potential for coercion and abuse, the possible vulnerability of people with disabilities, the implications for hospice palliative care and the potential for naïve political action. Because hospice palliative care expertise is available in providing quality end-of-life care, we should contribute to the debate.

At its spring 2005 Board meeting, the Canadian Hospice Palliative Care Association (CHPCA) Board of Directors struck a working group on the issue of Physician-Assisted Dying (PAD)¹. This working group has since changed its name to Euthanasia and Assisted Suicide Working Group. The working group held a series of teleconferences in 2005 and 2006. In March 2006, Health Canada sponsored a forum designed to assist in developing a Canadian Strategy for Palliative and End-of-Life Care. The forum, which involved members of the five working groups of the Canadian Strategy on Palliative and End-of-Life Care (Best Practices and Quality Care, Education for Formal Caregivers, Public Information and Awareness, Research, Surveillance), included a discussion of the implications of legalized euthanasia and physician-assisted suicide on the health care system. In December 2006, the CHPCA launched the first version of this discussion document, and began seeking the input of its members. In spring 2009, the CHPCA Euthanasia and Assisted Suicide Working Group reviewed all feedback received, as well as the evolving terminology and revised this document to reflect the input of its members as much as possible.

The Purpose of this Document

What This Document Is

This CHPCA issues paper summarizes the discussion to date. It is meant to inform and encourage discussion of this topic among hospice palliative care providers, as well as the public. It offers a foundation of facts from which its members and others may draw upon when discussing the issue of euthanasia and assisted dying.

¹ Definition: The term "assisted dying" refers to both "euthanasia" and "assisted suicide". These terms, and more related terms, are defined further in the glossary appended to this document.

What This Document Is Not

This document neither offers or denies support for the legalization of euthanasia or assisted suicide. The CHPCA recognizes that the opinions of its members range from deeply opposed to strongly supportive of a wide range of options in the assisted dying spectrum. It is therefore unrealistic for the CHPCA, as an organization representing its members' views, to declare a position for or against assisted dying.

Background

In Canada

Current Legal Status

Euthanasia and physician-assisted suicide are illegal in Canada. The *Criminal Code* of Canada prohibits culpable homicide (sections 222 and 229), which includes helping to end another's life through voluntary euthanasia, and makes "counselling a person to commit suicide" or "aiding a suicide" punishable offences (section 241). Section 14 of the Code makes it clear that having the consent of the person does not alter the criminal nature of the acts. Although there has been significant debate about voluntary euthanasia and assisted suicide (physician or other) over the past few years, there has been no change in the law. In 1993, in the case of Sue Rodriguez (the only case on this issue that has gone to the Supreme Court of Canada), a 42-year-old woman with amyotrophic lateral sclerosis (ALS), who claimed that section 241(b) violated her rights under the Charter of Rights and Freedoms, the Supreme Court dismissed her application (by a 5 to 4 margin). In 1994, a Special Senate Committee recommended that there be no changes to the offences related to euthanasia or physician-assisted suicide – although a minority of the committee did recommend that the *Criminal Code* be amended to "permit voluntary euthanasia for competent individuals who are physically incapable of committing suicide", as well as an exemption to protect people who assist in another person's suicide. The same Special Senate Committee recommended that, under certain circumstances, the Crown should be able to give less severe penalties to people found guilty of the offences related to counselling or aiding suicide or euthanasia.

Despite the lack of change to the law, there has been a clear trend toward leniency in sentencing and even charging people, some of them doctors, who have assisted in suicides and have been convicted under the Code. Some examples include:

- In September, 2004, Marielle Houle was charged with aiding and abetting the suicide of her 36-year-old son. After pleading guilty in January 2006, she was sentenced to three years' probation with conditions.
- In September 2006, 62-year-old Raymond Kirk pled guilty to aiding the suicide of his wife, who lived in tremendous pain due to a back spasm, after various specialists were unable to diagnose the problem or provide comfort. The Ontario Court of Justice suspended Mr. Kirk's sentence and imposed a sentence of three years' probation.
- In June 2007, a BC court sentenced Ramesh Kumar Sharma, a general practitioner, for aiding the suicide of Ruth Wolfe, a 93-year-old woman suffering from heart problems, by prescribing her a deadly dose of drugs. The court imposed a conditional sentence of two

years less a day to be served in the community. His license was also revoked by the province's college of physicians.

- In July 2007, the Royal Canadian Mounted Police (RCMP) decided not to lay charges in the assisted suicide case of Elizabeth MacDonald, a Canadian with multiple sclerosis who died in Switzerland (where assisted suicide is legal) with the assistance of an organization dedicated to assisting patients who wish to end their lives. Her husband, Eric MacDonald, was with her when she died. The RCMP stated that no infraction of the *Criminal Code* was committed in Canada.

The Practice in Canada

There is limited accurate data regarding how common voluntary euthanasia and assisted suicide are in Canada. Because these practices are illegal, they are rarely reported. As a result, most deaths do not come to the attention of the coroner – unless someone lodges a complaint or asks for an investigation – so it is difficult to assess to what extent deaths might be “assisted”.

Public and Professional Attitudes

In Canada, according to a 1994 survey, more than 75% of the general public support voluntary euthanasia and physician-assisted suicide for people who are terminally ill and who have a poor likelihood of recovery². However, between 75% and 83% opposed the practices for patients with reversible conditions, elderly disabled people who feel they are a burden on others, and elderly people with only minor physical ailments. The survey does not indicate whether respondents were aware of or were offered alternatives to physician-assisted suicide.³

The only published survey of Canadian physicians on this topic was done in 1996. It indicated that 76% would oppose being involved in euthanasia or assisted suicide but 24% would be willing to practice voluntary euthanasia and 23% would practice assisted suicide if these practices were legalized⁴. Slightly more than half of the responding physicians reported that they would not practice either, while between 20% and 22% were uncertain. Over 40% would be willing to refer patients for voluntary euthanasia or physician-assisted suicide. About 75% believe the practice of voluntary euthanasia, if it is legalized, should be restricted to physicians.

In an Ipsos Reid poll of 1,005 Canadians released in June 2007, 76% agreed with the right-to-die concept for people who want to die instead of enduring the full course of an incurable illness⁵. More recently, an Angus Reid public opinion poll released in February 2010 indicated that 67% of those surveyed were in support of legalizing euthanasia in Canada.⁶

² Genius SJ, Genius SK, Chang WC. Public attitudes toward the right to die. *CMAJ* 1994; 150(5):701-702.

³ Ibid.

⁴ Kinsella TD, Verhoef MJ. Reported in *The Medical Post* 1996; 32(34):90. (Cited with the permission of the authors.)

⁵ Vollmar, VJ. Recent Developments in Physician-Assisted Death. May 2007. p. 11.
<http://www.willamette.edu/wucl/pdf/pad/2007-10.pdf> Accessed June 22, 2009.

⁶ Two-Thirds of Canadians Express Support for Legalizing Euthanasia. February 2010.
<http://www.visioncritical.com/category/global-opinions-and-trends>. Accessed March 8, 2010.

Global Trends in Euthanasia and Assisted Suicide

Other countries are at different stages in their public debate about euthanasia and assisted suicide or – as it is also known – assisted dying. Physician-assisted suicide is now legal in the Netherlands, Belgium, Switzerland, Luxembourg and in the states of Oregon, Washington and Montana (USA). Only the Netherlands and Switzerland have legalized euthanasia. With the exception of Montana, which has yet to enact legislation, jurisdictions that have legalized assisted suicide have established procedures designed to safeguard patients and prevent abuse. For example, in some jurisdictions (Oregon, Belgium), anyone requesting physician-assisted suicide must undergo a full palliative care assessment. Because Montana has not yet (as of June 2009) enacted legislation, it currently has no guidelines in place.

On the other hand, most countries have not legalized euthanasia and/or assisted suicide as well as most states in the United States.

In Oregon, the state with the longest history of assisted suicide (legalized in 1998), the legalization of physician-assisted suicide has not resulted in a large increase in the number of people asking for and receiving physician-assisted suicide (16 in 1998 and 42 in 2003; 60 in 2008⁷), but it has resulted in a dramatic increase in hospice palliative care provision. For example, overall hospice use has jumped 84% since the implementation of the Death With Dignity Act in 1998.⁸ This may indicate that, when people have appropriate palliative care, they are less likely to ask for assisted suicide.

Factors Leading to Requests for Assisted Suicide

Based on the hospice palliative care community's extensive experience in providing end-of-life care, hospice palliative care providers have observed – and these observations are confirmed by research evidence⁹ – that the desire for euthanasia or physician-assisted suicide usually stems from one or more of the following factors:

- the pain and suffering caused by all terminal illnesses,
- the individual's need for control over the illness and his or her body/life,
- a desire not to be a burden on others,
- depression and psychological distress often associated with illness.¹⁰

The Role of Hospice Palliative Care

Comprehensive hospice palliative care – that is, care that strives to meet the physical, psychosocial, social and spiritual needs of people who are dying and their family members – can help alleviate many of the factors that may cause people to consider assisted suicide, particularly the burden on loved ones, depression and pain and symptom management. High quality hospice

⁷ Oregon Death with Dignity Act Annual Reports. <<http://www.oregon.gov/DHS/ph/pas/>> Accessed June 11, 2009.

⁸ O'Reilly, Kevin B., Oregon still stands alone: Ten years of physician-assisted suicide. American Medical News. May 12, 2008. <<http://www.ama-assn.org/amednews/2008/05/12/prsa0512.htm>> Accessed June 11, 2009.

⁹ Van der Maas PJ, van Delden JJ, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991; 338:669-674.

¹⁰ Chochinov HM, Wilson KG, Enns M et al. Desire for death in the terminally ill. *American Journal of Psychiatry* 1995; 152:1185-1191. A study of 200 patients found that 44.5% occasionally wished that death would come soon, but only 17 of these individuals (8.5%) acknowledged a serious and pervasive desire to die. Of those 17 people, about 10 (58.8%) had symptoms of depression (compared to 7.7% of the patients who had no strong desire to hasten death). It is particularly interesting to note that, in six of the 10, when their depression decreased, so did their desire to die (Chochinov, Wilson et al, 1995).

palliative care can also give the individual a greater sense of meaning and control over his or her life and body.

In the hospice palliative care community, it is our experience that some people advocating to legalize euthanasia and assisted suicide and some health care providers may be unaware of the options currently available as part of hospice palliative care. For example, people receiving hospice palliative care have the right to refuse treatment, food and/or water. Such withholding or withdrawing of therapy is both ethical and legal. In extreme circumstances, at the very end of life when all other methods of care have been tried and symptoms, such as uncontrollable pain or shortness of breath, are intolerable, patients with advanced, progressive illnesses in the very terminal phase have the option of therapies such as total sedation, which may relieve all forms of patient distress. This decision must be made with patient approval and family awareness of the decision. Consensus guidelines are being developed by the Canadian Society of Palliative Care Physicians for continuous sedation in Canada. In these situations, hospice palliative care practitioners continue to respect the patient and families' right to make these choices. The patient and family continue to receive compassionate hospice palliative care services and are not abandoned by hospice palliative care practitioners.

Analysis

The Canadian Hospice Palliative Care Association promotes excellence in care for all people with terminal illnesses and their families. Our policies must reflect their best interests as well as the values of the larger society. Part of our role is to advocate for policies, services and laws that meet the needs of people at end of life as well as the needs of their families.

In the hospice palliative care experience, the process of dying often has meaning and purpose for the person and his or her loved ones. As a field of practice, we have a responsibility to ensure that all those involved in providing hospice palliative care have the knowledge (including an understanding of the alternatives to assisted suicide), attitude and skills to help people at end-of-life manage both physical and emotional suffering, and to support family members. We also have a responsibility to ensure that patients seeking assisted suicide are aware of hospice palliative care and its programs and services.

However, the CHPCA recognizes that, even with access to comprehensive, compassionate end-of-life care, a very small number of Canadians may still ask for assistance to end their lives. The hospice palliative care community has a responsibility to respect and respond to these individuals, while still respecting our own values and principles.

CHPCA Statement

The CHPCA has therefore developed a statement that attempts to capture both our fundamental concern regarding issues related to euthanasia and assisted suicide, potential risks and our respect for those who hold a differing view.

The Canadian Hospice Palliative Care Association is committed to enhancing the quality of living and the quality of dying for people, with progressive life limiting illnesses especially as they approach the end of life, and their families, and does not view euthanasia or assisted suicide as part of quality end-of-life care.

Dying will always be associated with some suffering. Quality end-of-life care can reduce some of that suffering by relieving the burden on families, helping persons find meaning to the life lived and to dying, providing adequate psychological support,

providing care at home or in specialized hospice palliative care units and assisting with pain and symptom management. For the vast majority of people, high quality hospice palliative care will be a better option than euthanasia or assisted suicide.

However, despite access to high quality end-of-life care, a small number of Canadians may still choose to have control over their own death. As hospice palliative care providers, we will respect their right to choose and will not abandon them. We will continue to assess their reasons for this choice, to provide the same compassionate care to these individuals and to address their concerns and those of their families, but we also have a choice not to participate or to be expected to assist in any efforts that intentionally hasten death.

Recommendations

Before considering legalizing euthanasia and assisted suicide, Canada has a responsibility to ensure that comprehensive, compassionate hospice palliative care is available to all, and that Canadians are aware of these services and how to access them. Any discussion about legalizing euthanasia and assisted suicide must also address complex issues including: the person's capacity to make an informed choice, the implications for vulnerable persons/people with disabilities, ethics, access, the potential for legal challenges, insurance-related issues, and mechanisms to detect and prevent coercion or abuse.

The CHPCA recommends that, before introducing and discussing legislation to legalize euthanasia and assisted suicide:

1. Policy makers take time to become informed about the complex issues and implications of legalizing euthanasia and assisted suicide.
2. Policy makers and practitioners engage Canadians in extensive, open and public debates about the benefits and risks of legalizing euthanasia and assisted suicide, ensuring they understand the implications of the language being used and are knowledgeable about euthanasia, assisted suicide, and the options available to people at end of life.
3. All Canadian jurisdictions move swiftly to ensure that all their citizens have timely access to comprehensive compassionate hospice palliative care services, and ensure that all citizens and their health care providers are aware of the end-of-life services available to them.
4. All health care providers caring for people at end of life have the skills and knowledge to address the physical, emotional, social and spiritual suffering that may lead people to consider euthanasia and assisted suicide.
5. All health care providers ensure that patients and families are educated and informed about all aspects of end-of-life care, including advance care planning, living wills, pain and symptom management, issues of withdrawing or withholding therapy such as hydration and nutrition, the role of hospice palliative care services and alternatives to euthanasia and assisted suicide.
6. Any proposed legalization of euthanasia and assisted suicide include provisions and safeguards designed to reaffirm respect for individual dignity, protect vulnerable individuals, prevent coercion and abuse, and ensure the decision is not driven by the lack of availability of appropriate, high quality hospice palliative care.
7. The CHPCA work closely with partners to educate the public and policy makers about all aspects of end-of-life care, including advance care planning, living wills, pain and symptom

management, issues of withdrawing or withholding therapy such as hydration and nutrition, and alternatives to euthanasia and assisted suicide.

Ongoing Review

Assisted dying is a rapidly evolving global issue, with profound implications not only for individuals nearing the end of life, for those who survive them, but also for those who care for them. It is important for Canadians to understand that euthanasia or assisted suicide is not a part of quality end-of-life care. The CHPCA will continue to monitor developments and to analyze the potential impact on hospice palliative care providers.

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3. *Dying Justice: A Case for Decriminalizing Euthanasia & Assisted Suicide in Canada*, Downie J, Toronto, ON: University of Toronto Press Incorporated, 2004.
4. *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*. Quill T, Battin M (eds), Baltimore, MD: The Johns Hopkins University Press, 2004.
5. *The Case against Assisted Suicide for the Right to End-of-Life Care*. Foley K, Hendin H (eds), Baltimore, MD: The Johns Hopkins University Press, 2002.
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Additional Reading

Additional reading resources can be found on the CHPCA web site at:
http://www.chpca.net/public_policy_advocacy/pad_issues/pad_issues.html

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Glossary and Additional Information

assistance – providing the means to administer.

assisted dying – a broader term used to refer to both euthanasia and assisted suicide inclusively

assisted suicide – the act of intentionally assisting another individual in their attempt to take their own life. Assistance may include provision of knowledge, means or both.

physician-assisted suicide – the act of taking, or attempting to take, one's own life with the intentional assistance of a physician. The assistance offered may include the prescription of lethal drugs and may or may not include assistance in the administration of lethal drugs.

capacity – ability to understand the nature, consequences and significance a decision. Understanding of the results that will follow actions.

euthanasia – the putting to death, by a painless method, of a terminally-ill or severely debilitated person through the omission (intentionally withholding a life-saving medical procedure, also known as passive euthanasia*) or the commission of an act (active euthanasia).

* This should not be confused with refusal of treatment, which competent adults have the right to do.

voluntary euthanasia – the putting to death, by a painless method, of an individual, when it takes place in accordance with the wishes of a competent individual, whether these wishes have been made known personally or by a valid written, advance directive (see below). (A person is considered to be competent if he or she is deemed capable of understanding the nature and consequences of the decisions to be made and capable of communicating this decision.)

An example of voluntary euthanasia is when a physician gives a lethal injection to a patient who is competent and suffering, at that patient's request.

Non-voluntary euthanasia – the putting to death, by a painless method, of an individual, without knowledge of the wishes of the patient, either because the patient has always been incompetent, is now incompetent, or has left no advance directive, expressing any preference. (A person is considered incompetent when he or she is incapable of understanding the nature and consequences of the decision to be made and/or is not capable of communicating this decision.)

An example of non-voluntary euthanasia is when a doctor gives a lethal injection to an incompetent elderly man who is suffering greatly from an advanced terminal disease, but who did not make his wishes known to the physician when he was competent. Another example would be an adult mentally handicapped patient with incurable cancer who is incapable of formulating and expressing his or her preference and is killed by his sibling (who is also his surrogate decision-maker).

involuntary euthanasia – The putting to death, by a painless method, of a terminally-ill or severely debilitated person, against the wishes of a competent individual or against the wishes expressed in a valid advance directive. It is indistinguishable from murder or manslaughter,

Examples of involuntary euthanasia include a son who gives a lethal overdose of medication to his father who is suffering from cancer, but the father does not want the overdose. Another example is a physician who, despite the advance directive of a patient indicating that he or she does not want any actions to hasten death, gives a lethal injection to the patient who is now unconscious and suffering from the final stages of a terminal illness.

Other Terms You May Encounter

Advance directive - a verbal or written statement of the person's future desires in the event that he or she should be unable to communicate his or her intentions in the future.

Allow Natural Death (AND) – “refers to decisions that can be made NOT to have any treatment or procedure that will only delay the moment of death and applies only where death is about to happen from natural causes”¹¹. The CHPCA does not generally use this term; it is not a form of assisted dying, and the definition here is included only for reference.

Do Not Resuscitate (DNR) – an order given by a patient or family, directing medical staff not to start CPR if a person’s heart stops beating. It does not mean "do not treat." Until the point when the heart stops beating, aggressive medical interventions may still be used. This also is not a form of assisted dying; the definition is included here only for reference.

Glossary Bibliography

Tiedemann, Marlissa and Dominique Valiquet. Current Issue Review : Euthanasia and Assisted Suicide. Library of Parliament Parliamentary Information and Research Service. Revised July 17, 2008. Accessed June 22, 2009 at <<http://www.parl.gc.ca/information/library/PRBpubs/919-e.htm>>

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Website: Fraser Health>Advance Care Planning: Let’s Talk>Definitions. Accessed June 22, 2009 at <<http://www.fraserhealth.ca/Services/HomeandCommunityCare/AdvanceCarePlanning/Pages/Definitions.aspx>>

¹¹ <http://www.fraserhealth.ca/Services/HomeandCommunityCare/AdvanceCarePlanning/Pages/Definitions.aspx>