Bioethics for clinicians: 11. Euthanasia and assisted suicide

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Abstract

EUTHANASIA AND ASSISTED SUICIDE involve taking deliberate action to end or assist in ending the life of another person on compassionate grounds. There is considerable disagreement about the acceptability of these acts and about whether they are ethically distinct from decisions to forgo life-sustaining treatment. Euthanasia and assisted suicide are punishable offences under Canadian criminal law, despite increasing public pressure for a more permissive policy. Some Canadian physicians would be willing to practise euthanasia and assisted suicide if these acts were legal. In practice, physicians must differentiate between respecting competent decisions to forgo treatment, providing appropriate palliative care, and acceding to a request for euthanasia or assisted suicide. Physicians who believe that euthanasia and assisted suicide should be legally accepted in Canada should pursue their convictions only through legal and democratic means.

Ms. Y is 32 years old and has advanced gastric cancer that has resulted in constant severe pain and poorly controlled vomiting. Despite steady increases in her morphine dose, her pain has worsened greatly over the last 2 days. Death is imminent, but the patient pleads incessantly with the hospital staff to "put her out of her misery."

Mr. Z is a 39-year-old injection drug user with a history of alcoholism and depression. He presents at an emergency department, insisting that he no longer wishes to live. He repeatedly requests euthanasia on the grounds that he is no longer able to bear his suffering (although he is not in any physical pain). A psychiatrist rules out clinical depression.

What are euthanasia and assisted suicide?

A special Senate committee appointed to inform the national debate on euthanasia and assisted suicide defined euthanasia as "a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that
person's suffering where the act is the cause of death.\textsuperscript{1} Euthanasia may be “voluntary,” “involuntary” or “nonvoluntary,” depending on (a) the competence of the recipient, (b) whether or not the act is consistent with his or her wishes (if these are known) and (c) whether or not the recipient is aware that euthanasia is to be performed.

Assisted suicide was defined by the Senate committee as “the act of intentionally killing oneself with the assistance of another who deliberately provides the knowledge, means, or both.”\textsuperscript{11} In “physician-assisted suicide” a physician provides the assistance.

**Why are euthanasia and assisted suicide important?**

There is increasing pressure to resolve the question of whether physicians and other health care professionals should in certain circumstances participate in intentionally bringing about the death of a patient and whether these practices should be accepted by society as a whole. The ethical, legal and public-policy implications of these questions merit careful consideration.

**Ethics**

There is considerable disagreement about whether euthanasia and assisted suicide are ethically distinct from decisions to forgo life-sustaining treatments.\textsuperscript{3–10} At the heart of the debate is the ethical significance given to the intentions of those performing these acts.\textsuperscript{11,12} Supporters of euthanasia and assisted suicide reject the argument that there is an ethical distinction between these acts and acts of forgoing life-sustaining treatment. They claim, instead, that euthanasia and assisted suicide are consistent with the right of patients to make autonomous choices about the time and manner of their own death.\textsuperscript{11}

Opponents of euthanasia are also concerned that the acceptance of euthanasia may contribute to an increasingly casual attitude toward private killing in society.\textsuperscript{19} Opponents of euthanasia are also concerned that the acceptance of euthanasia may contribute to an increasingly casual attitude toward private killing in society.\textsuperscript{19}

Most commentators make no formal ethical distinction between euthanasia and assisted suicide, since in both cases the physician performing the euthanasia or assisting the suicide deliberately facilitates the patient’s death. Concerns have been expressed, however, about the risk of error, coercion or abuse that could arise if physicians become the final agents in voluntary euthanasia.\textsuperscript{19} There is also disagreement about whether euthanasia and assisted suicide should rightly be considered “medical” procedures.\textsuperscript{20,21}

**Law**

**Canadian legislation**

The Criminal Code of Canada prohibits euthanasia under its homicide provisions, particularly those regarding murder, and makes counselling a person to commit suicide and aiding a suicide punishable offences. The consent of the person whose death is intended does not alter the criminal nature of these acts.\textsuperscript{22}

**Canadian case law**

In 1993 the Supreme Court of Canada dismissed (by a 5–4 margin) an application by Sue Rodriguez, a 42-year-old woman with amyotrophic lateral sclerosis, for a declaration that the Criminal Code prohibition against aiding or abetting suicide is unconstitutional. Rodriguez claimed that Section 241(b) of the Code violated her rights under the Charter of Rights and Freedoms to liberty and security of the person, to freedom from cruel and unusual treatment and to freedom from discrimination on grounds of disability, since the option of attempting suicide is legally available to nondisabled people.\textsuperscript{4}

Despite the reaffirmation by the court in the Rodriguez case that assisting in the suicide of another person is appropriately viewed as a criminal activity, there has been a clear trend toward leniency at laying charges and at sentencing for those individuals, some of them physicians, convicted of such offences.\textsuperscript{23,24} At the time of writing, a Toronto doctor had been charged with 2 separate counts of aiding a suicide. He is the first Canadian physician to be charged under Section 241(b) of the Criminal Code. The outcome of his trial, which is expected to be completed by the end of 1997, will likely be of great importance in shaping Canadian law on the matter.
Other jurisdictions

On Sept. 22, 1996, a cancer patient in Australia’s Northern Territory became the first person in the world to receive assistance from a physician to commit suicide under specific legislation. In The Netherlands, a series of judicial decisions has made euthanasia permissible under certain guidelines since the 1960s, despite the fact that it is still officially a criminal offence. Several legislative initiatives in the US have either been narrowly defeated or have met with a constitutional challenge.

Recently, 2 federal courts of appeal in the US independently ruled that there is a constitutionally protected right to choose the time and manner of one’s death, and that this right includes seeking assistance in committing suicide. In the fall of 1996 the US Supreme Court began to hear arguments in appeals of both cases. The court’s decision is expected by the summer of 1997.

Policy

In 1993, Sawyer, Williams and Lowy identified 4 public-policy options available to Canadian physicians with regard to euthanasia and assisted suicide: (a) oppose any change in the legal prohibition, (b) support a modification of the law to permit euthanasia or assisted suicide or both under certain circumstances only, (c) support decriminalization on the assumption that there will be legislation to prevent abuse and (d) maintain neutrality. Despite differences of opinion within its membership, the CMA continues to uphold the position that members should not participate in euthanasia and assisted suicide. This policy is consistent with the policies of medical associations throughout the world.

Empirical studies

Perspectives of patients and the public

Requests for euthanasia and assisted suicide do not arise exclusively out of a desire to avoid pain and suffering. Clinical depression, a desire to maintain personal control, fear of being dependent on others and concern about being a burden to loved ones have all been reported as reasons underlying requests for euthanasia and assisted suicide.

In Canada, more than 75% of the general public support voluntary euthanasia and assisted suicide in the case of patients who are unlikely to recover from their illness. But roughly equal numbers oppose these practices for patients with reversible conditions (78% opposed), elderly disabled people who feel they are a burden to others (75% opposed), and elderly people with only minor physical ailments (83% opposed).

Physicians’ perspectives and practices

Results of a survey by Kinsella and Verhoef indicate that 24% of Canadian physicians would be willing to practise euthanasia and 23% would be willing to assist in a suicide if these acts were legal. These findings are similar to the results of surveys conducted in the UK and in Australia’s Northern Territory. Surveys of physicians in the Australian state of Victoria, as well as recent surveys in Oregon, Washington and Michigan indicated that a majority of physicians in these jurisdictions supported euthanasia and assisted suicide in principle and favoured their decriminalization. Some studies have documented physician participation in euthanasia and assisted suicide.

How should I approach euthanasia and assisted suicide in practice?

Euthanasia and assisted suicide violate the Criminal Code of Canada and are punishable by life imprisonment and 14 years in prison, respectively. Physicians who believe that euthanasia and assisted suicide should be legally accepted in Canada should pursue these convictions through the various legal and democratic means at their disposal, i.e., the courts and the legislature. In approaching these issues in a clinical setting it is important to differentiate between: (a) respecting competent decisions to forgo treatment, such as discontinuing mechanical ventilation at the request of a patient who is unable to breathe independently, which physicians may legally do; (b) providing appropriate palliative measures, such as properly titrated pain control, which physicians are obliged to do; and (c) acceding to requests for euthanasia and assisted suicide, both of which are illegal.

The cases

The case of Ms. Y involves a competent, terminally ill patient who is imminently dying and in intractable pain. The case of Mr. Z involves an apparently competent patient who is not dying but is experiencing extreme mental suffering.

In both cases the physician is confronted with a request to participate in euthanasia or assisted suicide. The physician should explore the specific reasons behind the request and provide whatever treatment, counselling or comfort measures that may be necessary. For example, for Ms. Y, it may be necessary to seek the advice of a pain specialist about alternative approaches to pain management and palliation. The case of Mr. Z is in many ways
more difficult, since depression has been ruled out as a contributing factor in the request. The physician must attempt to investigate and ameliorate any other psychosocial problems that are affecting the patient.

Providing euthanasia and assisted suicide in either case could result in conviction and imprisonment. However, increasing the morphine dosage for Ms. Y as necessary to relieve her pain is lawful, even though it may eventually prove toxic and precipitate death.

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References


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