

## Euthanasia in Canada: a Cautionary Tale



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We are Canadian physicians who are dismayed and concerned by the impact – on patients, on doctors, on medical practice – of the universal implementation, in our country, of euthanasia defined as medical “care” to which all citizens are entitled (subject to the satisfaction of ambiguous and arbitrary qualifying criteria). Many of us feel so strongly about the difficulty of practicing under newly prescribed constraints that we may be forced, for reasons of personal integrity and professional conscience, to emigrate or to withdraw from practice altogether. All of us are deeply worried about the future of medicine in Canada. We believe this transformation will not only be detrimental to patient safety, but also damaging to that all-important perception by the public – and by physicians themselves – that we are truly a profession dedicated to healing alone. Thus, we are alarmed by attempts to convince the World Medical Association (WMA) to change its policies against physician participation in euthanasia and assisted suicide.

Notwithstanding the disavowals of those promoting change of the WMA policies, such a change would encourage legalization of the procedures in other countries, and it is certain that this would have a major adverse impact on our patients and colleagues around the world. Hence, we believe it is important for them to reflect upon our perspective: that of Canadian physicians who refuse to kill our patients or to help them

commit suicide, who refuse to facilitate euthanasia or assisted suicide by others, and who practise in a country where such refusals are widely thought to reflect unacceptably extreme and unprofessional views. Our perspective has been missing in WMA discussions until now.

### The Law

In Canada, the federal government is responsible for criminal law and the provinces have jurisdiction over health care and enforcement of criminal law. In 2014, the Province of Quebec exploited this constitutional arrangement by legally redefining end-of-life medical care to include euthanasia [1]. The law came into force in December 2015.

In February 2015, the Supreme Court of Canada ruled in *Carter v. Canada* that physicians may provide euthanasia or assisted suicide for competent adults who clearly consent, who have a grievous and irremediable medical condition (including illness, disease, or disability) that causes enduring and intolerable physical or psychological suffering, and that cannot be relieved by means acceptable to the individual [2]. The criteria are broader than those specified in the Quebec statute.

The Criminal Code was amended in June 2016 to give effect to the ruling throughout

the country [3]. Quebec law allows only euthanasia, and only for someone “at the end of life” who is in an “advanced state of irreversible decline in capability” [1]. Similarly, the Criminal Code states that the natural death of the candidate must be “reasonably foreseeable” (an undefined term) and replicates Quebec’s requirement of an advanced state of decline. It also specifies that the candidate’s illness, disease or disability be incurable [3].

Determined patients who do not meet these requirements because of natural disease processes can opt to starve themselves to the point of qualifying for the procedures [4]. This has been denounced as “cruel” and suggested as a reason to abolish the requirements [5]. Lawsuits underway in British Columbia [6] and Quebec [7] assert the requirements are unconstitutional.

### Expanding Access to Euthanasia and Assisted Suicide

If current lawsuits are successful, euthanasia and assisted suicide will be available as a supposed “treatment” for mental illness, since not all mental illnesses permanently impair decisional capacity. Moreover, the Supreme Court did not rule out allowing euthanasia and assisted suicide for reasons beyond those identified in *Carter* [2].



Within a year of the ruling, the pressure for “Carter Plus” had become so great that the federal government legally committed itself to consider allowing euthanasia and assisted suicide for adolescents and children, for indications caused by mental illness alone, and by advance directive (for those who lack capacity, like patients with dementia) [8].

In sum, while the WMA regional meetings demonstrate there is no appetite for euthanasia outside some parts of Europe and the European diaspora, in Canada we have observed that even the prospect of legalization whets the appetite for it, and the appetite is not satisfied by legalization alone.

## The unreliability of Legal “Safeguards”

The Supreme Court of Canada believed that “a carefully designed and monitored system of safeguards” would limit risks associated with allowing physicians to kill patients or help them commit suicide [2]. However, the Vulnerable Persons Standard, developed to assist in establishing such safeguards, finds current Canadian law seriously deficient [9]. Even supplemented by provincial and professional guidelines, current criteria are so broad as to have permitted lethal injection of an elderly couple who preferred to die together by euthanasia rather than at different times by natural causes [10].

Despite this, only a year after legalization, Canadian Euthanasia and Assisted Suicide (EAS) practitioners were already complaining about having to meet with patients (perhaps more than once), review their often “lengthy and complicated” medical histories, counsel and overcome resistance from family members [11], refer patients to psychiatrists or social workers [12], find two independent witnesses to verify the voluntariness of a patient’s request [13], and manage the “paperwork and bureaucracy involved,” [14] such as having to com-

plete forms and fax reports to the coroner [13;15]. What others see as safeguards, they characterized as “disincentives” to physician participation that were creating “barriers” to access.

## Demand for Collaboration

EAS practitioners also claimed that there was “a crisis” because so few physicians were willing to provide euthanasia or assisted suicide [16]. Their alarm seems to have been triggered by a 46.8% increase in EAS deaths in the second half of the first year of legalization. Canada’s EAS death rate in the first year – about 0.9% of all deaths [17] – was not reached by Belgium for seven to eight years [18].

However, inter-jurisdictional comparisons indicate that, even in the first year of legalization, more than enough Canadian EAS practitioners were available to meet the demand [19]. This ought to make coercion of unwilling physicians unnecessary, but prominent, influential and powerful people in Canada disagree.

It is true that nothing in the Criminal Code requires physicians to personally kill patients or help them commit suicide [3]. However, nothing in the Criminal Code prevents compulsion by other laws or policies. Thus, for example, Canada’s largest medical regulator demands that physicians who are unwilling to personally provide euthanasia or assisted suicide must collaborate in homicide and suicide by referring patients to colleagues who are willing to do so [20].

We categorically refuse. Such collaboration would make us morally responsible for killing our patients; if not for the *Carter* decision, it would make us criminally responsible and liable to conviction for murder, just as it still does in most parts of the world. For refusing to collaborate in killing our patients, many of us now risk discipline

and expulsion from the medical profession. How has this come about?

## Access to Euthanasia and Assisted Suicide as Entitlements

Part of the explanation is that Canada’s state-run health insurance system pays for “medically necessary hospital and physician services” from public funds. Most Canadian physicians are independent contractors paid only for services we provide, but many Canadians now believe we are state employees, and we face an entrenched attitude of entitlement. Since taxpayers pay for “medically necessary” health services, many people think it is unacceptable for physicians to refuse to provide those [21].

And what counts as a “medically necessary” service? In brief, anything declared to be so by the state. As we have seen, in 2014 the Quebec government redefined medical practice to include euthanasia. Indeed, Quebec deliberately restricted the practice of euthanasia to physicians [1].

## Access to Euthanasia and Assisted Suicide as Human Rights

The sponsor of Quebec’s law claimed that euthanasia would remain “very exceptional” [24]. However, the law also said qualified patients had a right to euthanasia, and the exercise of a right cannot be exceptional. Thus, all public health care institutions (residences, long term care facilities, community health centres and hospitals – including palliative care units) are required to provide or arrange for euthanasia [1]. Even this, however, has not been enough.

McGill University Health Centre complied with Quebec law by arranging to transfer patients from the palliative care unit to be lethally injected elsewhere in the facility.

The Quebec Minister of Health forced euthanasia into the palliative care unit, citing “patients’ lawful right to receive end-of-life care” [23; 24].

Quebec law allows hospices to opt out of providing euthanasia [1], but when Quebec hospices opted out, the Minister of Health denounced them for “administrative fundamentalism,” declaring their refusal “incomprehensible.” Notwithstanding the law, a prominent Quebec lawyer urged that their public subsidies be withdrawn, accused them of compromising the right of access to care, and warned that allowing refusal was a slippery slope [25]. A similar situation is also being faced by the hospices in other provinces such as British Columbia [26].

Quebec physicians and health care practitioners now work in environments characterized by an emphasis on a purported ‘right’ to euthanasia. The notion that access to euthanasia and assisted suicide is a fundamental human right has spread across Canada since the Supreme Court of Canada ruling in *Carter*. We are accused of violating human rights – even called bigots – because we refuse to kill or collaborate in killing our patients [27].

## Providing Euthanasia as an Ethical/Professional Obligation

Leaders of the medical profession contributed substantially to the legal redefinition of euthanasia as a medical act and to the legalization of physician assisted suicide and euthanasia.

The Collège des médecins du Québec (CMQ) told Quebec legislators that actively causing the death of a patient is “a medical procedure” for which physicians must be completely responsible, insisting that physician assume “the moral burden” of killing patients [28]. The Federation of General Practitioners of Quebec was ada-

mant that only physicians should provide euthanasia [29].

The Canadian Medical Association (CMA) secured approval of an apparently neutral resolution on euthanasia and assisted suicide, supporting both physicians willing to provide the services and those unwilling to do so [30]. The CMA later told the Supreme Court of Canada those positions for and against physician participation in euthanasia/assisted suicide were both ethically defensible, and that its long-standing policy against physician participation would be revised to reflect support for both views [31].

However, in 2014, prior to the 2015 Supreme Court ruling its legalization, the CMA formally approved physician assisted suicide and euthanasia (subject to legal constraints) as responses to “the suffering of persons with incurable diseases.” It classified both practices as “end of life care,” and promised to ensure access to “the full spectrum” of end of life care (i.e., including euthanasia and assisted suicide) [32]. The Supreme Court cited the CMA’s new policy when it struck down the law two months later [2].

By redefining euthanasia and assisted suicide as therapeutic medical services [33], the CMA made physician participation normative for the medical profession; refusing to provide them in the circumstances set out by law became an exception requiring justification or excuse. That is why public discourse in Canada has since centred largely on whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide: hence the “long debate” about conscientious objection at the CMA’s 2015 annual meeting to which the CMA Vice-President, Medical Professionalism referred in his World Medical Journal article [34].

The CMA Vice-President, Medical Professionalism elsewhere noted that, for years,

physicians opposed to euthanasia and assisted suicide have lobbied the CMA to support their right to refuse to participate in the procedures. “They have made tearful pleas at several CMA General Council meetings, asking their non-objecting colleagues to support them and to defend their rights”[35]. We have had to do this precisely because of the reversal of CMA policy against physician participation in euthanizing patients, the reclassification of euthanasia and assisted suicide as medical services, and the insistence that there should be no “undue delay” in providing them [36].

To be fair, our pleading has not been in vain. The CMA does support physicians who refuse to provide or refer for euthanasia and assisted suicide, asserts that the state should develop mechanisms to allow patients direct access to the services without violating physicians’ moral commitments, and rejects discrimination against objecting practitioners [36]. But this advice can be ignored and, when it is, Hippocratic practitioners face the state in court and foot the bill for expensive constitutional challenges [37]. Further, public calls from influential voices have been heard for those medical students who are personally opposed to the euthanasia imperative, to either abandon, or refrain from applying for, medical training [38].

## Canada’s Euthanasia/ Assisted Suicide Regime

The CMA is sincerely convinced that it “did the right thing” in shaping the debate and law in Canada and that it is on the right side of history. It is urging the WMA to follow its lead [34]. Our colleagues in other countries thus need to be aware that the EAS regime in Canada is one of the most radical in the world.

Patients do not have a ‘right to euthanasia’ in the Netherlands [39] or in Belgium [40], though long practice inclines the public to the contrary view [41]. Euthanasia is not

permitted in either country unless a physician is personally convinced there is no reasonable alternative [42; 43]. Similarly, Dutch and Belgian physicians must be personally convinced that a patient's suffering is intolerable and enduring [42, 43], and Belgian physicians may insist upon criteria beyond those set by law [42].

In Canada, however, access to euthanasia and assisted suicide is seen as a tax-paid entitlement, is described as a "constitutionally protected civil and human right" [44], and homicide and suicide are legally and professionally defined to be therapeutic medical services. Moreover, a physician's conviction that there are other reasonable and efficacious alternatives is irrelevant; patients can insist upon lethal injection. Finally, the criterion of intolerable suffering is entirely subjective, established unilaterally by the patient.

Small wonder, then, that the onus seems increasingly to lie on physicians to show why euthanasia should be refused, and that health care administrators may be more anxious about being accused of "obstructing access" [45] than about "killing people who really ought not to be killed" [46].

Only a year after legalization, Dr. Yves Robert, Secretary of the CMQ was alarmed by "the rapidity with which public opinion seems to have judged [the new law] insufficient."

"If anything has become apparent over the past year, it is this paradoxical discourse that calls for safeguards to avoid abuse," he wrote, "while asking the doctor to act as if there were none. ... [W]e sees the emergence of pressure demanding a form of death à la carte," he warned [47].

## Patients and Palliative Care

As Hippocratic practitioners, our focus is on the good of our patients, avoiding thera-

peutic obstinacy and responding to their suffering with compassion, competence, and palliative care. We are disturbed that the number of Quebec practitioners entering palliative care dropped after legalization of euthanasia, and the CMQ and the Quebec Society for Palliative Care are concerned that patients are choosing euthanasia because adequate palliative care is unavailable [48].

We are disturbed and grieved by the story of a 25-year-old disabled woman in acute crisis in an Emergency ward, pressured to consider assisted suicide by an attending physician, who called her mother "selfish" for protecting her [49].

We are disturbed and angered to hear that hospital authorities denied a chronically ill, severely disabled patient the care he needed, suggesting euthanasia or assisted suicide instead [50].

And we were astonished to hear that some emergency physicians in Quebec were, for a time, letting suicide victims die even though they could have saved their lives. The incidents came to light at about the time the Quebec euthanasia law came into force, and the president of the Association of Quebec Emergency Physicians speculated that the law and accompanying publicity may have 'confused' the physicians about their role [51].

These incidents are entirely consistent with the acceptance of euthanasia and physician assisted suicide and they illustrate grave violations of traditional medical ethics. This is not coincidental.

## Euthanasia and the Transformation of Medical Culture

Canadian medical leaders learned that, in other jurisdictions, legalizing assisted sui-

cide and euthanasia caused "changes in the medical culture" leading to "general, overall comfort" with the law [52].

However, when emergency physicians refuse to resuscitate patients who attempt suicide and urge disabled patients in crisis to request euthanasia, such "changes in the medical culture" are not, in our view, consistent with ensuring patient safety, nor with maintaining the trust essential to preserving the Hippocratic physician-patient relationship.

And when physicians are told to write 'natural death' instead of 'euthanasia' on the death certificates [53,54] – and, by extension, to misrepresent facts – "changes in the medical culture" may make physicians comfortable, but we do not believe that they will sustain trust in the medical profession. Even newly released federal guidelines for monitoring euthanasia lack any emphasis on prevention of EAS, in favour of merely regulating these practices [55; 56; 57].

Finally, when a Jewish nursing home forbids euthanasia and assisted suicide on its premises out of respect for Jewish beliefs and concern for its residents (who include Holocaust survivors), "changes in the medical culture" may encourage applause for the EAS practitioner who crept in at night to lethally inject someone [58], but we do not applaud; we are aghast.

Our observations and personal experiences over the last two years confirm our belief that the practice of Hippocratic medicine is fundamentally incompatible with euthanasia and assisted suicide. Mandating system-wide provision and physician involvement in the practices can be expected to transform medical culture, ultimately making Hippocratic medical practice impossible.

The WMA regional conferences demonstrate that the great majority of physicians worldwide agree with us. Nonetheless, it is true that some physicians and patients seek



euthanasia or assisted suicide where the procedures are legal. Supposing that killing people or helping them to commit suicide might sometimes be an acceptable response to human suffering (something we do not concede), how might these demands be accommodated?

The answer is intuitively obvious: with the least possible disruption of existing long-standing medical practice. And from this perspective a completely non-medical solution would be best. Where this is no longer practicable, law and policy should allow medical practice to remain largely unchanged. Patients have no entitlement; practitioners and institutions have no duty; medical associations respectfully continue unresolved ethical debates; the amplitude of the phenomena remains proportional to minority demands. The introduction of euthanasia in Canada has caused doubt, conflict and crisis. In our view, new disciplines, new professions and new methods may arise to satisfy new social goals; but not in the name of Medicine. We believe that doctors, and medical associations, should vigorously defend the successful model inherited from our past. Euthanasia is not medicine.

As Canadians, we are saddened by this situation, but we hope that our experience and observations will serve as a warning for our colleagues in other countries, and their patients. Most important: The World Medical Association must recognize that accommodating the kind of radical change in medical culture underway in Canada is ill-advised. Mindful of the legacy of past WMA leaders, such as former Secretary General, Dr. Andre Wynen, who, based on his personal experience, stood courageously against any minimization of the dangers of euthanasia to patients and physicians [59], we advise against any compromising additions or modifications to existing WMA declarations, and strongly support a full defence of established policy against euthanasia and assisted suicide.

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