

Line between acts and omissions blurred, euthanasia critics argue

Decriminalization of assisted suicide and voluntary euthanasia is an unethical alternative to redressing current deficiencies in palliative care in Canada, physicians, ethicists and patient advocates argue.

Decriminalization would offer a false choice so long as Canadians lack access to palliative care, the critics contended while panning the recommendation of the Royal Society of Canada panel report, *End-of-Life Decision Making*, which called for sweeping reforms to the Criminal Code on the grounds that there is no ethical distinction between assisted suicide or voluntary euthanasia, and withholding or withdrawing life-sustaining treatment from competent adults (www.rsc-src.ca/documents/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf).

The critics assert that it is “naive” and “disingenuous” for the panel to blur the line by arguing there is no ethical distinction (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4059). The critics also contend that the Royal Society panel is giving short shrift to concerns about abuses that might occur if decriminalization of assisted suicide and voluntary euthanasia is implemented.

“What about people who already feel like they’re a burden? If it’s very difficult for their families, it’s a failure of our social services and health care system,” argues Rhonda Wiebe, cochair of the Council of Canadians with Disabilities’ end-of-life ethics committee. “They shouldn’t be paying with their lives because health and social services can’t step up to the plate.”

As many as 70% of Canadians lack access to hospice and palliative care, and what programs exist are uncoordinated and unevenly distributed across the country, the report states.

“When my wife passed away seven years ago, I was a guy who had worked in health care for 25 years as a physician, who knew the system, had a com-



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Critics of the decriminalization of assisted suicide argue that there have been cases in which doctors took consent to pain relief as consent to euthanasia.

fortable income, and yet I still couldn’t get her home because there was no way it could be done with the resources available,” says Dr. John Haggie, president of the Canadian Medical Association. “The solutions the report suggests [represent] failures of the palliative care process. By not having a system, we have a population that are afraid of the process of dying, and that drives them [to request suicide].”

Adequate access to palliative care may not entirely prevent requests for assisted suicide, but until people have “relatively good options to manage their suffering,” decriminalizing euthanasia would present a false choice between pain and death, argues Dr. Larry Librach, director of the Temmy Latner Centre for Palliative Care at Mount Sinai Hospital in Toronto, Ontario.

The report asserts that Canada cannot wait until palliative care is optimized to have a policy on assisted dying. But Dr. Romaine Gallagher, palliative care physician lead at Provi-

dence Health Care in Vancouver, British Columbia, counters legislation isn’t needed because there isn’t a great demand for assisted suicide or voluntary euthanasia.

“The uptake of the right to physician-assisted suicide in Oregon is about 1 to 2 deaths per 1000 deaths,” Gallagher says. “To me the low uptake of physician-assisted suicide in Oregon only demonstrates the greater need for improved palliative care.”

Critics also dismiss the proposition that high numbers of Canadians support assisted dying. “There is ongoing confusion in the general public and in some health care providers about what constitutes euthanasia and physician-assisted suicide. For example, many people will confuse the removal of life support in a terminally ill patient as euthanasia,” Gallagher says.

The Royal Society report contributed to the confusion by equating the act of killing a patient or giving a patient the means to kill themselves

with withholding or withdrawing life-sustaining treatment, she charges. “This is a very simplistic way of looking at the outcome while forgetting the underlying cause of the outcome as well as the intent of the practitioner.”

When a physician withdraws or withholds treatment, the intent is to “continue to provide care aimed at symptom management but no longer intervene to prevent what is naturally going to happen,” and the patient dies “naturally from their underlying illness,” Gallagher adds. Physician-assisted suicide or euthanasia, on the other hand, is “administered with the sole intent of killing the patient,” and they die due to the physician administering a toxic substance, rather than their underlying disease.

Gallagher and others also argue the report overlooks crucial evidence of abuse in other jurisdictions that have legalized assisted death, including reports that some 32% of doctors who committed such acts in Belgium did so without patient request or consent (www.cmaj.ca/lookup/doi/10.1503/cmaj.091876).

Margaret Somerville, founding director of the McGill Centre for Medicine, Ethics and Law in Montréal, Quebec, cites increasingly lax condi-

tions around who can request assisted suicide in the Netherlands as proof of a “slippery slope” toward abuse.

“When first allowed through a judicial decision, the conditions were that the person was an adult, terminally ill, in terrible pain and suffering ... competent, had given their informed consent and had asked for euthanasia over a considerable period of time,” she explains. “Not one of those conditions now applies.”

Somerville also asserts that there have been cases in which doctors took consent to pain relief as consent to euthanasia, to the point that “old people are frightened of going into nursing homes [and] hospitals, and they’re frightened of agreeing to pain relief treatment.”

At a press conference following the release of the report, panelists told reporters that instances of such abuse are unavoidable, but much less frequent in jurisdictions where euthanasia is regulated.

However, the evidence used to assert that abuse is relatively uncommon in such jurisdictions is “not very complete,” Gallagher says, adding that the data are based on voluntary physician reporting and surveys have indicated

that in such cases, physician response rates are under 60%.

Critics also argue that the Royal Society did not address several other ethical dimensions of the euthanasia debate.

“If the basic principle is autonomy and that’s always the overriding value, which is what they argue in the report, then if you’ve got a brokenhearted 18-year-old who wants euthanasia, how can you reject what she’s asking for?” Somerville contends.

Librach, who doesn’t oppose euthanasia for the terminally ill, nevertheless “shudders” at the notion of an assisted suicide for someone having a “rough patch in life.” Rather, he says, they should receive treatment for “existential suffering.”

Wiebe argues the report fails to account for societal pressure that will be placed on vulnerable populations, such as people with disabilities, to end their lives. “There’s this continual apology for your own existence and when you start internalizing that, what happens when you go to a doctor who is supposed to be helping you negotiate life with a disability, and they’re saying death is always an option?” — Lauren Vogel, *CMAJ*

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