Physician Assisted Suicide: The Great Canadian Euthanasia Debate

Prepared For: Legal Education Society of Alberta

48th Annual Refresher: Wills & Estates

Presented by:
Prof. Arthur Schafer
University of Manitoba
Winnipeg, Manitoba

For Presentation In:
Lake Louise – April 19 – 21, 2015
Physician Assisted Suicide: The Great Canadian Euthanasia Debate

Arthur Schafer
University of Manitoba

Author Note
Department of Philosophy, University of Manitoba
Centre for Professional and Applied Ethics, University of Manitoba

Correspondence concerning this article should be addressed to Professor Arthur Schafer, Director, Centre for Professional and Applied Ethics, University of Manitoba, 220 Dysart Road, Winnipeg, Manitoba, Canada R3M 0R9. E-mail: schafer@cc.umanitoba.ca
Abstract

A substantial majority of Canadians favours a change to the Criminal Code which would make it legally permissible, subject to careful regulation, for patients suffering from incurable physical illness to opt for either physician assisted suicide (PAS) or voluntary active euthanasia (VAE). This discussion will focus primarily on the arguments for and against decriminalizing physician assisted suicide, with special reference to the British Columbia case of Lee Carter vs. Attorney General of Canada. The aim is to critique the arguments and at the same time to describe the contours of the current Canadian debate. Both ethical and legal issues raised by PAS are clarified. Empirical evidence available from jurisdictions which have followed the regulatory route is presented and its relevance to the slippery slope argument is considered. The arguments presented by both sides are critically assessed. The conclusion suggested is that evidence of harms to vulnerable individuals or to society, consequent upon legalization, is insufficient to support continued denial of freedom to those competent adults who seek physician assistance in hastening their death.

Keywords: physician-assisted suicide, voluntary active euthanasia, slippery slope argument, patient autonomy, Lee Carter, Supreme Court of Canada
Ms. Gloria Taylor (aged 63) suffers from amyotrophic lateral sclerosis (ALS). She is claiming a constitutional right to choose physician assistance in hastening her death at a time and place of her choosing. A public opinion survey was conducted by Forum Research, in December of 2011, just after Ms. Taylor began her legal challenge to the Canadian law prohibiting physician-assisted suicide.\(^1\) The Forum poll showed that more than two-thirds of Canadians support a change to the Criminal Code - a change which would make it legally permissible for doctors to help the terminally ill to kill themselves. Forum’s President, Lorne Boznikoff, commented that “you don’t often find that many Canadians agreeing on anything” (Blackwell, 2011). The results of this public opinion survey are consistent with what Canadians have been telling pollsters for at least the past 15 years.

I have begun this discussion with a snapshot of current public attitudes because, in a liberal democratic society, widely accepted social attitudes set (or at least strongly influence) the parameters for policy and legislative options. This is not to say that controversial issues of constitutional rights should be settled by opinion poll. Nevertheless, in an earlier constitutional challenge to the prohibition of assisted suicide (Rodriguez v. British Columbia [Attorney General], 1993), the majority of the Supreme Court of Canada (SCC) made a point of commenting that there was (at that time) “no public consensus” among Canadians that “the autonomy interest of people wishing to kill themselves is paramount to the state interest in protecting the lives of its citizens” (Para 155). Also in Rodriguez, but writing for the minority, Justice McLachlin, took judicial notice of what she called “the pulse of the nation” (Para 224). Today, almost 20 years later, Canadian public opinion appears to have undergone a marked shift in favour of the autonomy interest of people wishing to kill themselves.

In Lee Carter, the British Columbia Supreme Court has now ruled in favour of Ms. Taylor and her fellow plaintiffs. Madam Justice Lynn Smith found that Canada’s prohibition of PAS discriminates against people who are too ill to take their own lives. The case is at present under appeal\(^2\) and it is expected that, once it has been heard by the B.C. Court of Appeal, whichever side loses will appeal to the SCC. This will give the SCC an opportunity to revisit its 1993 decision in the case of Sue Rodriguez, referred to above. Ms. Rodriguez also suffered from ALS and, like Gloria Taylor in Lee

---

1. Gloria Taylor was the last named of four plaintiffs in a current legal challenge to the Canadian ban on physician assisted suicide. The case is generally referred to as Lee Carter; after the first named plaintiff, Ms. Lee Carter who, along with her siblings, accompanied their mother, Kay Carter, to the Dignitas Clinic in Switzerland. At this clinic, Kay was assisted to die. Lee Carter and her siblings may have violated the legal prohibition against assisting suicide. The case was heard in Vancouver from November 14th to December 16th, 2011. The Court’s judgement, in favour of Ms. Taylor and her fellow plaintiffs, was delivered on 15th June, 2012.

Carter, challenged the prohibition against PAS. Ms. Rodriguez lost her case but only by the narrowest of margins: The SCC divided five to four against her (with then Chief Justice McEachern voting with the minority).

The discussion which follows will deal with a range of philosophical and legal arguments pertaining to end of life decision-making in Canada, but the discussion will focus most particularly on the issue of decriminalizing PAS. In the almost two decades which separate Rodriguez from Lee Carter, PAS has now become legally permissible in several American states (Oregon, Washington State and Montana) and in a number of European nations (the Netherlands, Belgium, Switzerland, and Luxemburg). The Dutch see no significant moral difference between PAS and voluntary active euthanasia (VAE) and therefore make no legal distinction between them. In the Netherlands and Belgium, both are legally permissible once a rigorous set of safeguards has been satisfied. Many bio-ethicists share the view of the Dutch that PAS and VAE are morally equivalent and, hence, that they should either both be legally permitted, subject to safeguards, or that they should both be legally prohibited (Brock, 1992).

In practical terms, however, it seems unlikely that the legalization of VAE will be on the Canadian political agenda anytime in the foreseeable future. For this reason, I will focus my discussion, in what follows, on the justifiability of PAS. That is “where the action is”, for the moment, at least, in Canada and in other North American jurisdictions.

**Physician-Assisted Suicide: The Canadian Debate**

Both euthanasia and PAS are presently illegal in Canada. A physician who kills or otherwise helps to end the life of his or her patient at the request of that patient and from the motive of mercy would nevertheless be guilty of “culpable homicide” (under sections 222 and 229 of the Criminal Code of Canada). Section 14 of the Criminal Code provides that: “No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted...” Nor does the motive of mercy provide a defence to a culpable homicide charge (R. v. Lewis, 1979).

Both counseling and aiding a person to commit suicide are punishable offences (section 241). The voluntary consent of the patient - even when s/he is a competent adult, rational and fully informed - is no defence (according to section 14).

Although it is a criminal offence, we know that PAS occurs in Canada (Ogden, 2010). Indeed, a 1998 survey of Canadian nurses working in HIV/AIDS care found that, of the 45 nurses sampled, 26
Oregon’s Experience
Prepared For: Legal Education Society of Alberta
48th Annual Refresher: Wills & Estates

Presented by:
Kevin Díaz
Compassion & Choices
Portland, Oregon

For Presentation In:
Lake Louise – April 19 - 21, 2015
2014 Report
Prepared For: Legal Education Society of Alberta
48th Annual Refresher: Wills & Estates

Presented by:
Kevin Díaz
Compassion & Choices
Portland, Oregon

For Presentation In:
Lake Louise – April 19 – 21, 2015
Oregon’s Death with Dignity Act--2014

Oregon’s Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

![Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014](image)

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.
• Since the law was passed in 1997, a total of 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under the DWDA.

• Of the 155 patients for whom DWDA prescriptions were written during 2014, 94 (60.6%) ingested the medication; all 94 patients died from ingesting the medication. No patients that ingested the medication regained consciousness.

• Eleven patients with prescriptions written during the previous years (2012 and 2013) died after ingesting the medication during 2014.

• Thirty-seven of the 155 patients who received DWDA prescriptions during 2014 did not take the medications and subsequently died of other causes.

• Ingestion status is unknown for 24 patients who were prescribed DWDA medications in 2014. For all of the 24 patients, both death and ingestion status are pending (Figure 2).

• Of the 105 DWDA deaths during 2014, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had at least a baccalaureate degree).

• While most patients had cancer, the percent of patients with cancer in 2014 (68.6%) was lower than in previous years (79.4%), and the percent with amyotrophic lateral sclerosis (ALS) was higher (16.2% in 2014, compared to 7.2% in previous years).

• While similar to previous years that most patients had cancer (68.6%), this percent was lower than the average for previous years (79.4%); in contrast, the percent of patients with ALS was higher in 2014 (16.2%) than in previous years (7.2%).

• Most (89.5%) patients died at home, and most (93.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (39.8%) was lower in 2014 than in previous years (62.9%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (60.2% compared to 35.5%).

• As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).

• Three of the 105 DWDA patients who died during 2014 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for 14 patients (13.9%) during 2014 compared to 15.9% in previous years.