A New Way To Die

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On Friday, February 6th, 2015 the Supreme Court of Canada changed the way some Canadians can die. It struck down a twenty-two-year old ruling denying access to assisted-suicide by modifying the Criminal Code such that all adults who "clearly consent" and who suffer from a "grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring suffering and that is intolerable to the individual in the circumstances of his/her condition" can access assisted-suicide [1].

This decision remains controversial despite the fact that 68% of Canadians support the legalization of assisted-suicide, according to one recent poll conducted by the Environics Institute, a not for profit research group [2]. Advocates of people who suffer greatly due to medical conditions defined above are ecstatic and relieved, while advocates of vulnerable populations (e.g. health care professionals, Council of Canadians with Disabilities) and some individuals with disabilities condemn the decision. It is a question of balance between a person's autonomy and dignity and the need to protect vulnerable people from coercion into suicide. Twenty-two years ago, the Supreme Court decided that Sue Rodriguez's case was not strong enough to lift the ban on assisted-suicide.

THE ORIGINAL CASE

Rodriguez, who suffered from Amyotrophic lateral sclerosis (a progressive neurodegenerative disease resulting in loss of skeletal muscle control and eventually death), was effectively denied access to physician-assisted suicide [3]. At the time, this was determined based on the Canadian public's opinion about the sanctity of life and on the need to protect vulnerable people who might otherwise be persuaded into suicide. It is very difficult to know if someone is being pushed into an undesired death by the health system or by family members who may have vested interests. For example, a physician would not necessarily be aware if a family member is persuading the patient into suicide because of a large inheritance. Once assisted-suicide is accessible, it could easily lead to a slippery slope towards homicide of disabled and vulnerable people.

Keywords: Assisted-Suicide; End of Life; Physician-Assisted Suicide

THE CURRENT CASE

Kathleen Carter and Gloria Taylor challenged this ruling in 2011 by arguing that the previous decision was too broad. They claimed that, as such, it also prohibited access to assisted-suicide to those outside the class of vulnerable persons, who are competent, fully-informed, and not being coerced [1]. The challenge against this ruling in 2011 by Carter, 89, who suffered from spinal stenosis (narrowing of the spinal canal with spinal cord compression), and Taylor, 64, who suffered from ALS brought the Rodriguez case back into question. These women had poor prognoses and were fighting for the right to die peacefully and with dignity.

This time the Supreme Court found that the current legislature was too broad and created a "duty to live" precedent, which goes against the constitutional rights of life, liberty, and security of the person [1]. This "duty to live" is in direct contrast with the "right to live," and it challenges the legality of any consent to stop treatment and/or life-sustaining therapy (which is currently an accepted practice). They took heavily into consideration evidence from other countries that have legalized assisted-suicide, which showed that regulatory systems in Belgium, the Netherlands, and the state of Oregon, do manage to protect vulnerable people. It was also argued that legalization of assisted-suicide would avoid a dangerous black market of assisted-suicide either within Canada or abroad (assisted-suicide tourism). Furthermore, access to assisted-suicide would permit people to live longer, as opposed to them having to take their own lives while they are still capable. Lastly, it was argued that unregulated end-of-life practices in Canada such as palliative sedation and withholding or withdrawal of treatment are considered ethically acceptable by the Canadian public and are not ethically different from physician-assisted suicide. Despite these facts, however, many are concerned about the implications of allowing assisted-suicide in Canada.

Firstly, the wording of the ruling (seen above) has some people worried because it permits not only terminally ill patients, but also people suffering physically and/or emotionally, access to assisted-suicide. This level of permissiveness worries many people, including advocates of people with disabilities who believe

that allowing assisted-suicide will lead to a slippery slope toward murder, despite the safeguards that will be incorporated into the laws. There are two types of safeguards that can be employed: direct (i.e. restrictions in the legislation) and indirect (i.e. research on and development of alternatives to assisted-suicide). Interestingly, the United Kingdom's Supreme Court recently found that the evidence on the effectiveness of safeguards was not sufficient to draw any conclusions [1]. They also found evidence of failure to comply with safeguards and of an expansion of inclusion criteria for access to assisted-suicide as time passed after legalization, which presents the potential for a slippery slope (as in Belgium) [1]. Furthermore, qualified and experienced physicians will likely perform the assisted-suicide. This entails a question of medical ethics because their primary objective as a profession is to preserve life, not to actively end it. Another argument suggests that the development of palliative care would cease if assisted-suicide were legalized, thereby limiting options for those who wish to continue living. However, the judge rejected this argument based on evidence from the countries that have legalized assisted-suicide, which showed not only that vulnerable populations are not "at heightened risk of accessing physician-assisted dying", but also that in some places, palliative care improved after the legalization of physician-assisted dying.

WHAT IS NEXT?

The court ruling is suspended for 12 months, and during this time Canada will be drafting laws to better define who should have access to assisted-suicide, how they must gain this access, who will perform the procedure, and how to regulate the process in order to avoid potential abuse. Since health is under both Federal and Provincial jurisdiction, the regulation of assisted-suicide will likely be done at both these levels with input from physicians' colleges. Furthermore, Canada will need to investigate how other countries with legal assisted-suicide regulate and implement their laws.

Switzerland, in order to avoid coercion, allows assisted-suicide if the individual assisting the suicide does not have selfish motives (i.e. financial incentive or vengeance). This is an interesting point, as physicians are compensated financially for all procedures. How could one be sure that the physician is acting in the patient's best interest if it is more lucrative to perform an assisted-suicide than to keep the patient alive? Furthermore, under Swiss law, assisted-suicide is provided by giving the means to commit suicide (prescriptions), and euthanasia (injections) is not permitted [4]. Interestingly, it also permits assisted-suicide for foreign nationals. However, Canada is a different country with different challenges and all of the evidence must be considered with this in mind. It is important to note that many of the statistics available from these countries after which we may model our laws may not be truly representative of the situation. In Belgium, for example, roughly 50% of all cases of euthanasia were not reported to their Federal Control and Evaluation Committee [5], and therefore did not figure into their statistics.

Given the importance of informed consent with assisted-suicide, the legal definition of competence should also be revisited. At present, it is defined as being "able to understand the information that is relevant to making a decision about the treatment […] and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision." If a person is found not competent, the decision made must be in keeping with the person's "best interests" [6]. It is difficult to define "best interests" in any situation, and the gravity of assisted-suicide may require more specificity.

Another important discussion that must be had is the degree of obligation of Canadian doctors in physician-assisted suicide. Will physicians volunteer to perform this procedure? Will there be clinics dedicated solely to physician-assisted suicide? A recent policy released by the College of Physicians and Surgeons of Ontario has implications about this. It states that the right of a physician to "limit the health services they provide for reasons of conscience or religion […] may impede access to care in a manner than violates patient rights under the Charter and Code" [7]. This implies that physicians may be obligated to play a role in assisted-suicide, even if it is just a referral. For many physicians, referring a patient to a clinic to die goes against their personal and/or religious convictions. There are no easy solutions to these issues, and there is significant work that needs to be done over the next year. Physician-assisted suicide will become an important discussion to have with family members over the next few years.

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