

The “Supremes” decide on assisted suicide: What should a doctor do?

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In the July 15 issue, lawyer Karen Capen reviewed the cases concerning euthanasia and physician-assisted suicide that had been sent to the US Supreme Court (Can Med Assoc J 1997;157:169-71). In this article, James Lavery and Peter Singer look at the court's ruling and its implications for Canadian physicians.

On June 26, 1997, the US Supreme Court ruled in 2 unanimous decisions that there is no constitutionally protected right to assisted suicide.^{1,2} Overturning 2 1996 Federal Appeals Court rulings that had struck down Washington and New York state laws prohibiting assisted suicide, the Supreme Court rejected 2 key arguments.

First, the Supreme Court rejected the argument that the right to liberty guaranteed by the US Constitution includes the right to seek the assistance of a physician to commit suicide. The court has previously assumed that the right to liberty includes decisions to forgo life-sustaining treatment. However, it drew a clear distinction between forgoing life-sustaining treatment, which was consistent with “the common-law rule that forced medication was a battery and the long legal tradition protecting the decision to refuse unwanted medical treatment,” and assisted suicide, which “may be just as personal and profound as the decision to refuse unwanted medical treatment . . . [but] has never enjoyed similar legal protection.”¹ The court found that “[t]he distinction between letting a patient die and making that patient die is important, logical, rational, and well established” and is “widely recognized and endorsed in the medical profession, the state courts, and the overwhelming majority of state legislatures.”²

Second, the Supreme Court rejected the argument that laws prohibiting assisted suicide violate the right to equal protection of the laws guaranteed by the US Constitution — that states must treat like cases alike. In the rejected argument, decisions to forgo treatment (which are legally permissible) were said to be the same thing as assisted suicide and so should be legally permissible, too. However, the court opined that permitting decisions to forgo treatment (but prohibiting assisted suicide) does not “[treat] anyone differently from anyone else, or [draw] distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted life-saving medical treatment; no one is permitted to assist a suicide.”²

The Supreme Court's decisions do not resolve the ethical or legal debate about euthanasia and assisted suicide. Instead, the court has returned these issues to the state legislatures, reflecting the reluctance of the Supreme Court Justices to substitute their views for the democratic will of the people. The court said simply that 2 state laws prohibiting assisted suicide withstood constitutional challenge, not that assisted suicide itself is or should be illegal. Therefore, these Supreme Court decisions would not necessarily prevent a state legislature from legalizing euthanasia or assisted suicide. In November 1997, residents of Oregon will vote for a second time on that state's controversial Death With Dignity Act, which was passed by a 51%-to-49% margin in a 1994 referendum but never implemented because of legal challenges.³ (In Canada the criminal law is a federal responsibility.)

In 1993 the Supreme Court of Canada also upheld the Criminal Code prohibition against assisted suicide, although by a narrow 5-to-4 margin, in the Sue Rodriguez case.⁴ Like the US Supreme Court, the Supreme Court of Canada held that the Canadian Charter of Rights and Freedoms' guarantee of security of



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This article has been peer reviewed.

Can Med Assoc J 1997;157:405-6



the person does not extend to assisted suicide. However, unlike the US Supreme Court, 4 of the 9 judges dissented, finding that Rodriguez was discriminated against on grounds of disability, in violation of the charter, because the option of attempting suicide, legally available to anyone, was not available to her because she was physically unable to commit suicide. The majority (of 5 judges) felt that even if she was discriminated against, the discrimination was deemed to be within the reasonable limits that could be imposed in a free and democratic society.

What should Canadian physicians make of these US and Canadian constitutional wranglings? The goal for physicians (and for hospitals and the health care system) should be to improve the quality of end-of-life care in Canada.

There are 3 practices along the spectrum of end-of-life care: palliative care, decisions to forgo treatment, and euthanasia and assisted suicide. The first 2 are ethically uncontroversial, legally permissible and part of quality medical care.⁵⁻⁷ The third is ethically controversial and clearly illegal.⁸ Canadian physicians should fully implement the legal means at their disposal by providing excellent palliative care and by facilitating patients' and families' choices to forgo treatment under appropriate circumstances.

Are we performing exemplary palliative care and effectively engaging patients and families in decisions about life-sustaining treatment? We do not think so. Go onto a ward of your local hospital and unfortunately you should have no trouble finding a dying patient who is in pain, or one who has not been effectively engaged in discussions about life-sustaining treatment decisions.

End-of-life care is disappointingly low on the Canadian health policy agenda. For instance, it was not identified as an important issue in the recent report of the National Forum on Health. Fortunately, real improvements in end-of-life care in Canada will come from practising physicians and nurses providing exemplary care to their individual patients. The solutions are local.

Although we recognize that perhaps every second reader of this article probably supports legalization of euthanasia and assisted suicide in selected circumstances, we strongly advise physicians not to perform these acts. Euthanasia and assisted suicide are illegal in Canada, and physicians are not above the law. Moreover, unlike most legal issues in medicine, these acts fall under the Criminal Code. By performing them, a physician is risking a charge of first-degree murder, which carries a mandatory sentence of life imprisonment, with no general eligibility for parole for 25 years.

First-degree murder is precisely the charge brought against Dr. Nancy Morrison of Halifax, who is alleged to have given a lethal injection on compassionate grounds to end the suffering of a dying patient. In these cases, the

real issue is not the crime but the punishment. Dr. Morrison is charged with the same crime — and if convicted would receive the same punishment — as a person who shoots and kills a grocery store clerk during a robbery. Most Canadians would feel that this similarity is unjust. The prosecution in Dr. Morrison's case should consider substituting a charge, such as manslaughter, without a mandatory prison term. In 1995 a special Senate committee appointed to address euthanasia and assisted suicide recommended that the Criminal Code be amended to include a new charge of compassionate homicide, which would carry a less severe penalty.⁹

One pragmatic issue is how to distinguish between palliative care and euthanasia. According to guidelines developed by the Chief Coroner of Ontario, an act is considered palliative care, and not euthanasia, if (a) it is intended solely to relieve the person's suffering, (b) it is administered in response to symptoms or signs of the patient's suffering and is commensurate with that suffering, and (c) it is not the deliberate infliction of death (Dr. James Young, Chief Coroner of Ontario: personal communication, 1997).

Ultimately, the way to address deeply controversial public issues such as euthanasia and assisted suicide in a democracy is through elected legislatures. This was the most fundamental message of the US Supreme Court's recent decisions. Democracy does not come from the needle of a syringe.

We thank Professor Bernard Dickens, Faculty of Law, University of Toronto, and the anonymous *CMAJ* reviewer for their helpful comments from a legal perspective.

Dr. Singer's work is supported by the National Health Research and Development Program through a National Health Research Scholar Award.

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

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