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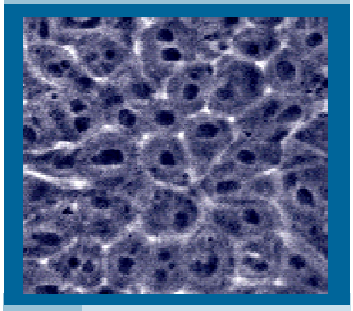

CANADIAN CATHOLIC BIOETHICS INSTITUTE

Bioethics Update

Euthanasia and Physician-Assisted Suicide Legislation: What we might expect in Canada

Moira McQueen, LL.B., M.Div., Ph.D.
Director, Canada Catholic Bioethics Insitute

The Canadian Justice Minister, Irwin Cotler, announced earlier this year that his department would be looking at the possibility of enacting the legalization of euthanasia and physician-assisted suicide. This may not happen for some time due to current political uncertainty, but it seems that Canada will eventually pursue this, given its commitment to other social platforms such as same-sex marriage.

"Rights" Language

These days, many people are talking about a "right to die". Dying is inevitable for every person, but what does it mean to call dying a right? The late Pope John Paul II warned us to beware of "rights" talk in issues involving beginning and end of life. Certainly, authentic human rights are extremely important, but we have to be alert to possible abuses of the concept. A good example here is the much trumpeted and widely accepted women's "right" to abortion. Naming something a "right" is often the first stage in persuading society that it is time to legitimate certain behaviours, formerly viewed as unethical, and so forbidden.

A deeper question is: where do rights come from? Are they inherent in persons? Or are they only constituted by judicial or parliamentary decisions? If they are the result of judicial or parliamentary fiat, what reasons are given for their assertion? Catholic teaching is clear that inherent rights and legal rights are different in nature, even if they coincide at certain points. Again "the right to choose" makes the point. Here the inherent right to life, the right of every person, is trumped by a legally given right to kill a person at his or her most vulnerable stage of existence.

The basic legal principle of the sanctity of life has been stood on its head for a long time now in Canada. In other words, inherent rights have been denied by the judiciary and by parliament. It will be interesting, therefore, to see how this newly asserted "right", the "right to die", will fare in Canada.

Proposed Legislation in the UK

A Bill introduced in the UK could serve as an indication of what we might expect here in Canada by way of proposed legislation, since laws in most areas of Canada are based on the English common law tradition. Since the whole country has many cultural similarities with Britain, it seems more likely that Canada will follow the United Kingdom's example rather than that of the United States. Add to this that Canada's experience is different from that of the United States with respect to the political power currently exercised by religious coalitions. The Bill was introduced as a Private Member's Bill in the House of Lords in 2003, and a First Report was published on April 4, 2005, by the Select Committee chosen to review it.

The introduction to the Bill announced its intention:

> To enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make provision for a person suffering from such a condition to receive pain relief medication. [1]

At first glance it would seem that physician-assisted suicide or indeed any

form of assisted suicide is the focus of the proposed legislation, not euthanasia in general. But Section 1(2) immediately states:

> For the purposes of this Act –"Assisted dying" means the attending physician, at the patient's request, either providing the patient with the means to end the patient's life or if the patient is physically unable to do so ending the patient's life.[2]

It is clear that both euthanasia and physician-assisted suicide are proposed. The Bill was referred to a Select Committee, where the point raised earlier about "rights" comes into play, since its Report declares that the proposed legislation "is based on the principle of personal autonomy and patient choice, the right of each individual to decide for themselves how best he or she should lead their lives" [3]. (*Sic)*

The patient has to have reached the age of majority (18 years old in the UK), has to have been a resident of the UK for at least 12 months, and has to have a terminal illness, defined here as "…the effects of which cannot be reversed by treatment…and which will be likely to result in the patient's death within a few months at most." [4] "Unbearable suffering" is defined as "suffering whether by reason of pain or otherwise which the patient finds so severe as to be unacceptable and results from the patient's terminal illness…" [5] The inclusion of a phrase such as "or otherwise" shows that the legislation is envisaging a very broad category of suffering, which includes not only physical pain, but also the wider category of mental suffering.

Palliative Care as a Response to "Unbearable Suffering"

One of the answers to people's dread of suffering, which could possibly lead them to choose euthanasia or assisted suicide, could be the assurance of the provision of good palliative care. Some expert witnesses at the Select Committee were of the opinion that there are people for whom even the best palliative care will never be enough, since there are personal needs that go far beyond the capacities of palliative medicine to remedy. Perhaps the truth is that, for all of us, there are some needs which will never be fulfilled on this earth, and we must come to terms with that hard reality. Christians know that nothing on earth can fill some of our voids, acknowledging with St. Augustine that "…our hearts are restless until they rest in Thee…". Still, we owe it to the suffering and dying to relieve as much of their pain as possible.

A fundamental concern for those who oppose euthanasia is to ensure that good palliative care is available: it is going to be very difficult to persuade people against some death-causing practices if this is not the case. There is homework to be done in terms of the provision and delivery of palliative care in Canada, and some of the findings of the Select Committee could be useful here.

Some expert witnesses reminded the committee that sometimes people are not so much looking for an "end to it all" as much as for some kind of reassurance, especially regarding their fear of being abandoned. Some think that the effects of improvements in the delivery of palliative care in Britain have been dramatic, but, unfortunately, it does not seem to be uniformly available. If this is the case in a country which people see as a role model, then we can only imagine the state of the provision of palliative care elsewhere.

The Report notes that the number of GP (family doctor) practices which had done adequate training in palliative care according to the standards of the Department of Health came to about 1 600 out of 10 000-11 000, with about 1 000 out of some 40 000 district nurses completing training. It will be interesting to find out the Canadian statistics, and to know if we have the same proportions.

The inadequate availability of palliative care is referred to several times, and the Committee says, "We are unanimously of the view that high priority should be given to the development and availability of palliative care services across the country, and we hope the efforts which are being made in this direction will be intensified". [6]

The situation in Oregon, where assisted suicide is legal, but euthanasia is not, is of interest. It seems that palliative care has improved since the Oregon Death with Dignity Act (ODDA) became law in 1997. This is rather paradoxical, and it would seem that the demand for assisted suicide has not been nearly as great in Oregon as in the Netherlands despite the fact that the Netherlands permits both euthanasia and physician-assisted suicide. Statistics show that the numbers of people requesting assisted suicide in Oregon have remained relatively stable, and a major reason for that seems to be that palliative care is widely available. The number of people

recorded as taking the medication prescribed for assisted suicide rose from 16 in 1998 to 42 in 2003, if the official figures are accurate. If it is true that few use the ODDA because of the availability of hospice care, that makes us question the real need for the legalization of euthanasia and assisted suicide in the first place, and emphasizes the importance of palliative care.

"Hospice" in Oregon is provided at home on a visiting basis rather than in a facility, and different agencies are used to provide 24-hour care where necessary. While even the smallest community has access to hospice care, only comfort care is provided. This has curtailed the number of aggressive interventions at the end of life, compared with statistics from other states – an interesting situation with implications for other countries, including Canada. [7] It should be noted, though, that statistics in the Netherlands, unlike Oregon, indicate a substantial increase in the numbers of people choosing euthanasia, so there is no room for complacency, should Canada be more similar to Holland than to Oregon, one of the smaller, less ethnically and culturally diverse American states.

The Slippery Slope – Once More

Many point towards the dangers of the "slippery slope" in the euthanasia debate, and the Select Committee also looked quite closely at these concerns, under the following five headings. (Note that religious stances are, on the whole, not being developed in this article. Rather, it tries to answer the rationales proposed in secular fashion, and to deal with those arguments on their own terms. As a Roman Catholic moral theologian, however, my understanding of the *imago dei* concept underlies my theological approach to all these points.)

1. *Incremental extensions to the law*
   The Report is concerned that although the law purports to be for those adults who are suffering unbearable pain and are terminally ill, inevitably some will want to use it for those who are younger, or are not terminally ill but consider themselves to be suffering unbearably.

My concern: instances of this are already happening in the Netherlands, where euthanizing of newborns with deficiencies has begun, and also of adults who declare they have lost the desire to live. [8]

2. *"Elastic" interpretations of the law's provisions*
   There is a concern that terms such as "unbearable suffering" will be so loosely interpreted that there will be far more requests for euthanasia or assisted suicide than expected.

My concern: initially, abortion was supposed to be done only for serious reasons, yet flimsy reasons are often advanced and accepted for the procedure. Others think that, if a procedure is legal, reasons are almost an afterthought, and "choice" constitutes reason enough. Will the same happen with euthanasia and assisted suicide?

3. *Hidden Pressures*
   The Report notes that there is often pressure from society on older people, especially if infirm, making them feel useless and burdensome. Some older people feel this way innately, and this is difficult to deal with, but if a family is poor, or otherwise in a difficult situation, it is hard to give older members the time and attention they deserve, and they may in fact begin to be perceived as burdensome.

My concern: added to the mix are the facts that people are living longer and may need more long term care, and, at the same time, more women, the traditional caregivers, are in full time employment. Families face different realities these days, as the demand grows for more senior residences and retirement homes at one end of the life spectrum, and for more childcare at the other.

If the law is changed, making euthanasia and assisted suicide "options", would elderly people feel they should oblige their families by "opting out"? The amount of this type of social pressure should not be underestimated, even as we note that it is morally reprehensible, based as it is on mostly economic factors. There is also the further risk that disabled people, of any age, would feel similar pressures to relieve their families of burden.

4. *Abuse of the law*
   The Select Committee noted that, while some think that euthanasia should be legalized so that assisted deaths can be overt, with no hidden factors, others fear that covert practices will continue. The Netherlands statistics show that about 1 000 cases of euthanasia occur every year without formal requests and formal procedures being observed. [9]

My concern: it has long been suspected that in many countries, not just the Netherlands, quiet arrangements

are made between patients or families and doctors, giving a nod in the direction of ending life. There is the further possibility that, while some believe they are acting out of love, to spare a family member from pain and suffering, some could just as easily be ensuring a hastier dispatch for someone whose existence represents a financial or personal burden to them, or whose demise represents financial gain upon the person's death.

5. *Paradigm Shift*
   The House of Lords' Report refers to this, noting that if euthanasia and assisted suicide become legalized, then they will pass into the medical world as "therapeutic options", and that pressure will develop to extend this "option" from those suffering unbearably to, say, the mentally incompetent. Perhaps the British Association for Palliative Medicine best describes this "death as therapy" paradox in remarking that "…the Bill postulates the ethical concept that death is a 'moral good'". [10]

My concern: if euthanasia and assisted suicide are beginning to be seen as "goods" for competent persons, how will we protect those who are incompetent, for whom these "goods" will be sought by others?

Physicians, too, have reason to be wary of euthanasia being seen as a "good", as well as a right. If euthanasia and assisted suicide become legal, then the practice could become part of a doctor's duty. The argument will be made that conscientious objection should take care of that, but there are increasing concerns in many countries about the protection afforded by that principle. At the same time, the doctor-patient trust relationship will be eroded, and relationships will take on a new form, unlikely to be personal, more likely to be increasingly technical. Yet there have been favourable responses to the Bill from many British medical organizations, and that may carry enough weight to propel the legislation ahead, despite strong objections and reservations from many other sizeable groups, including powerful religious groups and groups concerned with the protection of the disabled.

Conclusion

For us in Canada, similar changes in the law are likely to be proposed. Any review by a parliamentary committee will probably cover similar points to those raised in the UK, which in turn reflect the most common critiques of euthanasia and assisted suicide. It is important that we be familiar with the reasons that will be given for the practice, and also with counter arguments, in advance of any legislation. A concerted effort by professional ethicists, theologians, clergy, lay people and dioceses needs to be in place to meet this coming challenge with all the power that can be mustered. The grassroots response to the same-sex marriage bill shows that many people are keen to maintain values protective of life issues. Euthanasia and assisted suicide need to be challenged in a Christian spirit which defends the truth about human persons – their dignity as persons from conception until death, and their essential interconnectedness with other human beings.

The Ontario Conference of Catholic Bishops pointed to this truth when they wrote in 1996:

> Isolation and loneliness can be overcome, but only when we abandon the fantasy of radical autonomy and acknowledge how deeply we need other people in both our living and our dying. [11]

Endnotes

[1] Introduction, *Assisted Dying for the Terminally Ill Bill* (HL), London: The Stationery Office, HL Bill 17, January 8, 2004, p.1.
[2] Ibid., Section 1(2)
[3] *First Report,* Select Committee on *Assisted Dying for the Terminally Ill Bill,* Section 22. http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8605.htm
[4] *Assisted Dying Bill,* Section 1(2).
[5] Ibid.
[6] Ibid., Section 90
[7] Ibid., Sections 156 and 165
[8] John Keown, *Euthanasia, Ethics, and Public Policy*, Cambridge: Cambridge University Press, 2002, p. 119ff, and footnote 77, pp. 237-8.
[9] *First Report,* Sections 171 and 178
[10] Ibid., Section 102
[11] Ontario Conference of Catholic Bishops. *A Message from the Ontario Bishops on Euthanasia and Assisted Suicide,* January 1996, p. 4.

Canadian Catholic Bioethics Institute
81 Saint Mary St., Toronto, Ontario, Canada M5S 1J4
Tel. (+1) 416-926-2335 Fax (+1) 416-926-2336
Email: bioethics.usmc@utoronto.ca
Website: www.utoronto.ca/stmikes/bioethics