


Physician Assisted Suicide & Euthanasia: law, ethics and advocacy in Catholic health care organizations



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Canada Conference
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Overview



- This session will
 1. Examine the legal status of Physician Assisted Suicide (PAS) & Euthanasia in Canada;
 2. Summarize recent and coming attempts at reform and commentary in this area;
 3. Discuss how the challenges posed by the possible legalization of euthanasia and assisted suicide can be addressed.

I: The Criminal Code

- Under Canada's Criminal Code:
 - **222. (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.**
 - ...
 - (4) Culpable homicide is murder or manslaughter or infanticide.
 - (5) A person commits culpable homicide **when he causes the death of a human being,**
 - **(a) by means of an unlawful act;**
 - (b) by criminal negligence;
 - (c) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death; or
 - (d) by wilfully frightening that human being, in the case of a child or sick person.

I: The Criminal Code

Counseling or aiding suicide

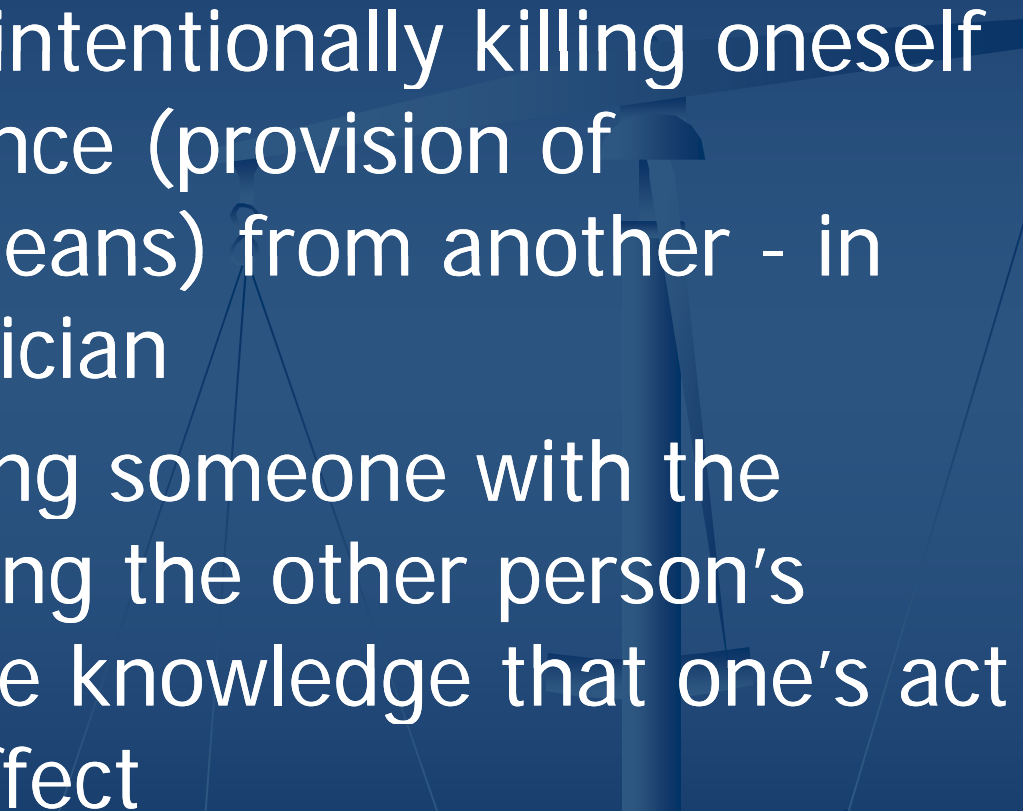
241. Every one who

(*a*) counsels a person to commit suicide, or

(*b*) aids or abets a person to commit suicide,

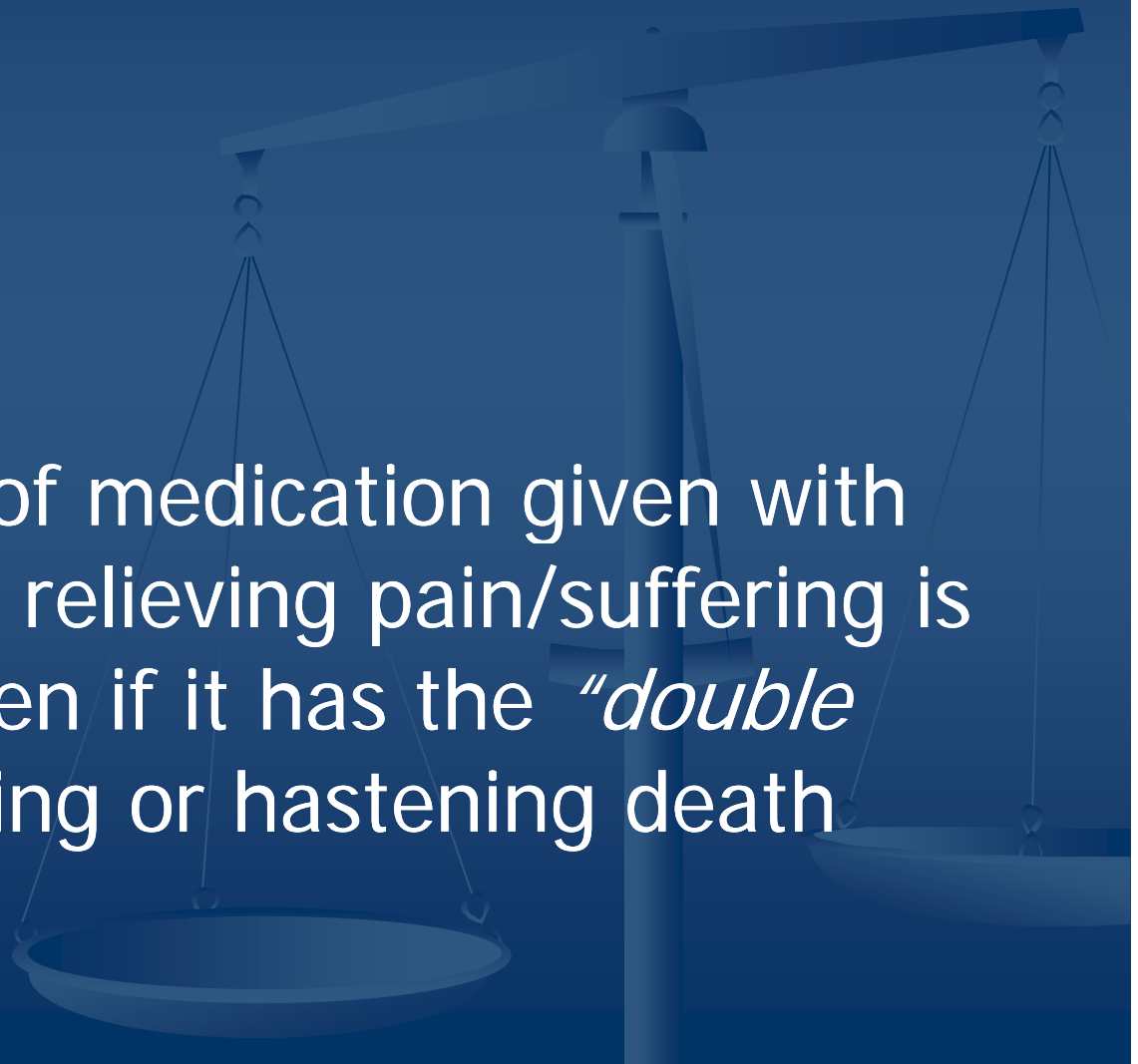
whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

I: What is PAS/euthanasia?

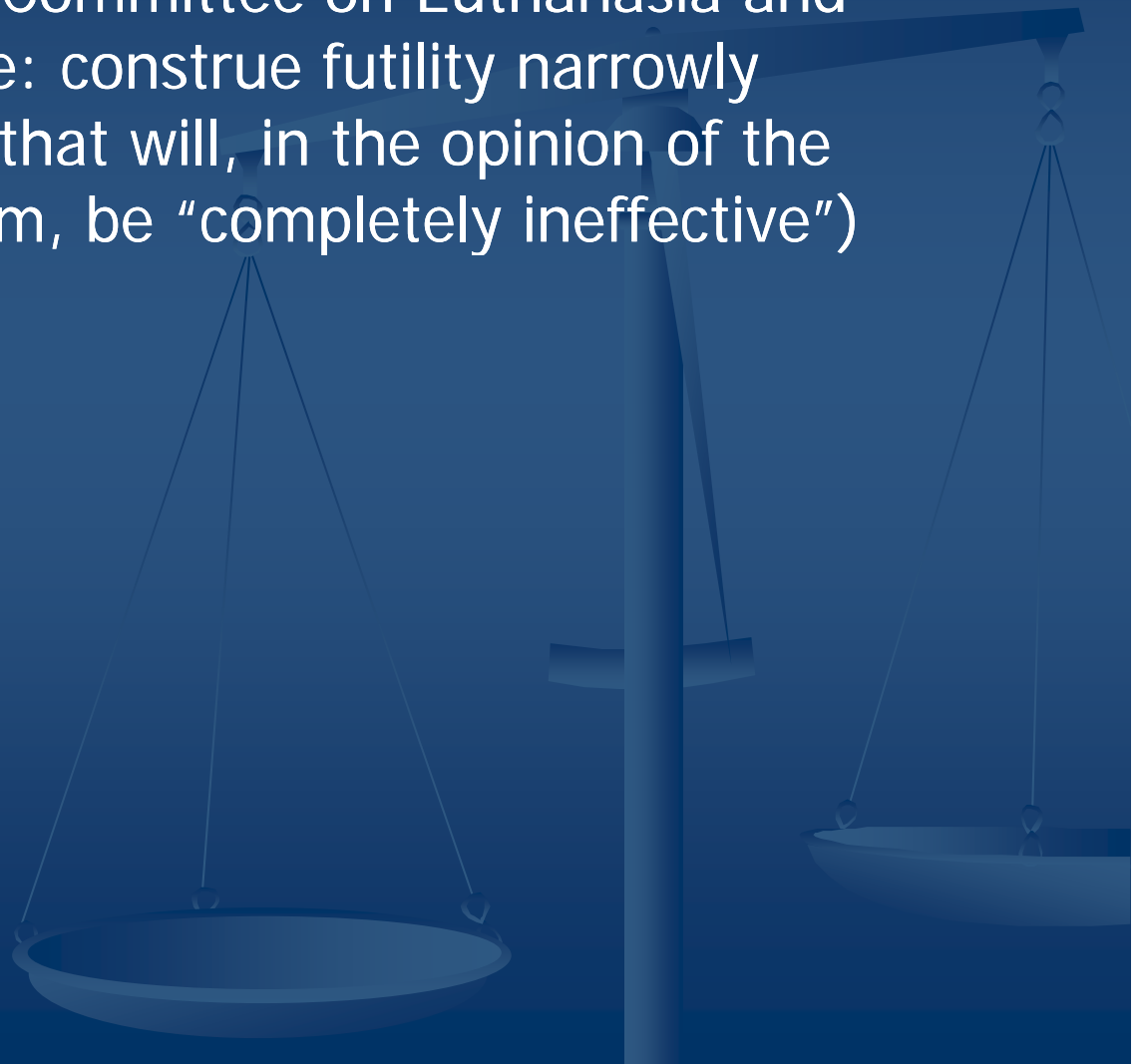
- PAS: the act of intentionally killing oneself with the assistance (provision of knowledge or means) from another - in this case a physician
 - Euthanasia: killing someone with the motive of relieving the other person's suffering and the knowledge that one's act will have that effect
- 

I: What it's NOT

- Administration of medication given with the intention of relieving pain/suffering is appropriate, even if it has the “*double effect*” of causing or hastening death

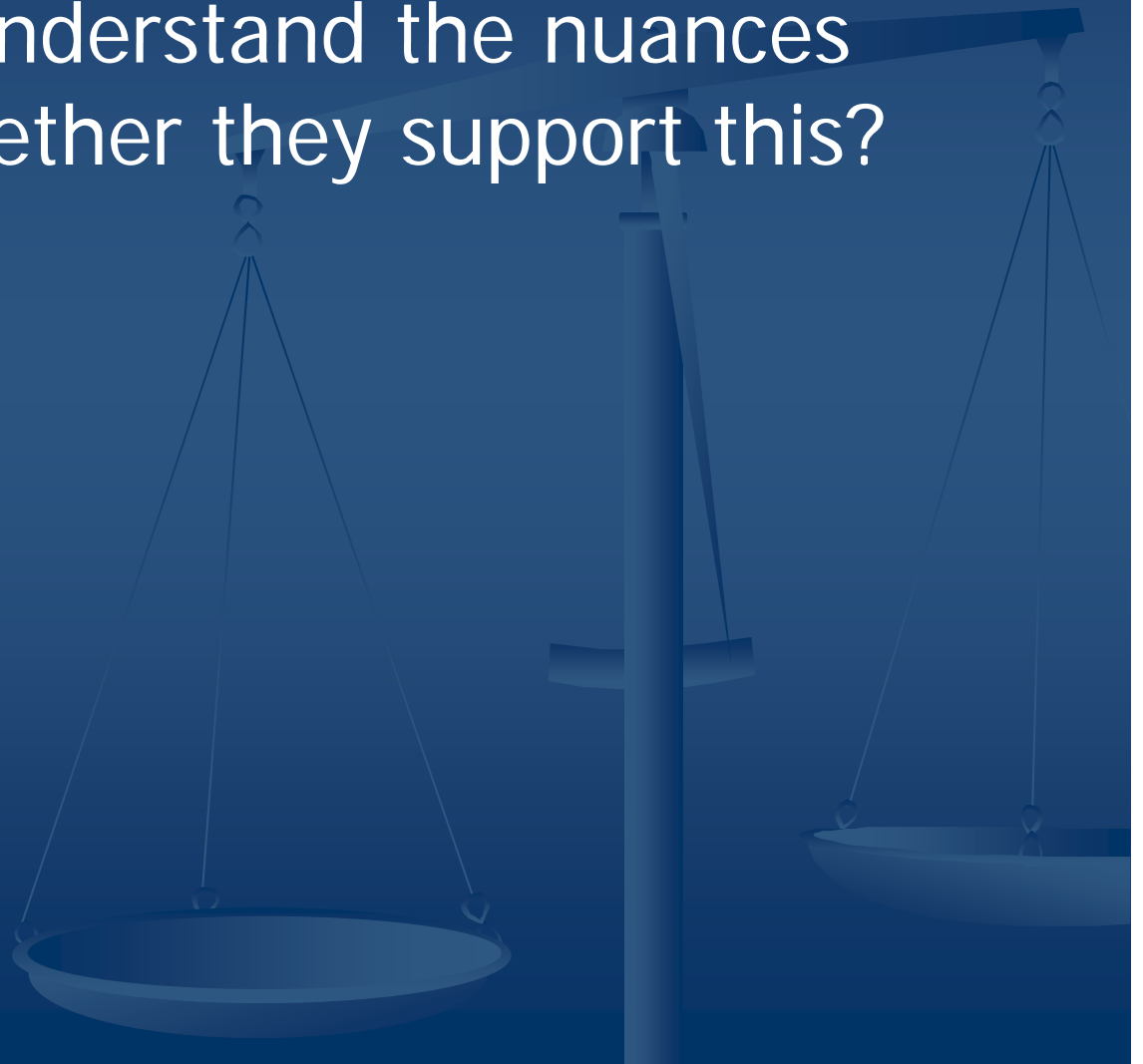


- Withholding/withdrawing treatment that is futile, overly burdensome
 - Senate Special Committee on Euthanasia and Assisted Suicide: construe futility narrowly (i.e. treatment that will, in the opinion of the health care team, be “completely ineffective”)



Public perception?

- Do Canadians understand the nuances when asked whether they support this?



I: Common misconceptions re the status quo

- Current practice = euthanasia done on the sly

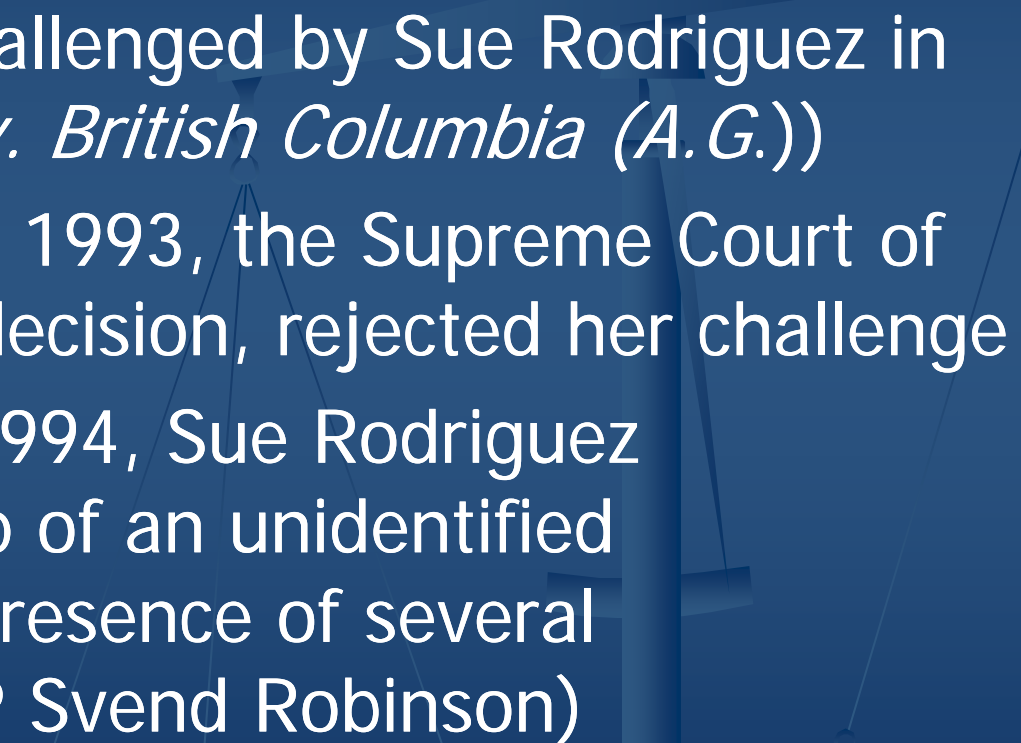
Example from *The Ottawa Citizen*, 21 July 2009:

“It certainly happens across the country that terminally ill patients are sometimes quietly given more painkillers despite the risk that they could die as a result.”

“By failing to acknowledge this is happening now... Canadians do not have a proper understanding of what the tolerance level really is... for... euthanasia.”

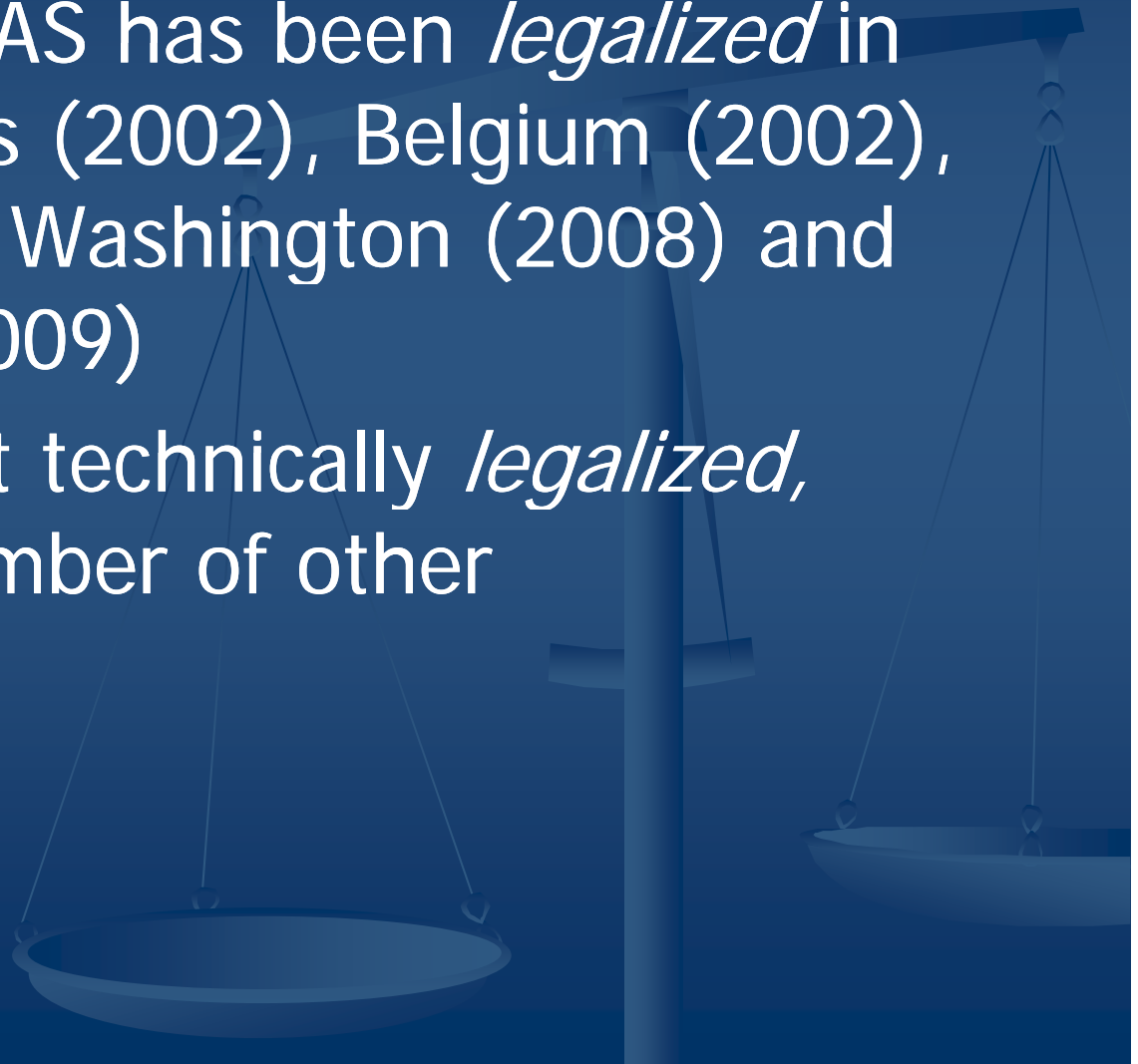
- “the status quo threatens physicians with criminal sanctions” (CMQ)
 - Morrison case, etc

I: Challenges to the Current Law

- The provisions prohibiting assisted suicide were constitutionally challenged by Sue Rodriguez in 1991 (*Rodriguez v. British Columbia (A.G.)*)
 - On September 30, 1993, the Supreme Court of Canada, in a 5-4 decision, rejected her challenge
 - On February 12, 1994, Sue Rodriguez died, with the help of an unidentified physician, in the presence of several observers (inc. MP Svend Robinson)
- 

I: Euthanasia & PAS Internationally

- Euthanasia or PAS has been *legalized* in The Netherlands (2002), Belgium (2002), Oregon (1994), Washington (2008) and Luxembourg (2009)
- It is, though not technically *legalized*, allowed in a number of other countries

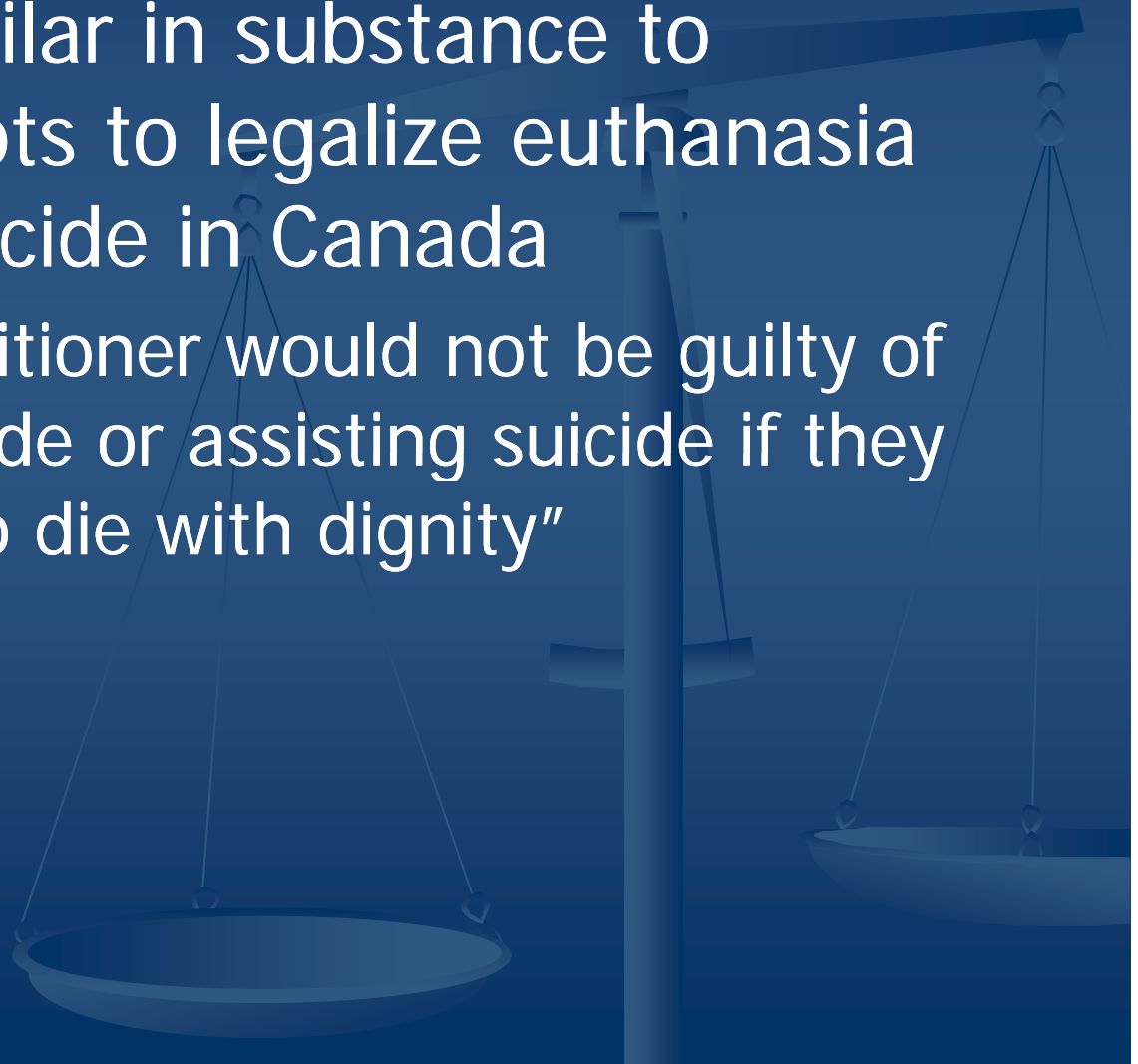


PART II: Bill C-384

- There have been several attempts to legalize euthanasia/assisted suicide in Canada
 - Bill C-385 (introduced in 1992 by Svend Robinson - was never debated due to the end of Parliament)
 - Bill C-407 (introduced in 2005 by Francine Lalonde) suffered the same fate
- May 13, 2009: Bill C-384

II: Bill C-384

- Bill C-384 is similar in substance to previous attempts to legalize euthanasia and assisted suicide in Canada
 - A medical practitioner would not be guilty of culpable homicide or assisting suicide if they “aid a person to die with dignity”



II: Bill C-384

- Requirements:

1. Patient must be at least 18

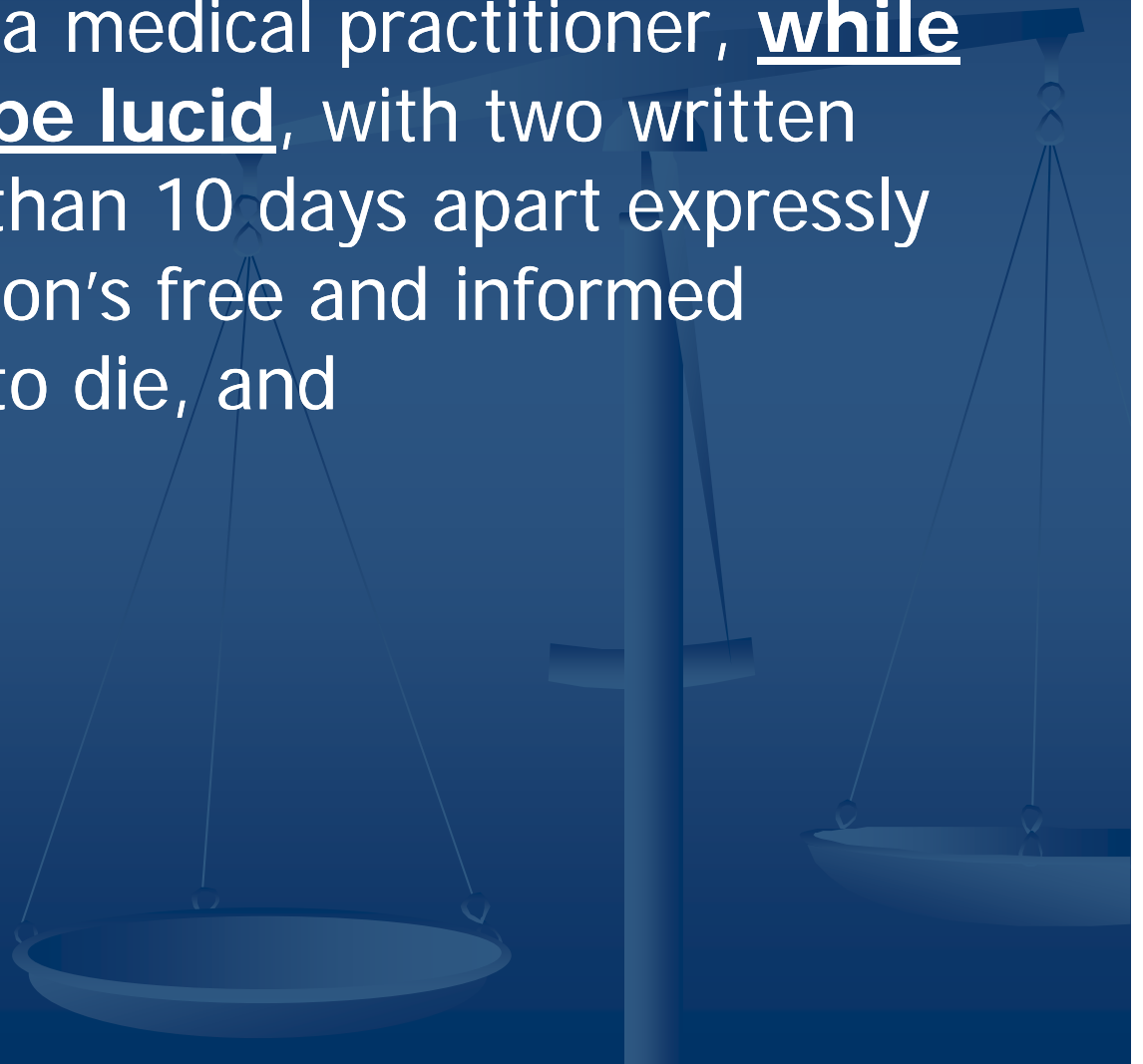
2. the patient must either

- (A) continue, after trying or expressly refusing the appropriate treatments available, to experience severe physical or mental pain without any prospect of relief, OR

- (B) suffer from a terminal illness

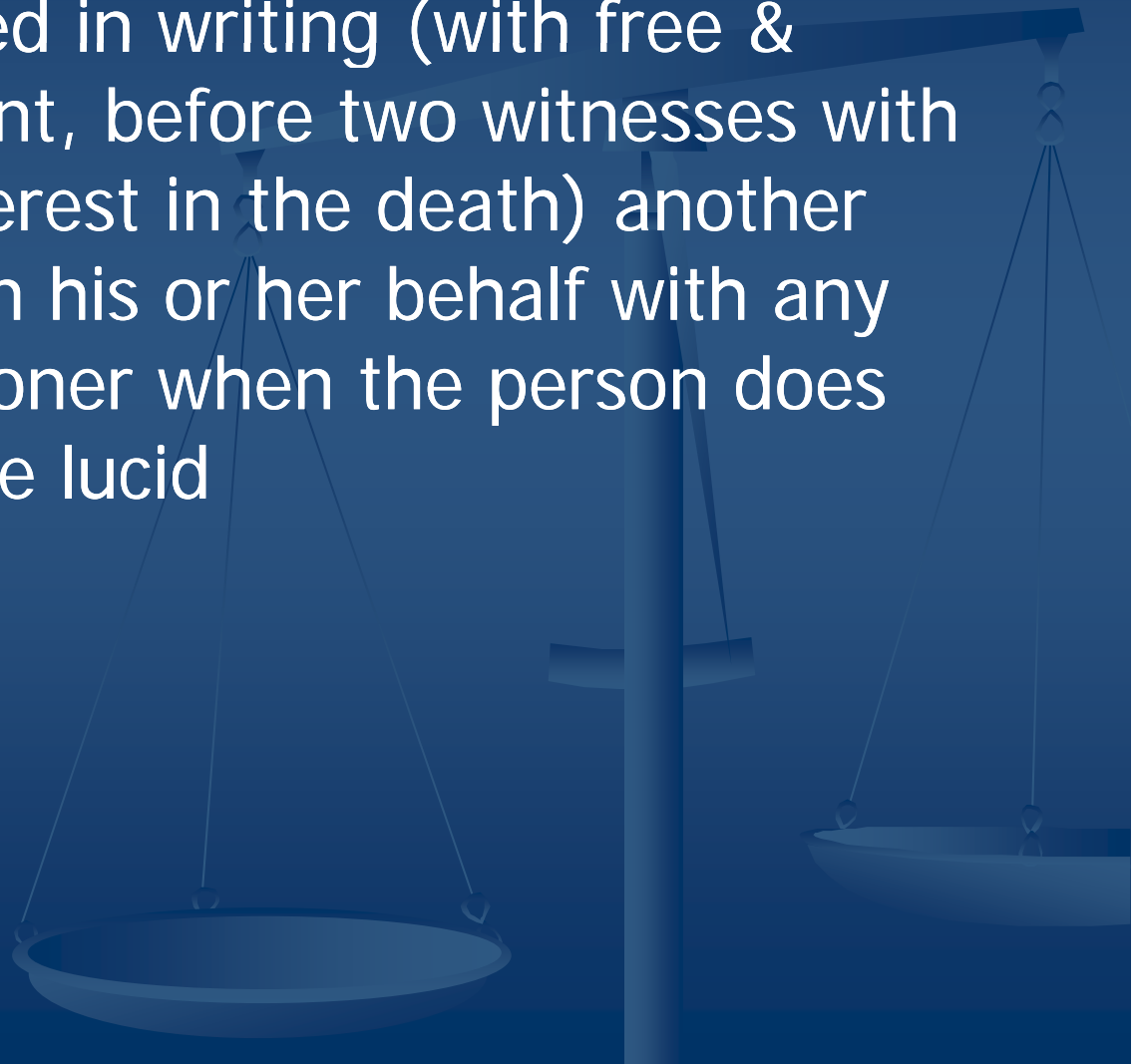
II: Bill C-384

3. have provided a medical practitioner, while appearing to be lucid, with two written requests more than 10 days apart expressly stating the person's free and informed consent to opt to die, and



II: Bill C 384

4. have designated in writing (with free & informed consent, before two witnesses with no personal interest in the death) another person to act on his or her behalf with any medical practitioner when the person does not appear to be lucid



The medical practitioner

(i) has requested and received written confirmation of the diagnosis from another medical practitioner with no personal interest in the death of the person

(ii) has no reasonable grounds to believe that the requests were made under duress or while the person was not lucid,

(iii) has informed the person of the consequences of his or her requests and of the alternatives available to him or her,

(iv) acts in the manner indicated by the person, it being understood that the person may, at any time, revoke the requests made

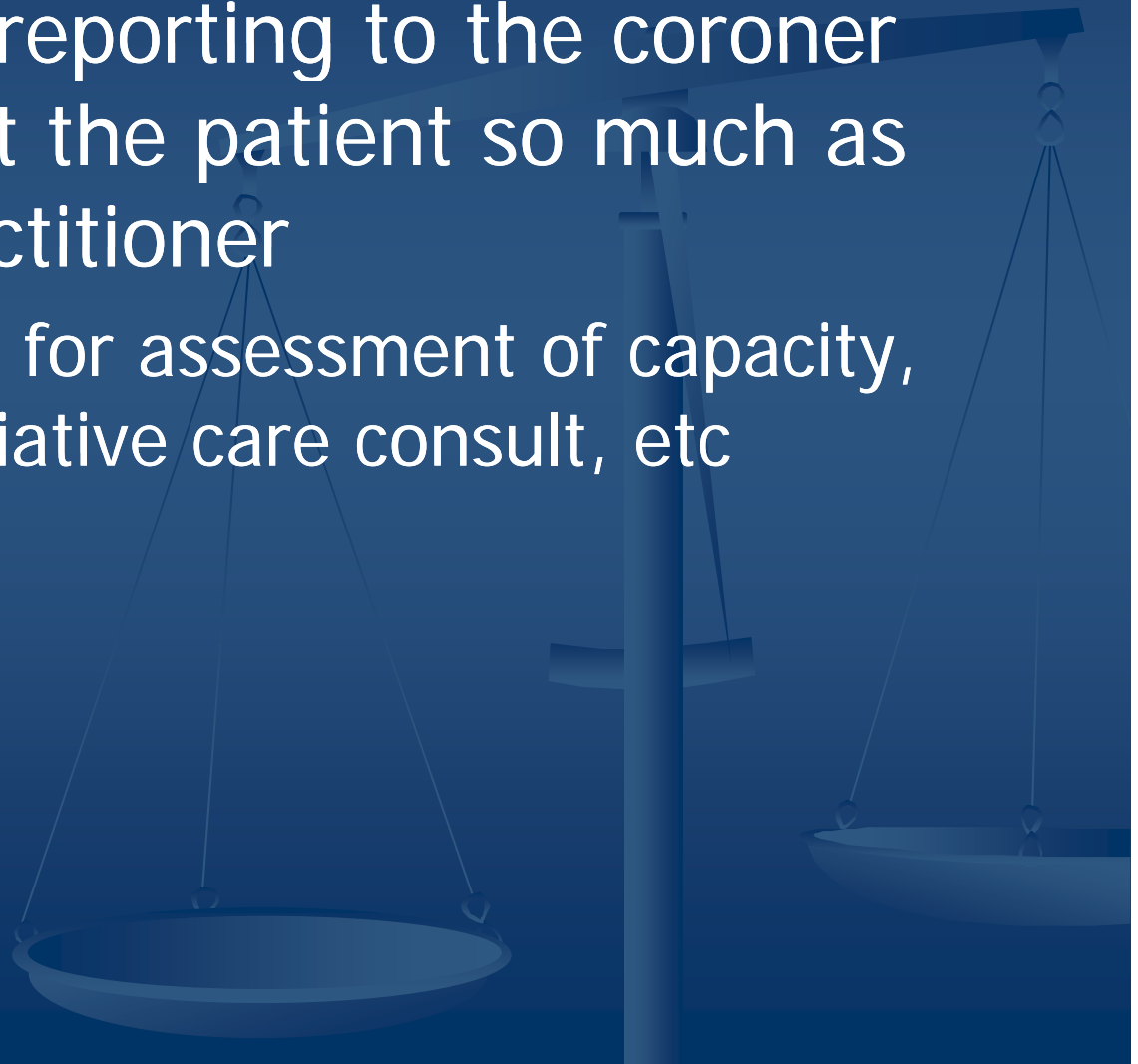
(v) provides the coroner with a copy of the confirming documentation

“good*” – a lot of detail left out

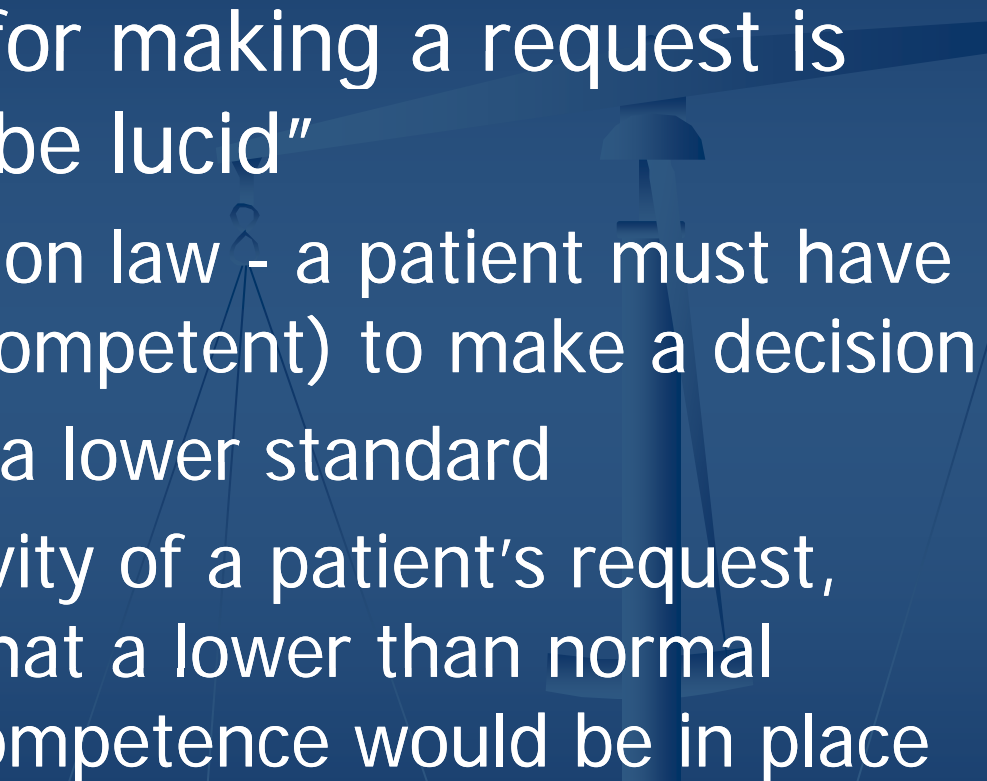


II: Comments re Bill C-384

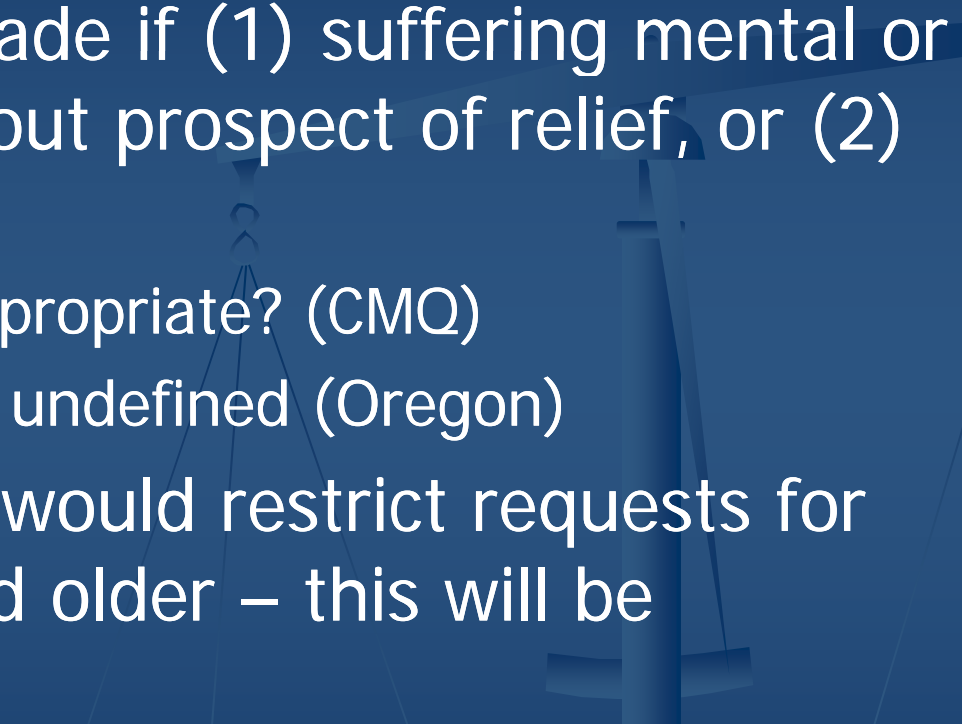
- “After the fact” reporting to the coroner does not protect the patient so much as the medical practitioner
 - No requirement for assessment of capacity, counseling, palliative care consult, etc



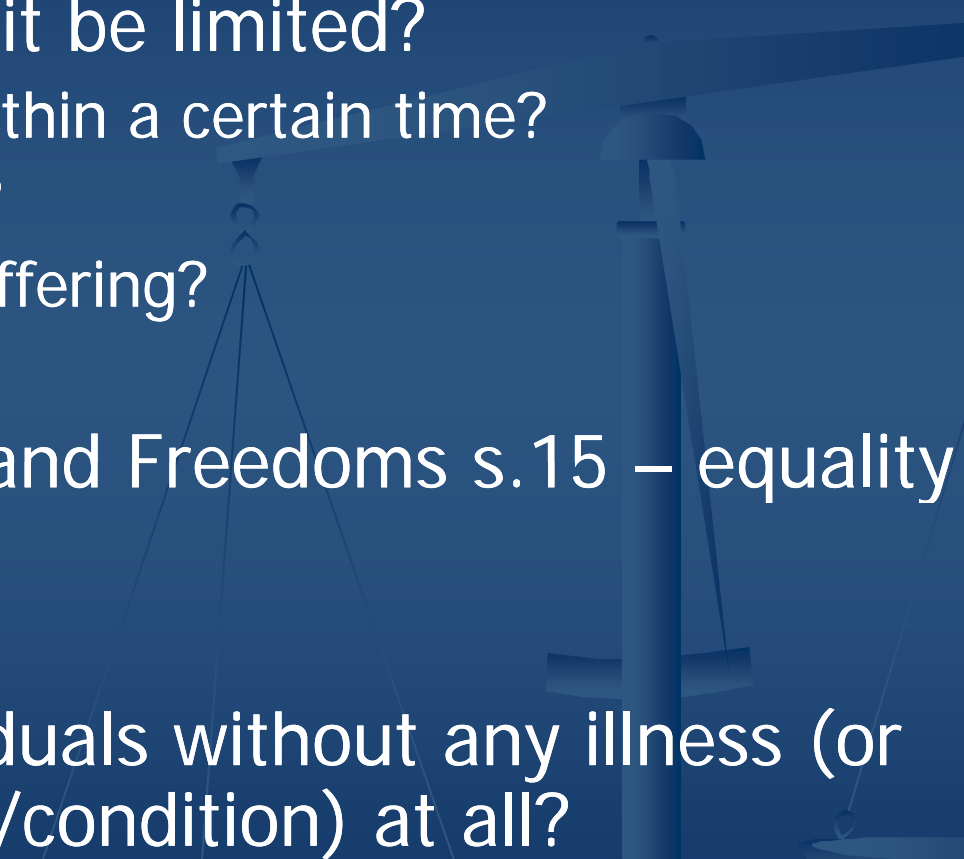
II: Comments re Bill C-384

- The standard for making a request is “appearing to be lucid”
 - Current common law - a patient must have capacity (be competent) to make a decision
 - “appearance” a lower standard
 - Given the gravity of a patient’s request, unjustifiable that a lower than normal standard of competence would be in place
- 

II: Comments re Bill C 384

- Request can be made if (1) suffering mental or physical pain without prospect of relief, or (2) terminal illness
 - Broad category appropriate? (CMQ)
 - Terminal Illness is undefined (Oregon)
 - The proposed *Act* would restrict requests for those 18 years and older – this will be challenged
- 

II: How far could this progress?

- If legalized, could it be limited?
 - Terminal illness within a certain time?
 - Restricted by age?
 - Exclude mental suffering?
 - Charter of Rights and Freedoms s.15 – equality under the law
 - What about individuals without any illness (or any serious illness/condition) at all?
- 

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Healthy Vancouver woman wants to die beside her ailing husband

Tom Blackwell, National Post
Published: Monday, April 13, 2009



Point Grey Pictures

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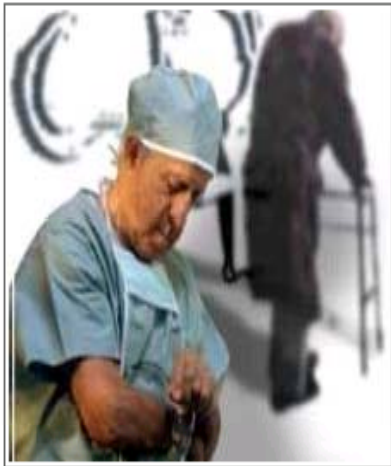
The End of Bill C-384

- On April 21st, a free vote occurred in Parliament after second reading and the Bill was defeated 228-59
- Supporters were mostly Bloc Quebecois (Francine Lalonde's party). Most MPs from the Conservative, Liberal and New Democrat caucuses either abstained or voted against this bill.

II: College des Medecins du Quebec

Quebec Doctors Tentative Proposal For Euthanasia Legalisation

Submitted by Anna Tomova on 2009, July 18 - 11:26 [Featured News](#) [Health](#) [Canada](#)



, the CMQ tentatively begins
spect of legalizing euthanasia
releases a "reflection
tempts to recast the debate
a part of appropriate end of

II: College des Medecins du Quebec

- "A new sensitivity is clearly evident among both doctors and the public that there are exceptional situations where euthanasia could be considered by their loved ones and by doctors and other caregivers as a final step in providing quality care to the very elderly."

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Quebec College of Physicians favours euthanasia in 'certain circumstances'

Canwest News Service
Published: Tuesday, November 03, 2009



Stefan Wermuth/Files/Reuters

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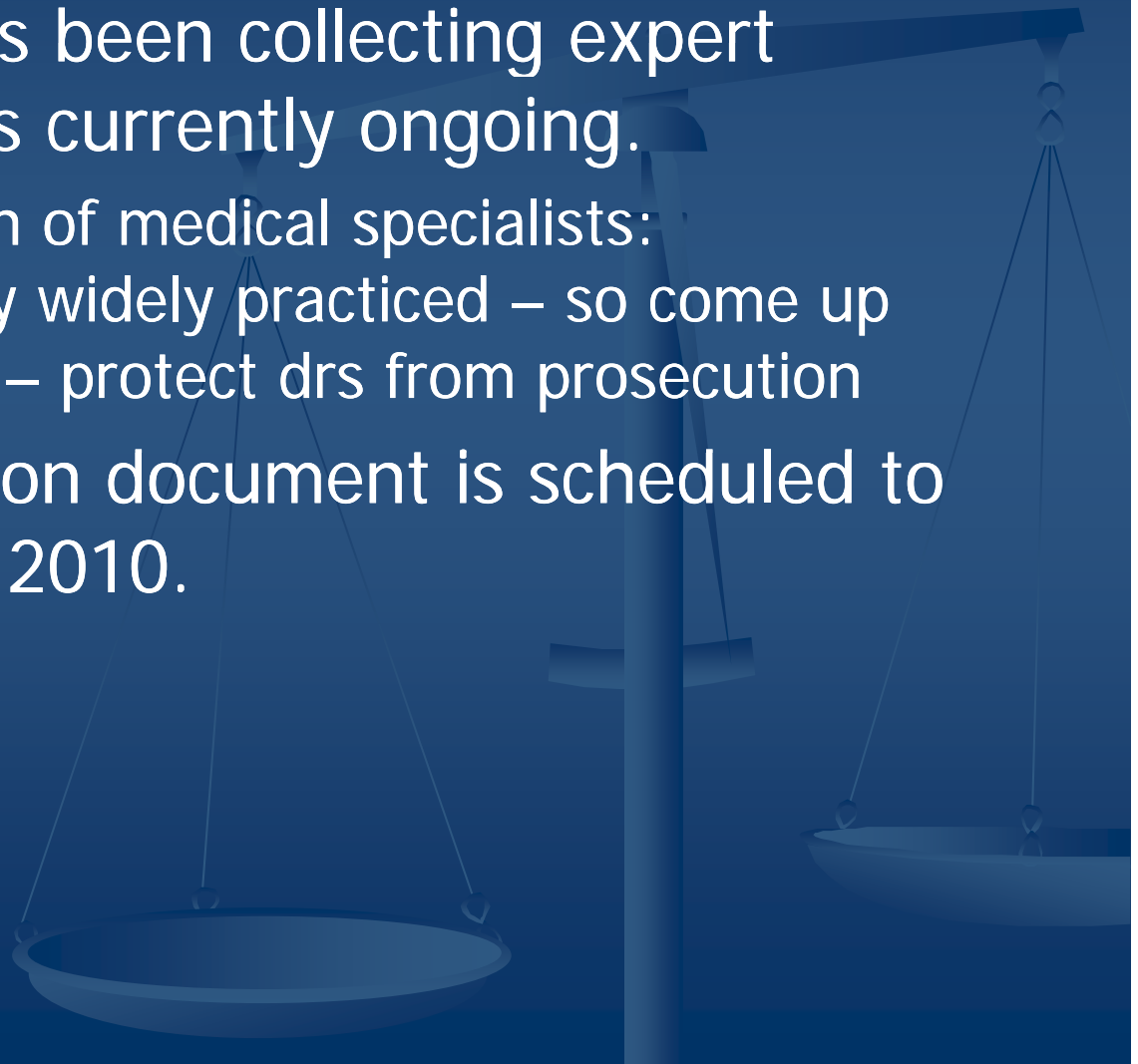
[Derek Leebosh](#)

II: College des Medecins du Quebec

- “Although certain distinctions must be drawn (e.g. between terminating treatment, relieving pain and euthanasia, between euthanasia and assisted suicide), the question of euthanasia must be integrated as part of appropriate end of life care **as soon as possible**”
 - For some, surest way to avoid aimless futile tx
 - Bill C-384 doesn't cover the “various clinical situations in which... shortening life is... envisaged as a final step in the provision of appropriate care”
 - Competent vs incompetent adults

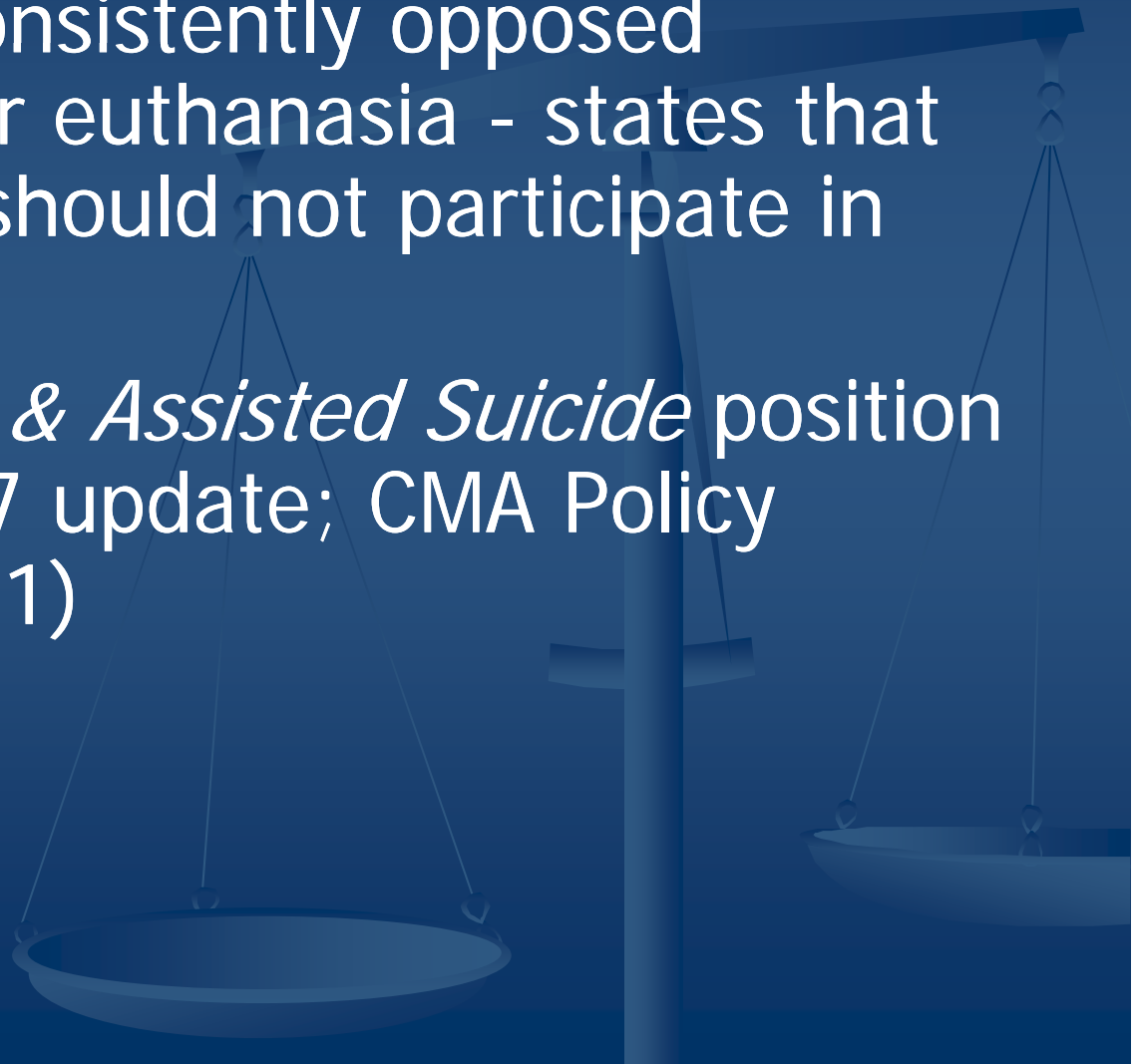
II: Quebec National Assembly

- Quebec's National Assembly struck a committee and has been collecting expert input. This process currently ongoing.
 - Head of Que asst'n of medical specialists: euthanasia already widely practiced – so come up with clear policies – protect drs from prosecution
- A public consultation document is scheduled to be released in fall 2010.



II: CMA Position on Euthanasia

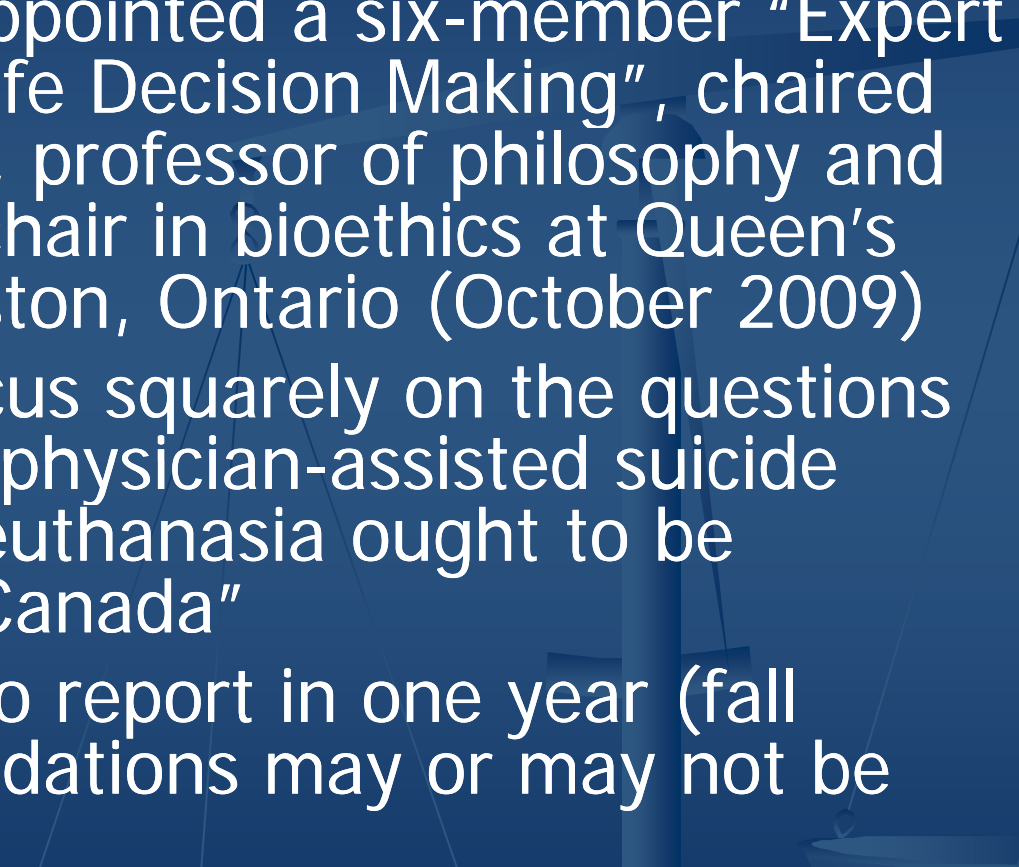
- The CMA has consistently opposed legalizing PAS or euthanasia - states that their members should not participate in either act
- See *Euthanasia & Assisted Suicide* position statement (2007 update; CMA Policy Number PD07-01)



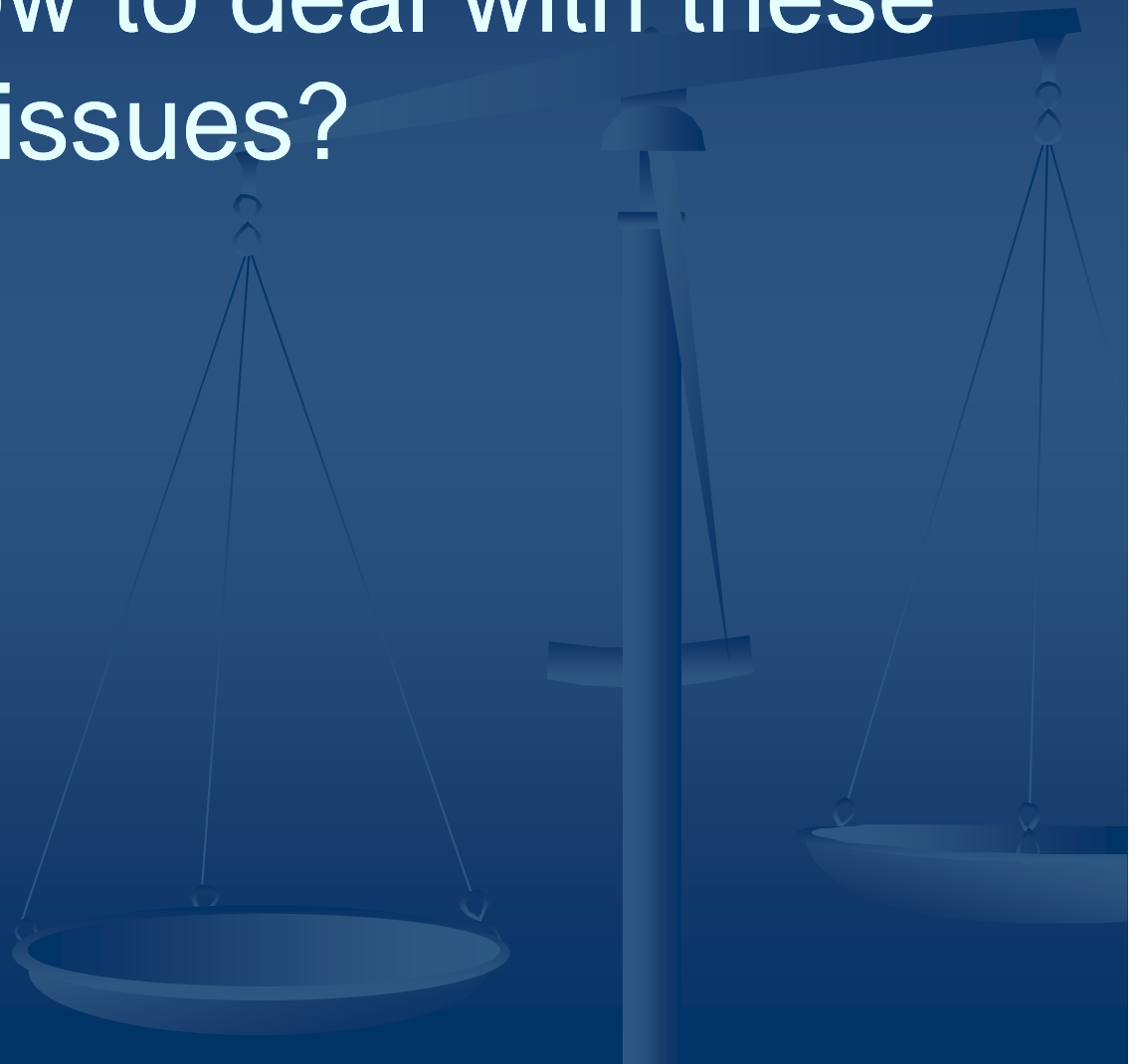
II: CMA Position on Euthanasia

- The CMA suggests the following must be addressed before considering the legalization of assisted suicide and euthanasia:
 - 1. Adequate palliative care services must remain available/be broadened.
 - 2. Suicide prevention program should be strengthened and maintained where necessary
 - 3. A study of medical decision making should be undertaken
 - 4. The public should be consulted about changes.
 - 5. Consideration should be given on whether the legislation can be restricted to intended indications.

II: Royal Society of Canada

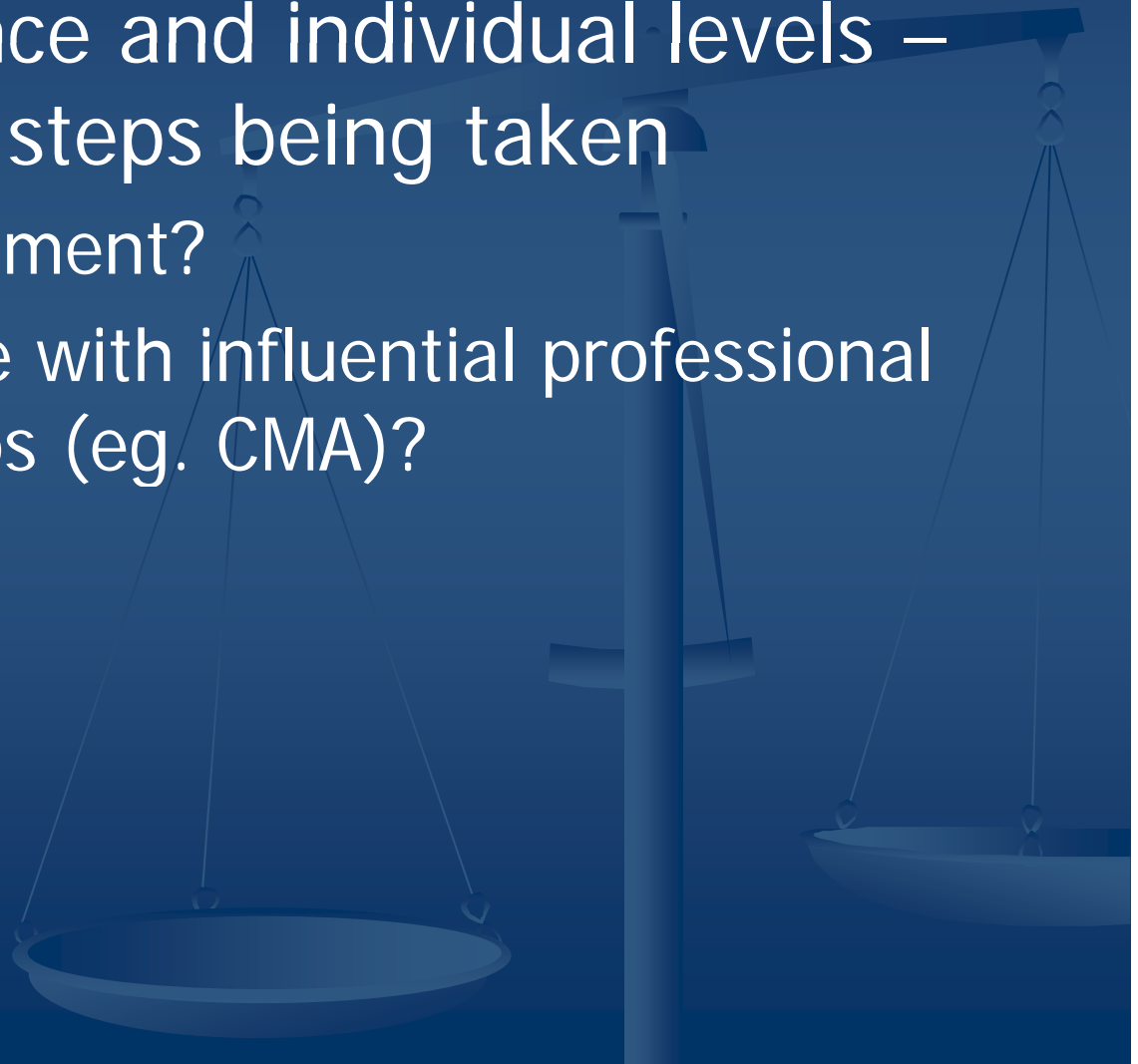
- The Society has appointed a six-member “Expert Panel on End-of-Life Decision Making”, chaired by Udo Schuklenk, professor of philosophy and Ontario research chair in bioethics at Queen’s University in Kingston, Ontario (October 2009)
 - The panel will “focus squarely on the questions of whether or not physician-assisted suicide and/or voluntary euthanasia ought to be decriminalized in Canada”
 - The panel is due to report in one year (fall 2010). Recommendations may or may not be issued.
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PART III: How to deal with these issues?



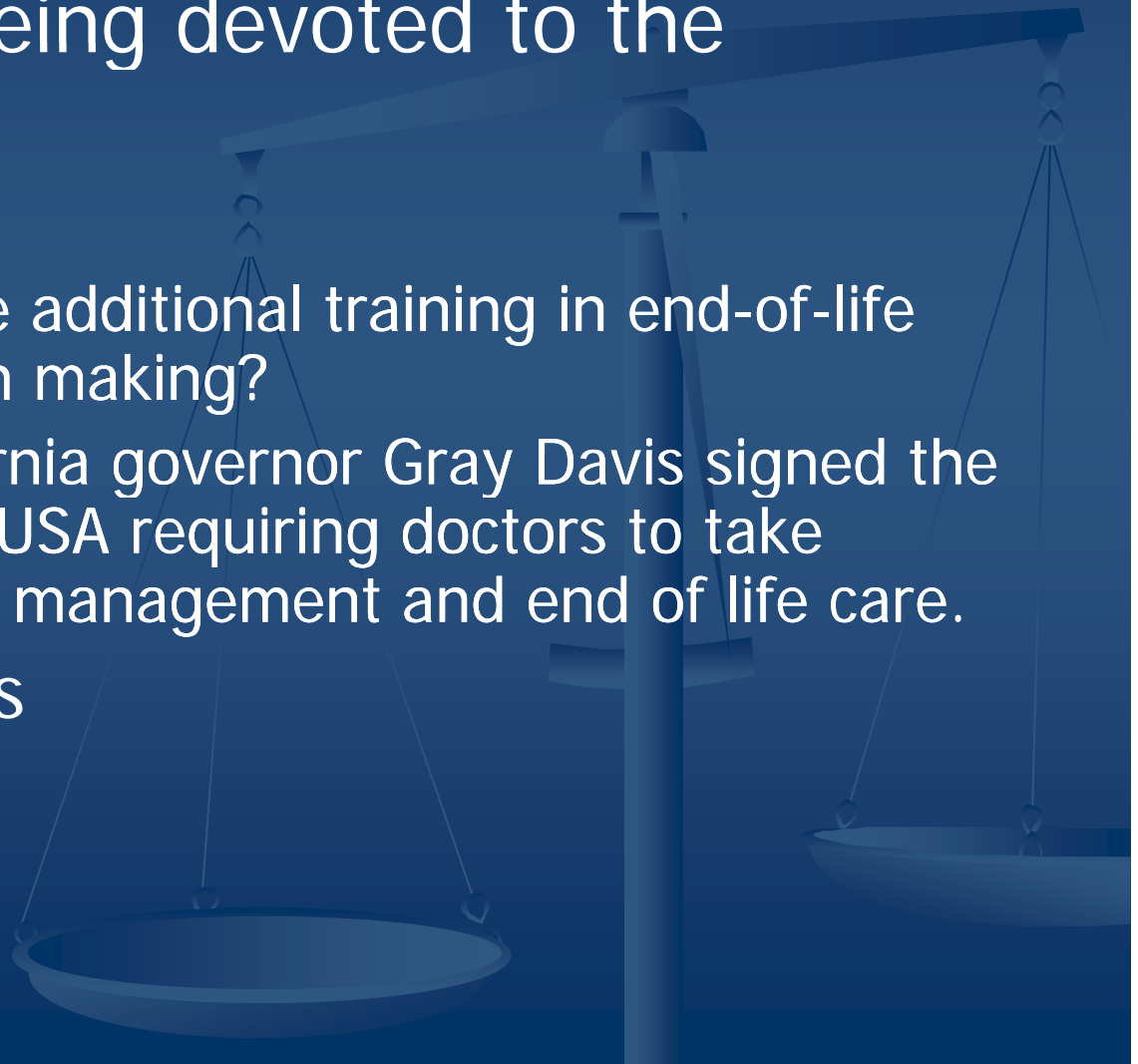
III: Advocacy

- At the governance and individual levels – are appropriate steps being taken
 - to lobby government?
 - to communicate with influential professional advocacy groups (eg. CMA)?



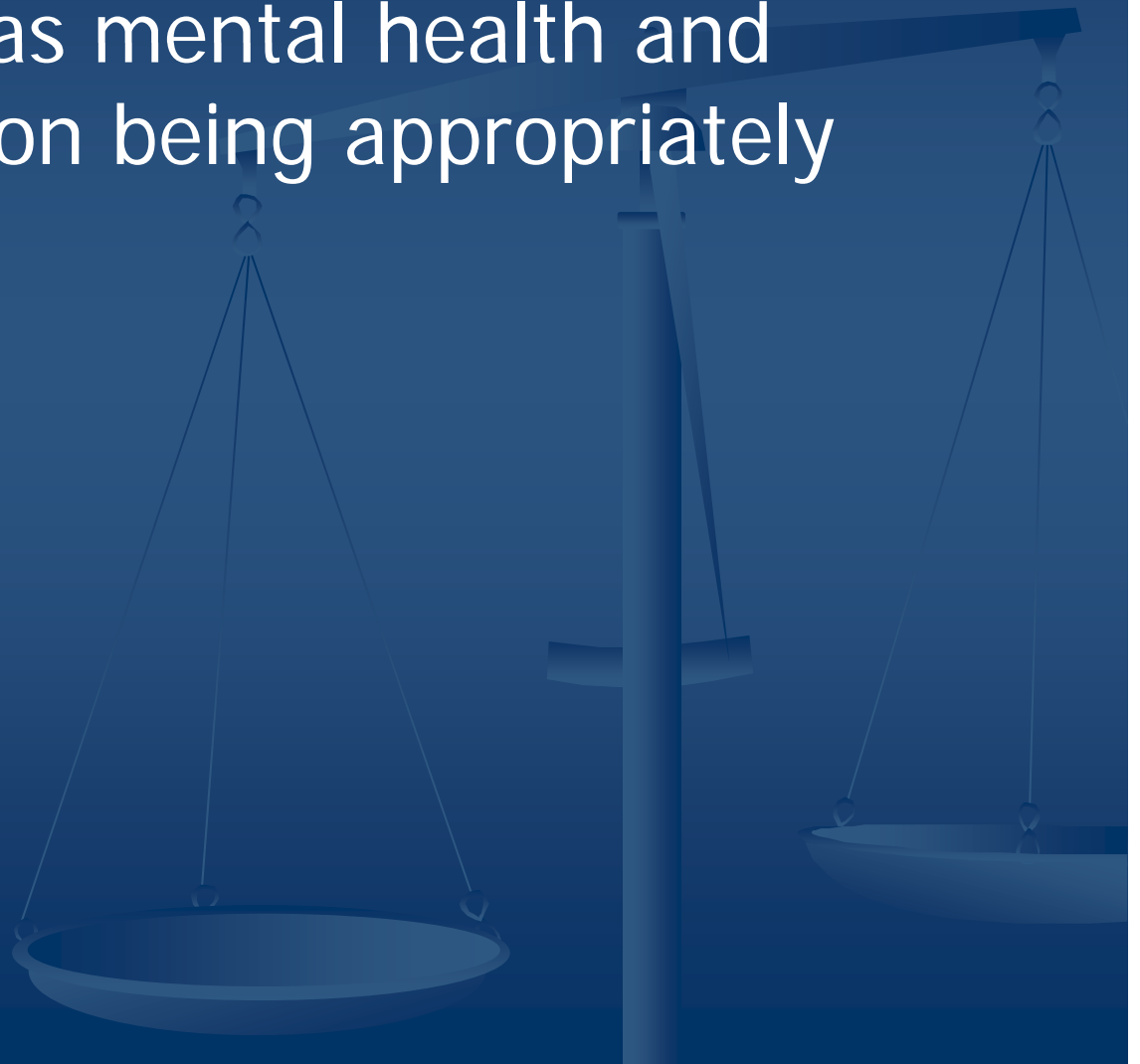
III: Education

- Are resources being devoted to the education of:
 - Staff
 - Do staff require additional training in end-of-life care or decision making?
 - In 2001, California governor Gray Davis signed the first law in the USA requiring doctors to take courses in pain management and end of life care.
 - Patients/families
 - The public



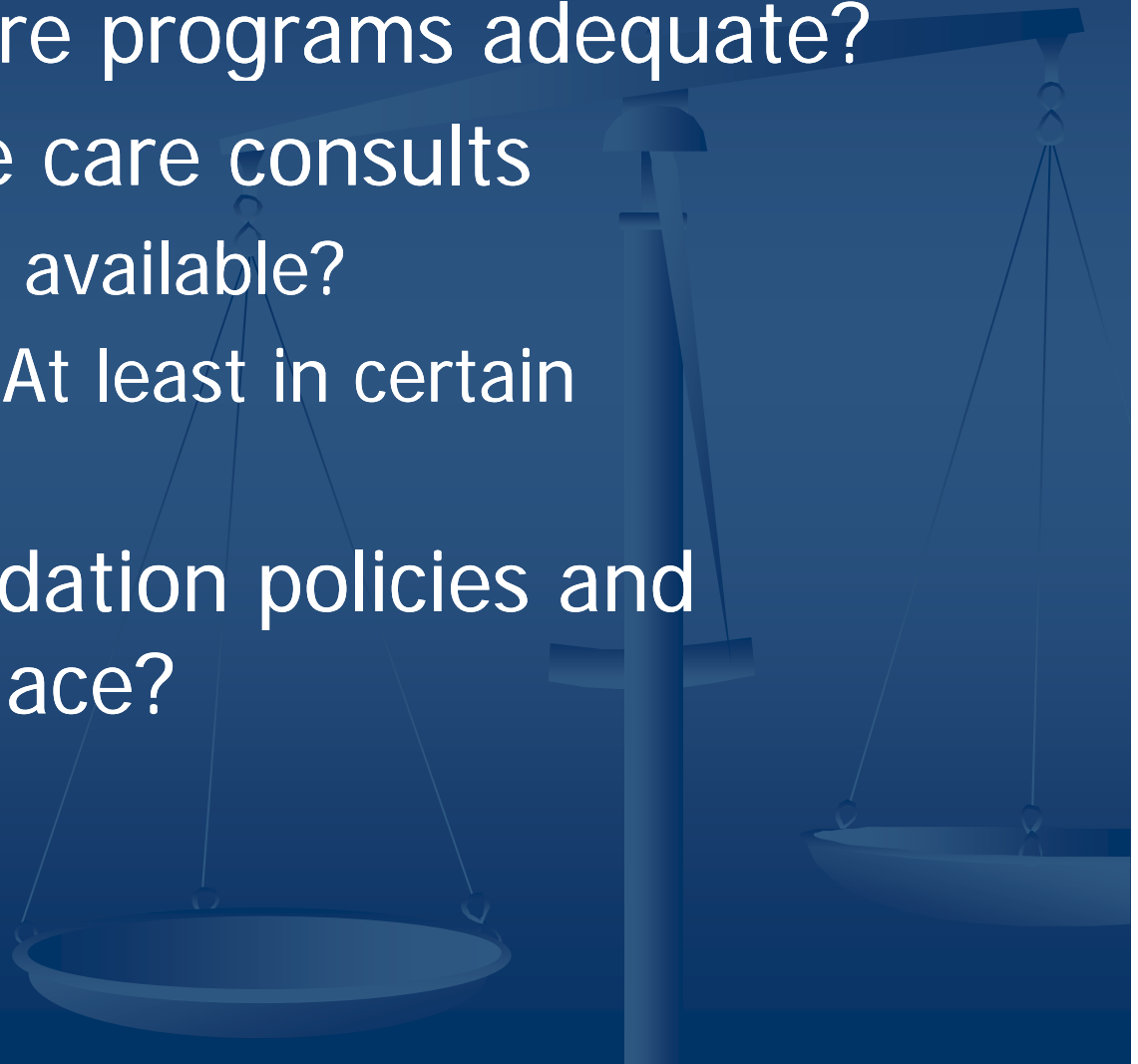
III: Adequate resources

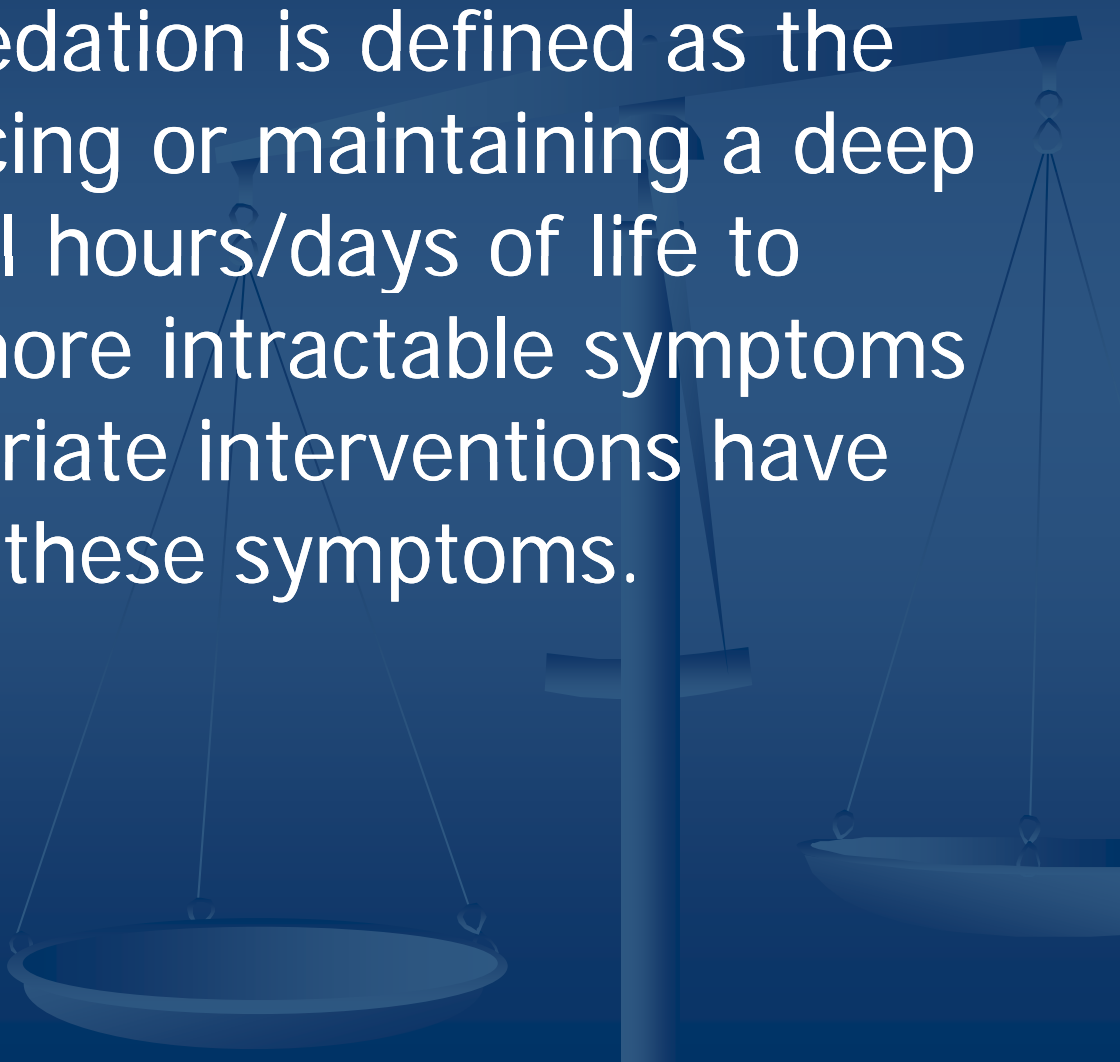
- Are areas such as mental health and suicide prevention being appropriately resourced?



III: Palliative Care

- Are palliative care programs adequate?
- Should palliative care consults
 - be more readily available?
 - be mandatory? At least in certain circumstances?
- Are palliative sedation policies and procedures in place?



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- 2.1: Palliative sedation is defined as the process of inducing or maintaining a deep sleep in the final hours/days of life to relieve one or more intractable symptoms when all appropriate interventions have failed to relieve these symptoms.

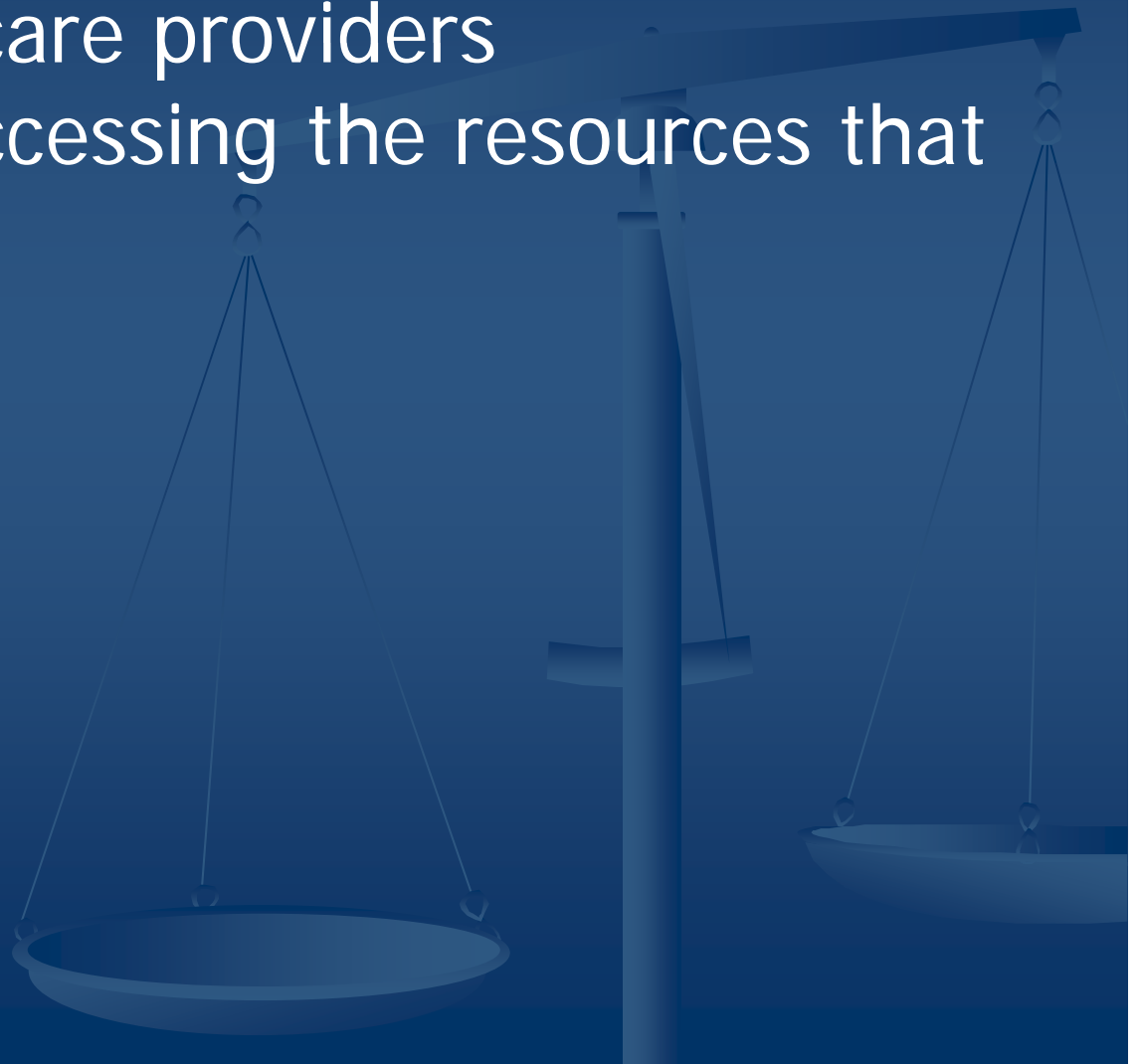


- General criteria include;

- A terminal disease
- Refractory symptom(s)
- In all but the most unusual circumstances, death must be imminent (within days)
- C2 goals of care designation must be in effect (*“Goals of Care and interventions are for physical, psychological and spiritual preparation for imminent death (usually within hours or days). Maximal efforts directed at compassionate symptom control. Transfer is usually not undertaken”*).
- Informed consent must be obtained from the patient or substitute decision maker in advance. If the patient is incapable or a substitute decision maker is not available, 2 physicians’ documented consent will also suffice
- Palliative care physician input must be obtained

III: Do we know enough?

- Are our health care providers appropriately accessing the resources that are available?



III: Safeguards

- If PAS/euthanasia become legal:
 - Have organizations addressed whether they would support willing physicians?
 - Do you have adequate safeguards in place to protect patients?
 - Do you have adequate safeguards in place to protect staff who are unwilling to participate in assisting suicide or euthanasia?

III: Safeguards

- For example, in Oregon's *Death with Dignity Act*, s. 127.885, s. 4.10 (4) states that

“(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider”

Questions/Further Discussion?

