

In June 2005, a private member's bill (Bill C-407) was introduced in the federal parliament to legalize euthanasia and physician-assisted suicide. Although this bill died on the order paper, there will 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 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 end-of-life care, palliative care leaders should contribute to the debate.

At its spring 2005 Board meeting, the CHPCA Board of Directors struck a working group on the issue of Physician-Assisted Dying (PAD)¹. The working group held one teleconference in the fall of 2005 and another in February 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.

This CHPCA issues paper summarizes the discussion to date, and sets out a possible statement and recommendations.

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 physician-assisted suicide 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

¹ Definition: The term "physician assisted dying" refers to both "euthanasia" and "physician assisted suicide".

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.

Despite the lack of change to the law, there is a clear trend toward leniency in sentencing people, some of them doctors, who have been convicted under the Code. 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.

The Practice in Canada

There is limited accurate data regarding how common voluntary euthanasia and physician-assisted suicide are in Canada. Because these practices are illegal, they are rarely reported. The current death certificate process does not identify the proportion of people who die at home as opposed to in a hospital or other care setting. As a result, most community home 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 home 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% oppose 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

A 1996 survey of Canadian physicians indicates that 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.

Global Trends in Euthanasia and Assisted Suicide

Other countries are at different stages in their public debate about euthanasia and physician-assisted suicide or – as it is becoming known – physician-assisted dying (PAD).

Physician-assisted suicide is now legal in the Netherlands, Belgium, and in the state of Oregon (USA). Jurisdictions that have legalized euthanasia and physician-assisted suicide have established procedures designed to safeguard patients and prevent abuse. For example, anyone requested physician-assisted suicide must undergo a full palliative care assessment.

In Oregon, the legalization of physician-assisted suicide has not resulted in an increase in the number of people asking for and receiving physician-assisted suicide, but it has resulted in a dramatic increase in the number of palliative care consultations. This may indicate that, when people have appropriate palliative care, they are less likely to ask for physician-assisted suicide.

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.)

Factors Leading to Requests for Physician-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 evidence^{5,6} – that the desire for euthanasia or physician-assisted suicide usually stems from one or more of the following factors:

- a desire not to be a burden on others
- the individual's need for control over the illness and his or her body/life
- depression and psychological distress often associated with illness⁷
- the pain and suffering caused by all terminal illnesses.

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 physician-assisted suicide, particularly the burden on loved ones, depression and pain and symptom management. High quality hospice 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. 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, hospice palliative care patients have the option of therapies such as total sedation which will relieve all forms of patient distress. This decision must be made with patient and family approval. However, clear, nationally accepted guidelines do not exist for palliative 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

Because 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.

⁵ 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.

⁶ Chochinov HM, Wilson KG, Enns M et al. Desire for death in the terminally ill. *American Journal of Psychiatry* 1995; 152:1185-1191.

⁷ A recent 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).

In the hospice palliative care experience, the process of dying 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 physician-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 physician-assisted suicide are aware of other options.

However, 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.

Draft CHPCA Statement

The CHPCA has developed a draft statement that attempts to capture both our fundamental concern regarding issues related to euthanasia and physician-assisted suicide 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 at the end of life and their families, and does not view euthanasia or physician-assisted suicide as a part of quality end of life care.

Dying will always be associated with some suffering. Good end-of-life care can reduce some of that suffering by relieving the burden on families and assisting with pain and symptom management. For many people, high quality hospice palliative care will be a better option than euthanasia or physician-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 practitioners, we will respect their right to choose and will not abandon them. We will continue to provide the same compassionate care to these individuals and 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 physician-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 physician-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 legislation to legalize euthanasia and physician-assisted suicide:

1. Policy makers are informed about the complex issues and implications of legalizing euthanasia and physician-assisted suicide.
2. Policy makers and practitioners engage Canadians in extensive, open and public debates about the benefits and risks of legalizing euthanasia and physician-assisted suicide, ensuring

they understand the implications of the language being used and are knowledgeable about euthanasia, physician-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 and spiritual suffering that may lead people to consider euthanasia and physician-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, and alternatives to euthanasia and physician-assisted suicide.
6. Any effort to legalize euthanasia and physician-assisted suicide include provisions 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 physician-assisted suicide.

Next Steps

The Canadian Hospice Palliative Care Association would like to hear from our members on this subject, and encourage more debate within the hospice palliative care community.

- Does the proposed statement reflect our values and views?
- Will the recommendations contribute to open, informed debate?
- What are the implications for hospice palliative care programs if euthanasia and physician-assisted suicide are legalized in Canada?

The CHPCA will use the feedback from members to develop an official position statement and to respond to any parliamentary committees on this issue.

Bibliography

1. Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide. Somerville M, Montreal, QC: McGill-Queen's University Press, 2001.
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3. Physician-Assisted Dying: The Case for Palliative Care and Patient Choice. Quill T, Battin M (eds), Baltimore, MD: The Johns Hopkins University Press, 2004.
4. 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.

Additional Reading

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

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