

A TIME TO LIVE AND A TIME TO DIE – WHO DECIDES?

CAN “THE GOOD DEATH” BE ACHIEVED WITHOUT THE NEGATIVE REPERCUSSIONS OF LEGALIZING EUTHANASIA AND ASSISTED SUICIDE FOR CANADA?

by **Dave Quist**

The 1973 science fiction movie *Soylent Green* is set in New York City in 2022. Policeman Sol Roth (played by Edward G. Robinson) decides he cannot live with his knowledge about the Soylent Corporation (he discovers they are turning human remains into food and deceiving the people, to boot) and opts to “go home” – he registers at a clinic for his own death.¹

A far-fetched sci-fi flick to be sure, but end-of-life decisions today are most assuredly not confined to the silver screen. There is noise to allow for more choices in public policy – even in death. From the Sue Rodriguez² and Robert Latimer³ cases in Canada, Terri Schiavo⁴ in the U.S., legalized euthanasia in Holland⁵ and the state of Oregon⁶ as well as a series of private member’s bills in the House of Commons, euthanasia is a topic under discussion.⁷ Must legalization of euthanasia and assisted suicide be part of Canada’s future or is there a better way?

Canada and euthanasia today

Currently, the Criminal Code of Canada devotes two sections to euthanasia and physician-assisted suicide:⁸

14. *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 on the person by whom consent is given.*
241. *Everyone who counsels a person to commit suicide or aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.*

The Canadian Medical Association is not in favour of allowing physician-assisted suicide or euthanasia. A statement posted on their website in 2007 reads that “Canadian physicians should not participate in euthanasia or assisted suicide” and furthermore that:

*The 1994 CMA General Council unanimously approved a motion that Canadian physicians should uphold the principles of palliative care. The public has clearly demonstrated its concern with our care of the dying. The provision of palliative care for all who are in need is a mandatory precondition to the contemplation of permissive legislative change. Efforts to broaden the availability of palliative care in Canada should be intensified.*⁹

Changing the laws – why and why now?

Those in favour of legalizing euthanasia and assisted suicide often base their arguments on some very real challenges, a few of which are addressed here:

We are living longer

Statistics tell us that we are living longer and this, coupled with higher expectations for a high quality of life, could fuel demands for euthanasia.

Canadian Life Expectancy (years)¹⁰

	1986	2002
Women	80.0	82.1
Man	73.3	77.2

Source: Statistics Canada

We expect a high quality of life

Medical diagnosis and technologies have made quantum leaps forward in past decades. The first heart transplant took place in Cape Town, South Africa, in 1967, under the guidance of Dr. Christiaan Barnard,¹¹ and today the list of medical advances goes on and on. Longer life spans coupled with the seemingly endless capabilities of doctors to provide a high quality of life may have led people to believe that quality of life should supersede life itself. This may also partner with the fear of “being a burden” on society, family and friends.

Rising cost of health care

	1995/1996	2004/2005	\$ Change	% Change
Federal Healthcare Budget ¹³	\$ 1,608,777,000	\$ 3,166,300,000	\$ 1,557,523,000	97%
Total Federal Budget	\$ 164,821,771,000	\$ 186,054,850,000	\$ 21,233,079,000	13%
Consumer Price Index ¹⁴	(April 1995) \$ 87.5	(March 2005) \$ 106.3	\$ 18.8	21.5%

Source: 2004 – 2005 Main Estimates from the Government of Canada and Consumer Price Index from the Bank of Canada

Financial considerations: Living longer costs more

There are also financial costs to living longer. As we age we make greater use of the health care services available to us. According to the Canadian Institute for Health Information, the vast majority of our health care expenses occur during the second half of our life.¹² The financial burden of health care has risen substantially. The cost of health care has outpaced the Consumer Price Index by over a 4:1 margin and the overall Federal Budget by over 7:1.

Higher costs of care lead some euthanasia advocates to push for legalized euthanasia on economic grounds.¹⁵

Canada’s ailing health care system: Can we provide good palliative care?

An unfortunate recent reality is that medical waiting lists are growing.¹⁶ Successive federal governments have attempted to deal with this issue, in concert with provincial governments, and yet the wait continues for many people to see specialists or even a general practitioner.¹⁷ If Canadians can’t get health care at many points in life, some may wonder how we can expect good palliative care at the end of life.

The problem of pain and how to eradicate it

Some who campaign for legalized euthanasia do so because they say it eradicates pain in a manner that nothing else can. The recent case of Robert Latimer, convicted of killing his daughter who had cerebral palsy, highlights this angle. Latimer told the media he does not believe any pain medication was available to his daughter. “One of the answers he’s seeking relates to assertions by the courts that he and his wife could have used other medication to manage their daughter’s pain more effectively,” read newspaper reports. “I want the identification

of that pain medication,” he said, adding that he believes no such alternatives were available. “Let’s face it, it’s a fraud. And they know that.”¹⁸

Personal autonomy

Euthanasia advocates play up the personal choice angle, without accounting for scenarios where the decision will be made by others: doctors, family members, lawyers. They desire the choice of “hastened death” amongst other options, for the sake of choice and control alone.¹⁹ It’s easier to advocate for personal choice in our increasingly atomized (read lonely) society. This also raises the image of aging or elderly folks, who have lived a full life and are still fully competent, who decide to end it. But actually much of the euthanasia/physician-assisted suicide debate today focuses on those whose lives have just begun – in the neo-natal wards or young people with complex and life-threatening illnesses and disabilities.

IF CANADIANS CAN’T GET HEALTH CARE AT MANY POINTS IN LIFE, HOW CAN WE EXPECT GOOD PALLIATIVE CARE AT THE END OF LIFE?

THE “GOOD DEATH” FROM A TO Z

by Tyler Chamberlain

To understand the debate one must know the terms and use them well. Below is a short list of standard definitions taken from medical dictionaries relating to “the good death”, otherwise known as euthanasia

Assisted suicide

The act of intentionally killing oneself with the assistance of another who provides the knowledge, means or both.¹ Also referred to as Physician-Assisted Suicide (PAS) where a physician helps.

Brain death

Total cessation of brain function for 24 hours as manifested by absence of spontaneous movement, absence of spontaneous respiration, and absence of all brainstem reflexes.²

Competency

The capacity to understand the nature and consequences of a medical decision and ability to communicate this decision.³

Persistent vegetative state

A persistent loss of upper cortical function. The patient is bedridden but does not require respiratory support or circulatory assistance for survival and is in a state of chronic wakefulness without awareness, which may be accompanied by some spontaneous eye openings, grunts or screams, brief smiles, sporadic movement of facial muscles and limbs.⁴ Also known as Cortical Brain Death.

Euthanasia

The deliberate act undertaken by one person with the intention of ending the life of another in order to relieve suffering.⁵

Living will

An authorization permitting another to give consent to medical treatment at any time when the person giving the authorization is no longer capable.⁶

endnotes

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Learn by example

Canada can and should look to other nations already engaged in legal euthanasia to ascertain its efficacy. Euthanasia was legalized in Holland in 1973. Some claim theirs is a success story, with doctors and patients playing by the new rules of death. But when they laid out a framework for infant euthanasia with the Groningen Protocol in 2002 even the toughest critics of the slippery slope took a second look.

In a September 2005 study, Dutch researchers published a paper, “Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients” and determined that:

*Of 138 patients, 32 patients had depressed mood at inclusion. Thirty patients (22 per cent) made an explicit request for euthanasia. The risk to request euthanasia for patients with depressed mood was 4.1 times higher than that of patients without depressed mood at inclusion.*²⁰

There also remains a great deal of controversy in the Netherlands over whether Dutch physicians really are playing by the rules. They might be “side-stepping the country’s year-old euthanasia law by using painkillers and sleep-inducing drugs to end patients’ lives by ‘terminal sedation’ rather than follow the new law, which requires a second opinion and formal reporting for all acts of euthanasia.”²¹

Many physicians suffer as a result of their involvement in euthanasia and PAS. Dr. Kenneth R. Stevens notes that, “Many doctors who have participated in euthanasia and/or PAS are adversely affected emotionally and psychologically by their experiences.”²²

Facing a mystery

Longer life spans and rising costs, a failing health system, pain eradication and loneliness can be overcome without turning to legalized euthanasia – the direct involvement of the state in the business of death. When we turn to the legalization of death enterprises, inevitably we contribute to what Dr. Margaret Somerville, founding director of the McGill Centre for Medicine, Ethics and Law, calls the de-mystification of death.

She refers to the loss of the mystery of death - “we don’t feel we have control when faced with mysteries”²³ and that in turn we “convert the mystery of death to the problem of death,”²⁴ hence attempting to control when we will draw our last breath. Control and choice, then, may be completely unattainable when it comes to our final moments. If we desire to guard ideas like those in the Hippocratic Oath,

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that physicians should first do no harm, then to engage in the possibilities of euthanasia will inevitably lead to moral and personal conflicts for individuals and society as a whole, in favour of an unattainable concept.

Are there other options?

Ultimately, there is another positive alternative to euthanasia, and it is in the further support, research and funding of palliative care and hospices.

According to the Canadian Institute For Health Information, right now we don’t even know “(t)he number, types and quality of palliative care services for gravely ill and dying people across the country.”²⁵ We do know that almost every region across Canada has some level of palliative care,²⁶ but that to be more effective, much growth is necessary.

Good palliative care means we would not have to watch loved ones suffer in pain. There remains much to study and do in areas of pain management, but the case is not as futile as someone like Robert Latimer would like us to believe. In working with the Alberta Cancer Board, Dr. Neil Hagen states, “I soon realized there’s a lot that can be done for these patients, pain control being one of the most important.”²⁷ Imagine that throughout history, anaesthesia was controversial and not used universally.²⁸

Furthermore, we may be *causing* pain for patients at the suggestion of euthanasia. Dr. Margaret Cottle told an audience on Parliament Hill, “It is said that euthanasia kills the patient twice: the first time when you look at the patient’s life and say, ‘Your life really isn’t worth living.’ The second time is when you actually do it.”²⁹



Policy recommendations

Strong leadership by politicians, medical and legal practitioners alike is needed in order to address the euthanasia debate. Positive alternatives are required and must be given philosophical, moral and financial support.

Human life is valuable and should not be subject to the life-ending possibilities imposed by other people based on economics, treatable medical conditions or politics. So what can be done to shore up against the argument for euthanasia and PAS? The following four policy recommendations should be considered:

1. Canada's parliamentarians should review all legislation and the Criminal Code in order to affirm its commitment to upholding and strengthening the existing legislation. The language should be brought up to date from 1985 to reflect more recent legal developments (Rodriguez, Latimer, etc.).
2. The federal and provincial governments should encourage all Canadian medical schools to incorporate a palliative care program as a core part of their curriculum.
3. The Canadian government should work with the Canadian Medical Association and its provincial counterparts to ensure that all practicing physicians are current with the latest in palliative care developments.
4. Recognizing the current problems in the state of Canada's health system; rising costs, long waiting lists, increased workload, patients without GPs, etc. – Canada should work with the provinces to agree upon an amount within the CHST that will be allotted specifically to palliative care. This amount may differ from province to province, depending upon the current and anticipated size of the provincial demographics.

The IMFC believes that Canada's decision makers should actively pursue these recommendations, without waiting for a test case to make its way through the judicial system, pending the decision of a small group of unelected officials. Public and social policy should not be determined outside of debate in the public square.

LONGER LIFE SPANS AND RISING COSTS, A FAILING HEALTH SYSTEM,
PAIN ERADICATION AND LONELINESS CAN BE OVERCOME WITHOUT
TURNING TO LEGALIZED EUTHANASIA – THE DIRECT INVOLVEMENT
OF THE STATE IN THE BUSINESS OF DEATH

endnotes

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- 6 Ibid., <http://www.parl.gc.ca/information/library/PRBpubs/prb0703-e.htm#boregon>.
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