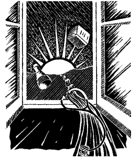
Bioethics for clinicians: 11. Euthanasia and assisted suicide



James V. Lavery, MSc; Bernard M. Dickens, PhD, LLD; Joseph M. Boyle, PhD; Peter A. Singer, MD, MPH

Education

Éducation

Mr. Lavery is a PhD candidate at the University of Toronto Joint Centre for Bioethics, University of Toronto, and coordinator of the HIV Ontario Observational Database, Sunnybrook Health Science Centre, Toronto, Ont.; Dr. Dickens is Professor in the Faculty of Law, the Faculty of Medicine and the University of Toronto Joint Centre for Bioethics, University of Toronto, Toronto, Ont.; Dr. Boyle is Principal of St. Michael's College and Professor in the Department of Philosophy, University of Toronto, Toronto, Ont.; Dr. Singer is Sun Life Chair in Bioethics and Director of the University of Toronto Joint Centre for Bioethics, Associate Professor of Medicine at the University of Toronto, and Staff Physician with The Toronto Hospital, Toronto, Ont.

Series editor: *Dr. Peter A. Singer, University of Toronto Joint Centre for Bioethics, 88 College St., Toronto ON M5G 1L4; fax 416 978-1911; peter.singer@utoronto.ca*

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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.

Résumé

L'EUTHANASIE ET L'AIDE AU SUICIDE entraînent la prise de mesures délibérées pour mettre fin ou aider à mettre fin à la vie d'une autre personne pour des raisons humanitaires. L'acceptabilité de ces actes et la question de savoir s'ils sont distincts, sur le plan éthique, de décisions de ne pas administrer de traitements de maintien de la vie suscitent des désaccords importants. L'euthanasie et l'aide au suicide sont des infractions punissables en vertu du droit criminel canadien, même si le public penche de plus en plus vers une politique plus permissive. Des médecins du Canada seraient disposés à pratiquer l'euthanasie et l'aide au suicide si la loi le permettait. En pratique, les médecins doivent établir une distinction entre respecter de décisions éclairées de renoncer au traitement, fournir des soins palliatifs appropriés et accéder à une demande d'euthanasie ou d'aide au suicide. Les médecins qui sont d'avis que la loi devrait permettre l'euthanasie et l'aide au suicide au Canada ne devraient donner suite à leurs convictions que par les voies légales et démocratiques.

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

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person's suffering where the act is the cause of death."[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."[1] 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.[2–10] At the heart of the debate is the ethical significance given to the intentions of those performing these acts.[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.[2,13]

Opponents of euthanasia and assisted suicide claim that death is a predictable consequence of the morally justified withdrawal of life-sustaining treatments only in cases where there is a fatal underlying condition, and that it is the condition, not the action of withdrawing treatment, that causes death.[14] A physician who performs euthanasia or assists in a suicide, on the other hand, has the death of the patient as his or her primary objective.

Although opponents of euthanasia and assisted suicide recognize the importance of self-determination, they argue that individual autonomy has limits and that the right to self-determination should not be given ultimate standing in social policy regarding euthanasia and assisted suicide.[15]

Supporters of euthanasia and assisted suicide believe that these acts benefit terminally ill patients by relieving their suffering,[16] while opponents argue that the compassionate grounds for endorsing these acts cannot ensure that euthanasia will be limited to people who request it voluntarily.[17] Opponents of euthanasia are also concerned that the acceptance of euthanasia may contribute to an increasingly casual attitude toward private killing in society.[18]

Most commentators make no formal ethical distinction between euthanasia and assisted suicide, since in both cases the person 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.[19] There is also disagreement about whether euthanasia and assisted suicide should rightly be considered "medical" procedures.[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.[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.[6]

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.[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.[25] 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[26] or have met with a constitutional challenge.[27]

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.[4,5] 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.[28] Despite differences of opinion within its membership, the CMA continues to uphold the position that members should not participate in euthanasia and assisted suicide.[29] This policy is consistent with the policies of medical associations throughout the world.[30]

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,[31] a desire to maintain personal control,[32] fear of being dependent on others[33] and concern about being a burden to loved ones[34] 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.[35] 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).[36]

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.[37] These findings are similar to the results of surveys conducted in the UK[38] and in Australia's Northern Territory.[39] Surveys of physicians in the Australian state of Victoria,[40] as well as recent surveys in Oregon,[41] Washington[30] and Michigan[42] 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.[30,38,43] Physicians in certain specialties (such as palliative care) appear to be less willing to participate in euthanasia and assisted suicide than physicians in other specialties.[27,34,37]

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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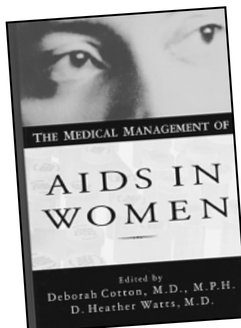
The views expressed in this article are the authors' and not necessarily those of their supporting groups or employers.

References

1. *Of life and death. Report of the Special Senate Committee on Euthanasia and Assisted Suicide*. Ottawa: Supply and Services Canada;1995:14 [cat no YC2-351/1-OIE].
2. Brock DW. Voluntary active euthanasia. *Hastings Cent Rep* 1992;22(2):10-22.
3. *Compassion in dying* v. *Washington*, 79 F 3rd 790 (9th Cir 1996).
4. *Quill* v. *Vacco*, 80 F 3rd 716 (2nd Cir 1996).
5. Rachels J. Active and passive euthanasia. *N Engl J Med* 1975;292:78-80.
6. *Sue Rodriguez* v. *British Columbia* (*Attorney General*) (1993) 3 SCR 519. [See Justice Cory's dissent.]
7. Roy DJ. Euthanasia: taking a stand. *J Palliat Care* 1990;6(1):3-5.
8. Dickens BM. Medically assisted death: *Nancy B.* v. *Hôtel-Dieu de Québec*. *McGill Law J* 1993;38:1053-70.
9. Gillon R. Euthanasia, withholding life-prolonging treatment, and moral differences between killing and letting die. *J Med Ethics* 1988;14:115-7.
10. Annas GJ. The promised end: constitutional aspects of physician-assisted suicide. *N Engl J Med* 1996;335:683-7.
11. Quill T. The ambiguity of clinical intentions. *N Engl J Med* 1993;329:1039-40.
12. Brody H. Causing, intending and assisting death. *J Clin Ethics* 1993;4:112-7.
13. Angell M. The Supreme Court and physician-assisted suicide — the ultimate right [editorial]. *N Engl J Med* 1997;336:50-3.
14. Foley KM. Competent care of the dying instead of physician-assisted suicide [editorial]. *N Engl J Med* 1997;336:54-8.
15. Callaghan D. When self-determination runs amok. *Hastings Cent Rep* 1992; 22(2):52-5.
16. Brody H. Assisted death: a compassionate response to a medical failure. *N Engl J Med* 1992;327:1384-8.
17. Kamisar Y. Against assisted suicide — even a very limited form. *U Detroit Mercy Law Rev* 1995;72:735-69.
18. Kamisar Y. Some non-religious views against proposed "mercy killing" legislation. *Minnesota Law Rev* 1958;42:969-1042.
19. Quill TE, Cassel CK, Meier DE. Care of the hopelessly ill: proposed clinical criteria for physician-assisted suicide. *N Engl J Med* 1992;327:1380-4.
20. Kinsella DT. Will euthanasia kill medicine? *Ann R Coll Physicians Surg Can* 1991;24(7):489-92.
21. Drickamer MA, Lee MA, Ganzini L. Practical issues in physician-assisted suicide. *Ann Intern Med* 1997;126(2):146-51.
22. Criminal Code, RSC (1985), ss 14, 222, 229, 241.
23. Ogden R. The right to die: a policy proposal for euthanasia and aid in dying. *Can Public Pol* 1994;1:5.
24. *Of life and death. Report of the Special Senate Committee on Euthanasia and Assisted Suicide*. Ottawa: Supply and Services; 1995:A80-A83 [cat no YC2-351/1-OIE].
25. Ryan CJ, Kaye M. Euthanasia in Australia: the Northern Territory Rights of the Terminally Ill Act. *N Engl J Med* 1996;334:326-8.
26. Cohen JS, Fihn SD, Boyko EJ, Jonsen AR, Wood RW. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. *N Engl J Med* 1994;331:89-94.
27. Alpers A, Lo B. Physician-assisted suicide in Oregon. *JAMA* 1995;274:483-7.
28. Sawyer DM, Williams JR, Lowy F. Canadian physicians and euthanasia: 5. Policy options. *Can Med Assoc J* 1993;148:2129-33.
29. Canadian Medical Association. Physician-assisted death [policy summary]. *Can Med Assoc J* 1995;152:248A-B.
30. Shapiro RS, Derse AR, Gottlieb M, Schiedermayer D, Olson M. Willingness to perform euthanasia: a survey of physician attitudes. *Arch Intern Med* 1994; 154:575-84.
31. Chochinov HM, Wilson KG, Enns M, Mowchun N, Lander S, Levitt M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995;152:1185-91.
32. Ogden R. *Euthanasia, assisted suicide and AIDS*. Vancouver: Perrault/Goedman Publishing, 1994:58.
33. Back AL, Wallace JI, Starks HE, Pearlman RA. Physician-assisted suicide and euthanasia in Washington State: patient requests and physician responses. *JAMA* 1996;275:919-25.
34. Emanuel EJ, Fairclough DL, Daniels ER, Clarridge BR. Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public. *Lancet* 1996;347:1805-10.
35. Singer PA, Choudhry S, Armstrong J, Meslin EM, Lowy F. Public opinion regarding end-of-life decisions: influence of prognosis, practice and process. *Soc Sci Med* 1995;41:1517-21.
36. Genuis SJ, Genuis SK, Chang W. Public attitudes toward the right to die. *Can Med Assoc J* 1994;150:701-8.
37. Wysong P. Doctors divided on euthanasia acceptance: preference is to refer euthanasia to another doctor. *Med Post* 1996;32(34):1,90.
38. Ward BJ, Tate PA. Attitudes among NHS doctors to requests for euthanasia. *BMJ* 1994;308:1332-4.
39. Managing a comfortable death [editorial]. *Lancet* 1996;347:1777.
40. Kuhse H, Singer P. Doctors' practices and attitudes regarding voluntary euthanasia. *Med J Aust* 1988;148:623-7.
41. Lee MA, Nelson HD, Tilden VP, Ganzini L, Schmidt TA, Tolle SW. Legalizing assisted suicide — views of physicians in Oregon. *N Engl J Med* 1996; 334:310-5.
42. Bachman JG, Alcser KH, Doukas DJ, Lichtenstein RL, Corning AD, Brody H. Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *N Engl J Med* 1996;334:303-9.
43. Fried TR, Stein MD, O'Sullivan PS, Brock DW, Novack DH. The limits of patient autonomy: physician attitudes and practices regarding life-sustaining treatments and euthanasia. *Arch Intern Med* 1993;153:722-8.

Correspondence to: *Mr. James V. Lavery, University of Toronto Joint Centre for Bioethics, 88 College St., Toronto ON M5G 1L4; fax 416 978-1911; lavery@inforamp.net*

THE MEDICAL MANAGEMENT OF AIDS IN WOMEN



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