



McGill Centre for Medicine, Ethics and Law

CSSS – 053M
C.P. – P.L. 52
Loi concernant les
soins de fin de vie
VERSION RÉVISÉE

Submission

by

Margaret Somerville

to

La Commission de la santé et des services sociaux

du Québec

Consultations

Auditions publiques sur le projet de loi n°52,

Loi concernant les soins de fin de vie

La salle Louis-Joseph-Papineau de l'hôtel du Parlement

9 octobre, 2013

TABLE OF CONTENTS

1. INTRODUCTION.....	3
2. REDEFINING HOMICIDE AS MEDICAL TREATMENT.....	4
3. UNDEFINED TERMS, EUPHEMISMS AND AMBIGUOUS LANGUAGE IN BILL 52....	6
i) “Medical Aid in Dying”	6
ii) “The Practice of Medicine”	8
iii) “End-of-life care”	9
iv) “Palliative Terminal Sedation”	11
4. WHO MAY HAVE ACCESS TO MAD?	13
5. PHYSICIAN-ASSISTED SUICIDE	17
6. LOGICAL AND PRACTICAL SLIPPERY SLOPES	18
7. DISCUSSION	20
8. CONCLUSION	23
APPENDIX	26

1. INTRODUCTION

Your invitation to appear before this committee to give evidence in relation to Bill 52, *An Act respecting end-of-life care*, presented me with a difficult decision. That's because Bill 52 deals with *the management* of legalized euthanasia.

We don't manage that which we believe to be inherently wrong; we *prohibit* it.

Euthanasia – a physician acting with a primary intention to kill a patient, whose death results from that act - is inherently wrong and, therefore, should remain legally prohibited.

My concern is that my appearance here might be perceived as my being complicit in helping you to develop Bill 52's "management guidelines" for euthanasia. I wish to make it clear that I totally reject legalizing euthanasia, Bill 52 and any such guidelines.

I further submit that even if you do not believe that euthanasia is inherently wrong and *assess its ethical acceptability from a utilitarian perspective*, the risks and harms of legalizing it far outweigh any benefits and, therefore, from this perspective, as well, it should remain prohibited.

You have already heard my arguments and views on two previous occasions as to why we should not legalize euthanasia, so, as you will presume, my goal today is to try to persuade you to reject Bill 52.

As I've explained previously, it is inherently wrong to intentionally kill another person, except in justified self-defence or the defence of others whom one has a duty to protect, which requires that such killing is the only feasible option to save human life. Euthanasia does not fulfill those requirements. But, quite apart from that reason to reject it, euthanasia should remain prohibited, because legal safeguards are unlikely to be respected by healthcare professionals, as, for example, a very recently published article on the situation in Belgium

clearly demonstrates.¹ Even more importantly, legalizing euthanasia would create a risk of the abuse of some of the most vulnerable members of our society – those who are old, sick, fragile, and mentally ill or who suffer from a disability.² Even if such abuse were rare in practice, augmenting the risk of it cannot be justified.

Despite my rejection of Bill 52, I will now deal with some of the issues raised by it. My comments are not intended to be corrective, but, rather, flaw-finding – that is, they are made on the basis that this Bill is wrong in its essence, but even if it were not, here are some examples of what is wrong with it. Further, I have extensively examined, elsewhere, the fundamental arguments against legalizing euthanasia and the reasons not to take that step.³ I do not canvas many of these in this submission. Rather, I look only at those issues directly raised by Bill 52.

2. REDEFINING HOMICIDE AS MEDICAL TREATMENT

Bill 52 seeks to legalize euthanasia by redefining homicide by lethal injection, which it calls “medical aid in dying” (MAD), as a form of medical treatment. To do so, it uses a pro-euthanasia strategy I have called “*legalizing*

¹ Raphael Cohen-Almagor, “First do no harm: pressing concerns regarding euthanasia in Belgium”, *International Journal of Law and Psychiatry*, Available online 13 July 2013. In Press, Corrected Proof [Int J Law Psychiatry](#). 2013 Jul 13. pii: S0160-2527(13)00068-X. doi: 10.1016/j.ijlp.2013.06.014. [Epub ahead of print] <http://www.ncbi.nlm.nih.gov/pubmed/23859807> (Accessed 22 September, 2013.) Cohen-Almagor raises concerns about “(1) the changing role of physicians and imposition on nurses to perform euthanasia; (2) the physicians' confusion and lack of understanding of the Act on Euthanasia; (3) inadequate consultation with an independent expert; (4) lack of notification of euthanasia cases, and (5) organ transplantations of euthanized patients.”

² For documentation of such abuse through reference to articles published in leading medical journals describing it, see Alex Schadenberg, “Exposing Vulnerable People to Euthanasia and Assisted Suicide”, ISBN 978-1-897007-27-3, London Ontario, 2012

³ Margaret Somerville, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide*, McGill Queen's University Press; Montreal, 2001, pp.433

euthanasia through confusion".⁴ This strategy involves equating euthanasia to medical interventions that are widely accepted as ethical and legal and then to confuse euthanasia with them by arguing that euthanasia is the same kind of intervention, so it too is ethical and should be legally accepted. But euthanasia differs from interventions such as refusals of treatment which result in death occurring sooner than it otherwise would or necessary pain management that could result in a shortening of life, with respect to the cause of death in the former case and in both cases the primary intention with which the intervention is carried out. In short, euthanasia is different in kind from these interventions. For the record, I note here that everyone has the right to refuse treatment, even if that will result in death, and, as the Declaration of Montreal,⁵ promulgated by the International Association for the Study of Pain and subsequently accepted by the World Medical Association⁶ establishes, it is now regarded as a breach of human rights to fail to provide fully adequate pain management.⁷

It's important to note that physicians have never regarded killing as medical treatment. Indeed, the Hippocratic Oath, which has been foundational in medical ethics for over two millennia, originated in order to separate the two roles – healer and executioner – of traditional "medicine men," the predecessors of physicians. Today's physicians pledge to care always, cure where possible, and never intentionally to inflict death. Bill 52 directly negates this last obligation.

⁴ Margaret Somerville, "Euthanasia by Confusion" (1997) 20:3 *University of New South Wales Law Journal* 550-575; also published in Margaret Somerville, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide*, *ibid*, chapter 7, pp. 119-143.

⁵ International Association for the Study of Pain, <http://www.iasp-pain.org/Content/NavigationMenu/Advocacy/DeclarationofMontr233al/default.htm> (accessed 6th October, 2013)

⁶ World Medical Association Resolution on the Access to Adequate Pain Treatment, Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October, 2011, http://www.painaustralia.org.au/images/pain_australia/Declaration/WMA%20Resolution.pdf (accessed 6th October, 2013)

⁷ See Margaret Somerville, "Exploring Interactions between Pain, Suffering and the Law", in Nathan Palpant and Ronald Green, eds. *Suffering and Bioethics*, Oxford University Press (in press).

From a legal perspective, classifying euthanasia as medical treatment is clearly a strategy to try to avoid the application of the Canadian *Criminal Code* to euthanasia (MAD), which prohibits it as first degree murder, and to bring its governance within Quebec provincial jurisdiction to govern health and social services.⁸ If Bill 52 is enacted, it will certainly be challenged as unconstitutional and it will be up to the courts to rule on the legal validity of this approach.

3. UNDEFINED TERMS, EUPHEMISMS AND AMBIGUOUS LANGUAGE IN BILL 52

Bill 52 employs undefined terms, euphemisms and ambiguous language, I presume in order to make euthanasia less likely to be rejected by undecided members of the general public; create confusion which could, likewise, make more Quebecers favour legalizing euthanasia; and to try to bring Bill 52 within the legislative jurisdiction of the Quebec Legislative Assembly. I note some examples of such terminology and language below.

i) “Medical Aid in Dying”

Bill 52 does not use the word euthanasia, but refers to “medical aid in dying” (MAD) which it does not expressly define. Rather, it leaves it to the council of physicians, dentists and pharmacists of each institution “in accordance with the clinical standards established by the professional orders concerned, to adopt clinical protocols applicable to terminal palliative sedation and medical aid in dying”.⁹ But it’s clear that MAD is a euphemism for euthanasia or, at the least, is intended to include euthanasia. To avoid any possible confusion on such a fundamental and important change in the law, and so people properly understand that Bill 52 would authorize euthanasia, that should be stated expressly in the Bill, as well as a clear definition of euthanasia.

⁸ J. Donald Boudreau and Margaret Somerville, “Euthanasia is not medical treatment”, *British Medical Bulletin* 2013; 106: 45–66, DOI:10.1093/bmb/ldt010
<http://bmb.oxfordjournals.org/content/early/2013/03/26/bmb.ldt010.full?keytype=ref&ikey=IKP7zm8pfcR3INH>

⁹ Section 32

Even the Quebec College of Physicians and Surgeons, which supports legalizing euthanasia, in its submission to this Commission agrees that more definitional clarity is required:

"It also seems useful to better clarify in this section or elsewhere in the Bill, what is meant by "medical aid in dying." As we have already stated elsewhere, this term suits us as long as the act is performed by a physician in a care setting, which excludes physician-assisted suicide. *The fact remains that it is an act of intentionally causing the death of a person* but in the context of end of life care, in exceptional circumstances and under the conditions established by law."¹⁰
(emphasis added)

That the term “medical aid in dying” is likely to cause confusion, such as I note above, has just been confirmed by a very recent Ipsos Marketing poll carried out for *Vivre dans la dignité*. The survey, carried out 18th to 20th September, 2013, covered 2078 Canadian respondents, 1010 of them from Quebec. The summary of the findings reads, in part:

The expression “medical aid in dying” seems very vague to the Quebec population, and is subject to diverse interpretations. Indeed, one third of Quebecers interpret it as being a patient’s request for lethal injection by a medical professional, while nearly 30% understand that it means relieving symptoms through palliative care. Finally, nearly 40% of those surveyed associate it with a discontinuation of intensive medical treatment, or with assisted suicide. This wide diversity of responses demonstrates the uncertainty that surrounds the term “medical aid in dying”.

¹⁰ Collège des Médecins du Québec, Projet de loi no 52, Loi concernant les soins de fin de vie, Mémoire présenté à la Commission de la santé et des services sociaux, 17 septembre 2013, CSSS – 006M C.P. – P.L. 52 Loi concernant les soins de fin de vie, p.5 (unofficial translation)

In comparison, the term “euthanasia” seems to be much clearer for Quebecers, even if nearly 40% of them ascribe an erroneous meaning to it. As such, 60% of individuals understand that it means having a medical practitioner administer a lethal injection as per a patient’s request.¹¹

This information throws serious doubt on previous polls measuring the public’s support for “medical aid in dying” or “euthanasia”, since, respectively, a majority or a large percentage of people expressing their support for these two procedures were supporting palliative care or discontinuation of intensive medical care, not euthanasia as properly defined. Consequently, claims by proponents of euthanasia of clear public support for it in Canada must, at the very least, be seriously questioned.

Bill 52’s approach of leaving it to the councils of physicians, dentists and pharmacists of each institution to adopt “clinical protocols” for “terminal palliative sedation”(TPS) and MAD,¹² and to every institution to include a clinical program for “end-of-life care”, which includes TPS and MAD,¹³ also raises the question what if each council and each institution adopt different clinical protocols and clinical programs that all define MAD or TPS differently?

And how will healthcare professionals, who believe euthanasia is murder, feel about working in an institution where their professional governing body has drawn up guidelines for undertaking this and some of their colleagues are carrying it out?

ii) “The Practice of Medicine”

Likewise, the definition of “the practice of medicine” in the Quebec *Medical Act* is extended to include a physician “administering the drug or substance allowing an end-of-life patient to obtain medical aid in dying under the Act

¹¹ Ipsos Marketing, “Survey among the Canadian population about end of life issues”, September 18th – 20th, 2013. Ipsos PowerPoint 13-077483-01 Vivre dans la dignité, Rapport 02-10-2013

¹² Section 32

¹³ Sections 9,10

respecting end-of-life”, that is, one presumes, euthanasia. Again, this should be made explicit.

iii) “End-of-life care”

“End-of-life care” is defined as palliative care that includes MAD and “palliative terminal sedation”. In other words, Bill 52 defines “medical aid in dying” (euthanasia) as a legitimate part of “palliative care”. A very large majority of palliative care physicians reject such a definition of palliative care, ninety percent of them reject euthanasia,¹⁴ and a majority of physicians, in general, reject euthanasia.¹⁵ These physicians do not want to work in a healthcare system or institution in which any of their colleagues are carrying out euthanasia. Moreover, they see euthanasia as highly destructive of the very soul of medicine and its caring and healing ethos.¹⁶

Bill 52 creates a *right* to “end-of-life care”, hence creating a *right to euthanasia*.

Bill 52 states that physicians *must* administer MAD to “end-of-life patients”,¹⁷ who fulfill the necessary conditions,¹⁸ unless the physicians have conscientious objections.¹⁹ In other words, Bill 52 creates a positive obligation to provide euthanasia. This is a basic presumption for physicians that “yes, as a physician I have an obligation to provide you with euthanasia, but not if I have conscientious objections to it”. That means the burden of proof of justifying a

¹⁴ Canadian Society of Palliative Care Physicians, “CSPCP Euthanasia Survey Results”, <http://www.cspcp.ca/indexdocuments/SurveyResultsFINAL.pdf>

¹⁵ Canadian Medical Association Bulletin, “MD views on euthanasia, assisted suicide vary widely: survey”, CMAJ, March 5, 2013, 185(4) 357. “A survey of CMA members’ views on major end-of-life issues has found that only 20% would be willing to participate if euthanasia is legalized in Canada, while twice as many (42%) would refuse to do so. Almost a quarter of respondents (23%) are not sure how they would respond, while 15% did not answer. The results are similar for physician-assisted suicide: 16% of respondents would assist, while 44% would refuse. More than a quarter of respondents (26%) are not sure how they would respond to such a request, and 15% did not answer.”

¹⁶ J Donald Boudreau and Margaret Somerville, *supra* note 8

¹⁷ Section 29

¹⁸ Section 26

¹⁹ Section 44

refusal to provide euthanasia is on the physician and in cases of equal doubt as to whether the physician has fulfilled the burden of proof, the physician must provide euthanasia. In addition a physician who has a conscientious objection *must* notify the director of professional services (DPS) who “*must* then take the necessary steps to find another physician willing to deal with the request...”.²⁰ This is not a true protection of freedom of conscience for the physician, who, moreover, is forced to be a party to a criminal act in referring the matter to the DPS and the DPS himself has *no* possibility to raise a conscientious objection.

Bill 52 also requires that “institutions,” such as local community service centres (CLSC’s), hospitals, and certain “residential and long-term care centres,” likewise, *must* be able to give patients who qualify access to MAD.²¹

The word “must” appears 64 times in Bill 52. In short, the legislation is focused on creating obligations. Some of those obligations, such as access for all who need it to good palliative care, as normally defined, we can all agree with. Others, which involve administering euthanasia or complicity in its administration by creating duties to refer patients to physicians willing to provide it,²² we certainly cannot.

The context and the medical system in which euthanasia occurs are relevant to assessing the validity of a free and informed consent to it, were it to be legalized. If the system is inadequate and people could fear being left in pain and serious suffering, their consent to euthanasia is not free, that is, not voluntary.^{23,24}

²⁰ Section 30

²¹ Section 8

²² Section 30

²³ Margaret Somerville, "Structuring the Issues in Informed Consent", (1981) 26:4 *McGill Law Journal* 740-808.

²⁴ Margaret Somerville, "Labels versus Contents: Variance between Philosophy, Psychiatry and Law in Concepts Governing Decision-Making", (1994) 39 *McGill Law Journal* 179-199.

iv) “Palliative Terminal Sedation”

The term “palliative terminal sedation”, including its lack of definition, creates confusion between sedation which is *not* euthanasia and euthanasia. It seems reasonable to assume that creating such confusion is not unintentional.

Bill 52 would give “end-of-life patients” a choice of “fast” or “slow” euthanasia. Fast euthanasia (MAD) would be a lethal injection; slow euthanasia would be what the Bill calls “terminal palliative sedation” (TPS). In addition, TPS escapes all the prior conditions of sections 26 and 28 applicable to MAD and the requirement of reporting to the end-of-life Commission.²⁵

The term TPS is confusing, because some sedation at the end of life is not euthanasia and some can be. It’s another example of the strategy of promoting euthanasia by confusing it with interventions which are not euthanasia and are ethically acceptable and arguing that there are no relevant differences among them and, therefore, all are ethical and acceptable.

“Palliative sedation,” which is relatively rarely indicated as an appropriate medical treatment for dying people, is used when it is the only reasonable way to control pain and suffering and is given with that intention. It is not euthanasia.

“Terminal sedation” refers to a situation in which the patient is not otherwise dying at that time and is sedated with the primary intention of precipitating their death. This is euthanasia.

Euthanasia advocates argue that we can’t distinguish the intention with which these interventions are undertaken and, therefore, this distinction is unworkable. But the circumstances in which such an intervention is used and its precise nature allow us to do so. For instance, if a patient’s symptoms can be controlled without sedation, and especially if the patient is not otherwise dying and food and fluids are withheld from the sedated patient with the intention of causing death, that is clearly euthanasia.

²⁵ Section 41

In the Netherlands, terminal sedation is not defined as euthanasia and there has been a substantial increase in its use.²⁶ Some commentators have pondered whether it's being used instead of lethal injections, because it allows physicians to avoid the reporting and other requirements euthanasia entails. The same would be likely under the provisions of Bill 52. The requirements for using "terminal palliative sedation" seem to be at the discretion of the physician, provided that the patient or, if they are incompetent, their surrogate decision-maker gives informed consent to it. The requirements for access to and reporting on MAD are far more onerous and more limiting, and a surrogate decision-maker could not authorize it.

A protocol for the use of deep sedation, called the *Liverpool Care Pathway* (LCP), for use in hospitals and nursing homes was introduced in the United Kingdom. Its stated purpose was to "provide quality healthcare to the dying", but it was seriously abused. Patients who were not terminally ill were put into an induced coma and food and fluids were withheld until death occurred.²⁷ "There have also been suggestions that the pathway has been used to help hospitals save money. NHS Trusts do receive payouts for hitting targets related to its use - but the suggestion that the pathway has been used for cynical reasons has been vigorously denied by the Department of Health."²⁸ Even if the Department of Health is correct, this arrangement constitutes a serious conflict of interest. Because of such abuses and the public outrage they rightly generated, the LCP is being abandoned.²⁹ However, its initial goal of trying to ensure that dying patients

²⁶Bregje D Onwuteaka-Philipsen, Arianne Brinkman-Stoppelenburg, Corine Penning, Gwen J F de Jong-Krul, Johannes J M van Delden, Agnes van der Heide, "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey", *www.thelancet.com* Published online July 11, 2012, [http://dx.doi.org/10.1016/S0140-6736\(12\)61034-4](http://dx.doi.org/10.1016/S0140-6736(12)61034-4) 1

²⁷ "A lethal power? Jacqueline Laing addresses concerns about the Liverpool Care Pathway", *New Law Journal*, 23 November 2012, <http://www.newlawjournal.co.uk/nlj/content/lethal-power> (Accessed 24 September, 2013)

²⁸ BBC News Health, "Liverpool Care Pathway 'should be phased out'", 13 July 2013 <http://www.bbc.co.uk/news/health-23283820> (Accessed 24 September, 2013)

²⁹ Ibid

were not ignored and received the care they required remains an essential pursuit.

Most jurisdictions which have legalized euthanasia or physician-assisted suicide have, at least initially, limited it to adults who are competent and consenting at the time it is administered. However, Bill 52 would allow MAD to be carried out pursuant to a patient's advance directive consenting to it. To have a firsthand glimpse of how this could be abused, I recommend viewing the documentary film *End Credits*.³⁰ It records the situation of an old Belgian man, in a nursing home, who had given consent to euthanasia in an advanced directive. The man's nephew is urging the healthcare professionals to administer it, because, he says, his uncle is no longer mentally competent, so can't validly change his mind. The physician tries to clarify with the old man whether he wants euthanasia. Suddenly, the old man has a burst of energy and shouts, "You want to kill me", and is clearly horrified by the thought. Sometime later, he dies a natural death.

4. WHO MAY HAVE ACCESS TO MAD?

Bill 52 provides that "end-of-life" patients who want MAD and fulfil the necessary conditions have a right of access to it.³¹ But, strangely enough, when we come to the pre-conditions to have MAD found in sections 26 and 28, the expression "end-of-life" patient is omitted. We do not know whether this is intentional or just bad legal drafting. In any event, who is an "end-of-life" patient?

In Bill 52, euthanasia is not limited to people who are terminally ill; to be "suffer[ing] from an incurable serious illness" is enough on this count.³² They must also "suffer from an advanced state of irreversible decline in capability; and suffer from constant and unbearable physical or psychological pain which cannot

³⁰ *End Credits*, Director: Alexander Decommere, Writer: Marc Cosyns. Contact & info: endcredits.be (Description of the film: "This is a low quality screener (Dutch with English subtitles) of the Belgian documentary "End Credits", on the practice of euthanasia, ten years since the Belgian law was finalized in 2002. Adelin, 83, and Eva, 34, two very different people who are at the dawn of the end of their lives, ask for help with and care for a decent passing away.)

³¹ Section 5

³² Section 26 (2)

be relieved in a manner the person deems tolerable.”³³ These requirements in Bill 52 are similar to the Belgium euthanasia law³⁴ and, as has become obvious in Belgium, would allow for the law to apply to a very broad group of people. For example, many people with disabilities or who are old, frail or vulnerable would fulfil these criteria. And recall that MAD may be administered in “residential and long-term care centres” or a person’s home.

I note here that a strong majority of the media erroneously report that MAD would only be available to terminally ill people and, in a conversation I had with Maitre Jean-Pierre Ménard,³⁵ author of the Ménard Report on legally implementing the recommendations on which Bill 52 is based,³⁶ he seemed to believe the same. The confusion probably arises because Bill 52 speaks of “end-of-life care” and “end-of-life patients”, but the criteria it establishes for access to euthanasia do not require the person to be imminently dying. So, “end-of-life patients” include, not only, those who are imminently dying, but also, those who fulfil Bill 52’s criteria for access and want to end their lives, even though they are not dying.

A recent newspaper report on an earlier hearing by your committee in this series, in which the euthanasia of a Belgian woman was considered, raises the critical issue of whether the way in which Bill 52 is drafted is the cause of serious confusion about who may have access to euthanasia. Commenting on the case of Godelieva De Troyer, a 64 year old Belgium woman with depression who was euthanized under Belgium law, Dr. Yves Robert of the Quebec College of Physicians and Surgeons is reported as responding:

³³ Section 26(4)

³⁴ The Termination of Life on Request and Assistance with Suicide (Review Procedures) Act, 1 April 2002, Royal Decree of 15 March 2002. OJ 2002; 165.
<http://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda%20Ley%202002.pdf> (accessed 3 October, 2013).

³⁵ “The Tommy Schnurmacher Show”, CJAD 800 radio station, Montreal, 24th January, 2013

³⁶ Mourir dans la dignité - La ministre Hivon rend public le rapport du comité Ménard sur la mise en œuvre juridique des recommandations de la Commission spéciale, 15 janvier, 2013, <http://communiqués.gouv.qc.ca/gouvqc/communiqués/GPQF/Janvier2013/15/c6027.html>

“Quebec is not Belgium. ...This case would not have been allowed in Quebec under Bill 52. ... No stakeholders want this.”

The newspaper article continues:

The proposed law specifies three conditions: there must be an incurable disease, imminent death and unbearable suffering — which rules out depression, Robert said. “Under these medical criteria, this woman would not have had access to medical help to die in Quebec,” he added.”³⁷

But, is Dr. Robert correct? Because this is such an important question, at the risk of being repetitive on some points, let’s more closely examine Bill 52, precisely in relation to Dr. Robert’s claim.

Although, as noted earlier, the word euthanasia is not used in Bill 52, presumably for the Quebec Legislative Assembly to try to avoid problems with the Bill trespassing on federal jurisdiction, where the *Criminal Code*³⁸ prohibits euthanasia, the history and development of the euphemism “medical aid in dying” and its current use before this committee shows that “end of life care”, which expressly includes “medical aid in dying”,³⁹ is clearly meant to encompass euthanasia. And, as stated already, Bill 52 provides that “end-of-life” patients, who want “medical assistance in dying” and fulfil the requirements for access to it, must be offered it. So, who is an “end-of-life” patient?

First, as explained, the person need not be terminally ill, but only “suffer[ing] from an incurable serious illness”.⁴⁰ So Dr. Robert is wrong if he is reported correctly and believes that “imminent death” is required. And it seems that he does not believe serious depression can be “an incurable serious illness”. Many would disagree.

³⁷ Charlie Fidelman, “Dying-with-dignity laws can hit a slippery slope”, *The [Montreal] Gazette*, Sept 17, 2013, A3

³⁸ R.S.C., 1985, c. C-46 (as amended), sec. 222

³⁹ Section 3(3)

⁴⁰ Section 26 (2)

The person must also “suffer from an advanced state of irreversible decline in capability; and suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable”.⁴¹ In other words, a person need not be physically ill; a mental illness such as serious depression, one can reasonably assume, would be sufficient.

And, the person need not have tried all reasonable treatments to relieve her suffering before having access to euthanasia, because the Bill provides, “A person may not be denied end-of-life care for previously having refused to receive a treatment or procedure or having withdrawn consent to a treatment or procedure”.⁴²

Moreover, the person need only make a subjective judgment that her suffering is not tolerable, as one assumes Ms. De Troyer decided. This is consistent with the informing principle behind Bill 52, in that “the Act recognizes the primacy of freely and clearly expressed wishes with respect to care”.⁴³ In short, respect for personal autonomy and self-determination is the value that always takes priority in relation to “end-of-life” decision making, including euthanasia, provided other requirements for access to it are met.

These requirements for access to euthanasia in Bill 52 would seem to allow for the law to apply to a broad group of people, including, as Ms. De Troyer’s case shows, those who are seriously depressed.

Consequently, to say the least, it’s puzzling how Dr Robert can say, “This case would not have been allowed in Quebec under Bill 52”⁴⁴ and that euthanasia for serious depression is ruled out.

And it would be deeply concerning if people, such as Dr. Robert, who is an official spokesperson for the Quebec College of Physicians and Surgeons, which is

⁴¹ Section 26(4)

⁴² Section 7

⁴³ Section 1

⁴⁴ Fidelman, *supra* note 37

strongly advocating the passage of Bill 52, were not to understand the law in such an important respect as who will be eligible for euthanasia under its provisions.

Indeed, the Quebec College of Physicians and Surgeons' own submission to this Commission acknowledges that Bill 52 is not clear as to who may have access to MAD:

"As well, we believe that the requirement that death is inevitable and imminent should be made more explicit, using the concept of "terminal phase". The easiest way would probably require that the person be in terminal phase... This requirement would replace the requirement that the medical condition of the person is characterized by an advanced state of irreversible decline in capability. *Psychiatrists have advised us that many of their patients could apply and meet the eligibility criteria as currently formulated. The same applies to patients with a degenerative disease still at an early stage. It is easy to understand the reluctance of physicians to satisfy such requests.*"⁴⁵ (Emphasis added)

5. PHYSICIAN-ASSISTED SUICIDE

It is an open question whether MAD may include physician-assisted suicide (PAS), as the media have constantly reported it does. The uncertainty arises, in part, because Bill 52 provides that "If a physician determines... that medical aid in dying may be administered to a patient requesting it, the physician must administer such aid personally and take care of the patient until their death"⁴⁶ and the Quebec Legislative Assembly committee report, *Dying with Dignity*, which informed Bill 52 rejected physician-assisted suicide.

The reasons to exclude PAS might include that it's more difficult to frame PAS as a "medical act", as the report recognized; that society doesn't want to promote the idea that suicide, in general, is an appropriate response to suffering, as the report also emphasized; that we want to maintain the current medical

⁴⁵ Supra note 10, p.8 (unofficial translation)

⁴⁶ Section 29

norm that the appropriate medical act in dealing with attempted suicide is to try to save life; or that the Quebec government hopes to “immunize” Bill 52 from legal challenge by avoiding the precedent in the *Rodriguez* case, in which the Supreme Court of Canada upheld the constitutional validity of the crime of assisted suicide.

6. LOGICAL AND PRACTICAL SLIPPERY SLOPES

Before I address the issue of “slippery slopes”, I want to make clear that even if it could be guaranteed that these slopes would not result if euthanasia were to be legalized, the risks and harms of legalizing euthanasia still far outweigh any benefits. These harms include the impact on important societal values; that euthanasia will be normalized and become the norm; harmful effects on healthcare institutions, professions and professionals, and patients’ trust in all of these, and so on. In short, pro-euthanasia advocates’ argument that slippery slopes can be prevented by strict legal regulation, such as they propose Bill 52 would establish, even if correct, does not, as they claim it does, justify legalizing euthanasia.

I quote from a paper Dr. Donald Boudreau and I wrote called *Euthanasia is not medical treatment*, a copy of which is attached as an appendix and forms part of this submission:

Many proponents of euthanasia like to claim that opponents rely on two types of unsound arguments: one based on empirical data and the other anchored in axiology.

In the first instance, they allege that the outcomes data available from jurisdictions where euthanasia or assisted suicide has been legalized, suggest that our fears of potential abuse are groundless. They deny that there is a ‘logical’ slippery slope—that the situations in which euthanasia will be available will expand over time—or a ‘practical’ slippery slope—that euthanasia will be used abusively.

Pro-euthanasia advocates claim that evolving legislation does not pose a threat to persons with a disability, does not lead to euthanasia without consent, does not invite extension of the practice to vulnerable populations—in short, that it has not become a ‘run-away train’. They usually express satisfaction with individual clinicians’ professional restraint and integrity as well as with administrative safe guards.⁴⁷

But, the evidence for the existence of a *practical slippery slope* in both the Netherlands and Belgium, the two jurisdictions most often referenced, is very convincing.⁴⁸ This was recently affirmed by the High Court of Ireland, in a judgment in which they held prohibiting assisted suicide did not contravene the Irish Constitution.⁴⁹

As to the *logical slippery slope*, we can trace a phenomenon in applied ethics, in general, that I propose is relevant to the euthanasia debate. When first faced with a given practice, we can start with serious ethical concerns about it (our reaction is sometimes called the “ethical yuck factor” – our moral intuitions warn us it is ethically wrong). Then, as we become accustomed to the practice our ethical concern diminishes to neutrality and then even to acceptance of the practice as ethical. And, finally, we often go on to expand our acceptance to include logically connected wider applications of the practice. In some cases, among which I would include euthanasia, allowing this phenomenon even to commence in the first place is not justified, let alone allowing it to progress to the logical expansion phase, as it has done in both the Netherlands and Belgium. Not allowing it to start demands that Bill 52 be rejected.

A relatively recent dramatic example of the logical slippery slope’s gravitational pull – the incremental extension of access to euthanasia - is the euthanizing, in December 2012, of 45-year-old twins in Belgium. Deaf since childhood, Marc and Eddy Verbessem were facing the additional disability of

⁴⁷ J. Donald Boudreau and Margaret Somerville, *supra* note 8

⁴⁸ See Cohen-Almagor, *supra* note 1

⁴⁹ *Fleming-v-Ireland & Ors* [2013] IEHC 2.

blindness. Their physician accepted that they were irremediably suffering and euthanized them.⁵⁰

Articles published in medical journals report organs being taken from euthanized people in Belgium for transplant.⁵¹ In at least one of these cases the woman donor was mentally ill, but not physically ill. The documentary film *End Credits*,⁵² mentioned previously, also follows a young Belgium woman who suffers from mental illness (probably severe depression), who wants to donate her organs after euthanasia, but is refused permission to do so by the relevant authority. Watching the scenes showing the physician euthanizing her and filling out the necessary reporting forms is a chilling experience. Belgium is also considering making euthanasia available for children, which is already the case in the Netherlands, and for people with dementia.

7. DISCUSSION

The above comments on Bill 52 are far from comprehensive and are intended simply to identify and articulate some of the arguments, reasoning and strategies that it manifests and issues it raises. My hope is that they might serve as warning signals of just some of the dangers, I believe, Bill 52 presents.

We know that people who are old or fragile or suffer from a disability often perceive themselves as a burden on their families and society. If euthanasia is an option, they could feel they should relieve that burden through euthanasia. They could even feel that they have a duty to die, in particular, if healthcare costs are an influence or factor in such decision making.

⁵⁰ Deaf Belgian twins bought new suits and shoes before killing themselves. Mail Online. Published January 15, 2013. Available at: <http://www.dailymail.co.uk/news/article-2262630/>.

⁵¹ D. Ysebaert, G. Van Beeumen, K. De Greef, J.P. Squifflet, O. Detry, A. De Roover, M.-H. Delbouille, W. Van Donink, G. Roeyen, T. Chapelle, J.-L. Bosmans, D. Van Raemdonck, M.E. Faymonville, S. Laureys, M. Lamy, and P. Cras, "Organ Procurement After Euthanasia: Belgian Experience", *Transplantation Proceedings*, 41, 585–586 (2009), http://www.coma.ulg.ac.be/papers/death/organ_euthanasia09.pdf

⁵² Supra note 30

Legalizing euthanasia has emerged as an issue in the context of aging populations and rising healthcare costs in the Western world. Reaching an old age used to be considered a great blessing; now it can be regarded as a curse. In this regard, discussion in the context of the euthanasia debate of the healthcare and sometimes other costs of caring for aged people, which used to be forbidden ground, has become more common in the last few years, although Madame Véronique Hivon, the Quebec Minister for Social Services and Youth Protection, is reported as saying that Bill 52 has nothing to do with cost saving. I accept that she is being honest with respect to the goals and intention behind the Bill, but that does not mean that healthcare cost saving would not influence its application in practice, in particular, at the institutional or hospital level, even if not at the level of the individual physician-patient relationship.

Discussion of euthanasia for people with dementia, once adamantly denied by pro-euthanasia advocates as a possibility, has also become more common.⁵³ More than 35 million people worldwide live with dementia today, according to a new report. By 2050, that number is expected to more than triple to 115 million.⁵⁴ "The majority requires constant care; they're dependent.... People with dementia have special needs for care. ...They need more personal care, more hours of care, and more supervision, all of which is associated with greater caregiver strain, and higher costs." ⁵⁵

⁵³ See, for example, Fidelman, *supra* note 37, who reports on evidence given before this commission by Dr. Yves Robert of the Quebec College of Physicians and Surgeons, as follows: "Quebec's legislation excludes patients who are declared "inapt", for example, those with dementia, and who cannot consent for themselves, Robert said, and the government will have to address that in the future because the bill does not cover all cases." Note as well that the Report of the Quebec National Assembly Select Committee on *Dying with Dignity* did not rule out euthanasia being administered to people with dementia. Rather, it recommended a special committee be formed to consider whether this should be allowed (at pp.92-93).

⁵⁴ Alzheimer's Disease International, 2013 World Alzheimer's Report, "Journey of Care", which "examines global trends related to older people who need dementia care, including those with Alzheimer's disease." http://www.cnn.com/2013/09/19/health/world-alzheimers-report-caregivers/?hpt=he_c2 (Accessed 20th September, 2013)

⁵⁵ Fidelman, *supra* note 37

We don't discuss the acceptability of justifications, such as cost-saving, that we would never consider using, or the feasibility of actions such as euthanizing people with dementia that we would never consider undertaking, because we consider doing so would be inherently wrong. Therefore, incorporating into the euthanasia debate the discussion of healthcare and other costs of caring for people, or euthanasia for people with dementia, is a frightening development.

Legalization of euthanasia gives the value of individual autonomy priority over that of respect for human life. Its message is that personal control is the primary human good. Loss of control is equated with loss of dignity and the protections, especially that of respect for life, which it provides. Because characteristics such as loss of control and of independence are often true of old people or people with disabilities, acceptance of this line of analysis is especially dangerous for them, including because it devalues them in their own eyes and that of others.

All of the reports and documents on the basis of which Bill 52 was drafted give priority to individual autonomy of the person who wants euthanasia as the overriding value. But, as some feminist legal scholars are proposing, we should recognize the need for some intelligent restraints on "pure individualism".⁵⁶ They have developed a concept of "relational autonomy" – the idea that a person is not an isolated being, but exists in a context that influences their decisions and that context must be taken into account when judging the validity of those decisions. Taking that approach can operate as such a restraint. I propose that the context in which euthanasia would occur means that the dangers of abuse are such that it should not be legalized.

Likewise, we must recognize that the impact of individuals' decisions – especially, their collective impact - is not limited to those persons, but affects others, in particular, the families of people euthanized, the healthcare professions, and society as a whole. The last is especially true of euthanasia. The

⁵⁶ See, for example, Jennifer Nedelsky, [Law's Relations: A Relational Theory of Self, Autonomy, and Law](#) Print publication date: 2012, Published to Oxford Scholarship Online: January 2012 DOI: 10.1093/acprof:oso/9780195147964.001.0001

damage that legalizing it would do to the value of respect for human life, in general, in our society should cause us to reject its legalization.

We should keep in mind in this regard that in a secular society, such as Quebec, medicine and law are the two major societal institutions which carry the value of respect for life for the society as a whole. Euthanasia requires society's complicity in changing the law – whether in substance or in how it is applied - to allow it, and, if Bill 52 were enacted, either *de jure* or *de facto* authorizing physicians to carry it out. The value of respect for life at the general societal level cannot escape being seriously damaged in so doing.

One way to understand more fully what euthanasia involves is to take the medical cloak off it, that is, to propose that if it were to be legalized someone other than physicians should carry it out.⁵⁷ Many people who agree with legalizing euthanasia strongly reject such a proposal, which indicates that they are judging the acceptability of euthanasia according to who is undertaking it, namely, physicians whom they regard as ethical, not what it is the physicians are doing, killing their patients. It is also likely that people's emotional responses to euthanasia and moral intuitions about it warn them that it is unethical, when this judgment is not affected by seeing it as a medical procedure.⁵⁸

8. CONCLUSION

The case for euthanasia is logical, direct and utilitarian, and focuses on a suffering individual person who wants euthanasia, so it's easy to make and communicate. The video recently made by highly respected, Toronto physician Dr Donald Low, shortly before his death, in which he pleaded for PAS to be legalized, is an excellent example of the power of such appeals. For those of us who oppose legalizing PAS and euthanasia, we must respond to the people who make these pleas with moral regret. This means that although we believe that it would be

⁵⁷ This proposal is discussed in depth in Boudreau and Somerville, *supra* note 8.

⁵⁸ See Margaret Somerville, *The Ethical Imagination: Journeys of the Human Spirit*, Toronto; House of Anansi Press, 2006, pp28-31.

unethical for us to provide what they request and, therefore, that we must not do so, we sincerely regret the hurt our refusal to comply with their wishes causes them. We must also take whatever measures we can, within ethical limits, to relieve their suffering. This requires that all people who need it must have ready access to high quality palliative care.

In contrast to an approach that is predominantly direct, utilitarian and focused on an individual, in order to properly understand the case against euthanasia, as well as using reason, we need to use all our other “human ways of knowing”, especially, our moral intuition, examined emotions, human memory (history) and ethical imagination in relation to all aspects of euthanasia at individual, institutional and societal levels.⁵⁹ I believe that if we do so, we will decide that legalizing euthanasia is a very bad idea.

The basic question that euthanasia raises is: Is it inherently wrong for one person intentionally to kill another? I believe that it is.

So, to conclude as I began, first, if something is inherently wrong, the issue of how best to manage it – how to prevent abuses, the main issue with which Bill 52 purports to deal – does not arise. We only manage activities that are ethically acceptable; we prohibit those that are not. As author and publisher Peter Stockland says, the central question in the euthanasia debate is not whether the system will work as designed to prevent abuses, as pro-euthanasia activists argue it will, but what the system is designed to do.⁶⁰ And that requires us to address geriatrician Dr. Catherine Ferrier's challenging question: "If it's not killing, what is it?"

Second, if one does not agree that euthanasia is inherently wrong, even from a utilitarian perspective its risks and harms, especially to vulnerable people and to fundamental societal values, far outweigh any benefits. In particular, as the Netherlands and Belgium which have legalized euthanasia demonstrate, it is not

⁵⁹ Ibid

⁶⁰ Personal communication, December 19th 2012.

possible to prevent either the logical slippery slope – the extension of the circumstances in which it may be used - or the practical slippery slope - its abuse.

Third, legalizing euthanasia is not, as it is framed to appear in Bill 52, an incremental step. It would constitute a radical change in our shared values regarding respect for human life; in what we view as ethical medical treatment or, indeed, as medical treatment - it does not form part of what has been called “a continuum of care”; and in what has been seen for millennia as ethically prohibited conduct on the part of physicians and an essential element of the ethos of the institution of medicine, namely, a prohibition on their intentionally inflicting death.

I suggest that the push for legalizing euthanasia results from a failure of our ethical imagination both as to what euthanasia involves in practice – killing another human being – and as to where that would lead in the future. Consequently, I once again urge you not to proceed with legislation that would have a goal of allowing euthanasia in Quebec. In short, I am asking you to reject Bill 52 to the extent that it seeks to allow intentional termination of people’s lives, that is, euthanasia (“medical assistance in dying”) or “terminal palliative sedation”, when this would constitute euthanasia. And I strongly urge you to enact measures that would ensure that all Quebecers who need it can have access to the highest quality palliative care, understood as excluding euthanasia.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read 'Margaret Somerville', enclosed within a thin rectangular border.

Margaret Somerville

Montreal

7th October, 2013

Euthanasia is not medical treatment

J. Donald Boudreau^{†*} and Margaret A. Somerville^{‡§}

[†]Department of Medicine, and Core member, Center for Medical Education, Faculty of Medicine, McGill University, Montreal, QC, Canada; [‡]Faculty of Medicine, Samuel Gale Professor of Law, McGill University, Montreal, QC, Canada, and [§]Centre for Medicine, Ethics and Law, McGill University, Montreal, QC, Canada

Introduction or background: The public assumes that if euthanasia and assisted suicide were to be legalized they would be carried out by physicians.

Sources of data: In furthering critical analysis, we supplement the discourse in the ethics and palliative care literature with that from medical education and evolving jurisprudence.

Areas of agreement: Both proponents and opponents agree that the values of respect for human life and for individuals' autonomy are relevant to the debate.

Areas of controversy: Advocates of euthanasia and assisted suicide give priority to the right to personal autonomy and avoid discussions of harmful impacts of these practices on medicine, law and society. Opponents give priority to respect for life and identify such harmful effects. These both require euthanasia to remain legally prohibited.

Growing points: Proposals are emerging that if society legalizes euthanasia it should not be mandated to physicians.

Areas timely for developing research: The impact of characterizing euthanasia as 'medical treatment' on physicians' professional identity and on the institutions of medicine and law should be examined in jurisdictions where assisted suicide and euthanasia have been de-criminalized.

Keywords: euthanasia/assisted suicide/palliative care/suffering/healing/medical legislation

Accepted: March 2, 2013

...tha'll nivver feel it, tha'll be out of existence i' two minutes

*Correspondence address.
Center for Medical
Education, Faculty of
Medicine, McGill
University, 1110 Pine Ave.
West, Montreal, QC,
Canada, H3A 1A3. E-mail:
donald.boudreau@
mcgill.ca

James Billington

Background

Physician-assisted suicide (PAS) and euthanasia are among the most contentious issues faced by the medical profession. Numerous scholars have argued in favor of¹ or against² 'assisted death', as these interventions are euphemistically called. These debates generally take it for granted that the person carrying out euthanasia will be a physician. That assumption has been questioned, most recently, by two ethicists from the Harvard Medical School who propose a limited role for physicians in assisted dying.³ We discuss their proposal shortly. The possibility of deleting the physician from the equation has certainly not been salient in professional discourse.

In this article we will examine factors, highlighting historical contexts and the influence of language, which have helped campaigners who aim to sanitize 'assisted dying' by associating it with medicine. We broach the issue of whether euthanasia can be considered medical treatment by focusing on the irreconcilability of euthanasia with medicine's mandate to heal.

In the remainder of this text, we use the word euthanasia to include PAS, unless the contrary is indicated. We do so in accordance with the fact that both procedures raise the same ethical and legal considerations with respect to many of the issues discussed in this article. In PAS and euthanasia, physicians and society are complicit in helping persons to commit suicide or giving them a lethal injection, respectively. Moreover, whether or not a society will alter its laws to allow 'medically induced death' is a binary decision.

The implication of a medicalized dying process

Are medical doctors, by being responsible for the prolongation of the dying process, blameworthy for the existence of conditions that elicit a desire for hastened death? The profession has indeed created circumstances, through overly aggressive technical interventions, whereby persons' illness narratives have included chapters with alienating, de-personalizing and dehumanizing plots and characters. The following trajectory of a hypothetical patient with amyotrophic lateral sclerosis is all too common: first, non-invasive nocturnal ventilation enters the scenario; next, a wheelchair; then a Dobhof feeding tube, promptly replaced by a jejunostomy; innumerable venous punctures and catheterizations; intervening urinary tract infections; recurrent aspiration pneumonias, followed by invasive ventilation, eventually necessitating a tracheostomy; accompanied by unrelenting despondency; and finally,

progressive somnolence and terminal sepsis. Too many patients find themselves in a sickroom in such a state, one of spent physical resources and suspended hope or even total despair. Some would add that this metaphoric dwelling is also inhabited by a crushed spirituality.

Pro-euthanasia advocates sometimes present such scenarios to support their views that the profession is, in some measure, responsible for the condition in which a patient may conceive of no escape or redress other than self-willed death. A comment such as, 'I'd rather die than slog on with deformity, disfigurement and disability', is not infrequently heard and, when expressed, often denounces a sequence of medical interventions rather than the original illness. In dire situations, one of the few avenues that can seem to offer a sense of comfort is that of personal control. Control, usually packaged in a discursive frame of politico-judicial personal autonomy, can be manifest as a desire to manage the ultimate mode of exit from life, that is, for patients to select the method, place and hour of their death. Moreover, some may want this stance to be legitimized by societal approval and even see it as a heroic act and as furthering a common cause, by promoting shared values and ideologies.⁴

It would, however, be an overstatement to attribute all changes in the nature of death to the health professions. Improvements in general socioeconomic conditions have decreased the incidence of death from catastrophic accidents, trauma and obstetrical mishaps and have lessened the impact of previously deadly infectious diseases. Undeniably, the shift in prevalence from acute and preventable conditions to chronic degenerative diseases, as well as many cancers, is a consequence of a prolongation of life resulting from improvements in public health, universal literacy and preventive interventions. Nonetheless, there is a kernel of truth in the notion, expressed in commentaries dating from Hellenistic to modern times, that physicians have invented 'lingering' death.⁵ We believe that some of the profession's approaches in responding to illness in modern society may have fueled the clamour for radical solutions such as euthanasia.

The process has been abetted by those who espouse so-called 'progressive values', in what are often referred to as the 'culture wars', and who often manifest a pervasive questioning of authority.⁶ A desire for unfettered individual decision-making powers—seeing 'radical autonomy' as always being the overriding value—and the demotion of established religions as influential voices in the public square are also important factors in the rise in demands to legalize euthanasia. We consider euthanasia a misguided solution to a complex socio-cultural transformation. It is reasonable that the medical profession not deny its contributions to the situation; but, it would be perverse if it allows

itself to be co-opted by a perceived need for atonement. It must be vigilant to avoid over-compensating by endorsing society-sanctioned euthanasia.

The profession must not disown its ethical tradition or abandon its basic precepts. The potential harm is not only to individuals, but also to the institutions of medicine and law and the roles they play in society, especially in secular societies, where they are the primary carriers of the value of respect for human life, at the level of both the individual person and society. Ironically, they are more important in this regard now than when religion was the main carrier of the value of respect for life.⁴ Therefore, the degrees of freedom, in terms of legitimate actions and behaviours available to physicians confronted with a dying patient are, and must remain, clearly and strictly limited.

The historical case against physicians assisting suicide

The injunction against physician involvement in hastening death has recurred throughout recorded history, the Hippocratic Oath providing the following emblematic statement: 'I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect'.⁷ This unambiguous prohibition has oriented medical practice towards specific ends and means and away from certain others for over 2400 years. Its enduring impact was apparent in early-modern Western society. Euthanasia was discussed by the lawyer Casper Questel in a book entitled 'De pulvinari morientibus non subtrahendo'.⁸ Translated as 'On the pillow of which the dying should not be deprived', it described common practices that were thought to hasten death. These popular practices included removing pillows from dying persons so that, with their bodies completely supine, ventilatory capacity would be constricted and death accelerated. Another strategy was to transfer dying persons from their beds to the ground. Perhaps the latter operated through a tacit understanding that the bodily cold thereby induced would bring dying persons closer to their natural demise. Regardless of the underlying pathophysiologic mechanism, it is highly probable that symbolism (for example, facilitating passage of the soul from the shell of the dying body to life eternal) was at play. We note that it was natural death that was sought, not terminating the life of the person.

An intriguing and noteworthy feature of this ancient text is that such practices were popular amongst the general public. They were not acts delegated by society to a particular group and certainly not restricted to medical doctors. Questel was aware of undesirable ramifications if they were practiced by physicians. Physicians risked losing trust should they be discovered to have intentionally shortened the lives of dying

patients. Trust is of paramount importance to a successful doctor–patient encounter and is indispensable to the implicit moral contract between the profession and society.⁹ Maintaining the trust of individual patients and of society is a *sine qua non* for the maintenance of professional status. Participating in euthanasia carries the risk of vitiating trustworthiness.

Constraints on physician complicity in euthanasia are to be found throughout history. An 1826 Latin manuscript by a physician, Carl Friedrich Marx, referred to medical euthanasia as the skillful alleviation of suffering.¹⁰ He absolutely forbade physicians from engaging in any attempt at accelerating death, stating: ‘... and least of all should he be permitted, prompted either by other people’s request or his own sense of mercy, to end the patient’s pitiful condition by purposefully and deliberately hastening death’. Examples of more recent statements of such prohibitions include the defeat in the House of Lords in 1932 of the ‘Voluntary Euthanasia Bill’¹¹ and the Canadian parliament’s clear rejection in 2010, by a vote of 228 to 59, of Bill C-384, a private member’s bill that would have permitted PAS and euthanasia.¹²

Certain jurisdictions, notably the Netherlands and Belgium, have legalized euthanasia. In America, Oregon’s ‘Death with Dignity Act’, which permits PAS, came into force in 1997 and Washington state followed suit in 2008. However, on 6 November 2012, Massachusetts voters defeated a ballot that would have allowed assisted suicide, 51–49%. There have been discussions, debates and proposed legislation in many other American states and other countries in the recent past. Generally, these have reaffirmed the ban on medical assistance in killing (whether in the context of end-of-life or, in the USA, physicians’ involvement in carrying out capital punishment through lethal injections). The Benelux and a few American states represent the exception to the rule. ‘Do not kill’ has been considered a moral absolute for most physicians for millennia, and remains so for physicians even in jurisdictions where the public has looked favorably on legislative change. That medicine has all to do with healing, and nothing to do with the purposeful ending of life, has been a reverberating imperative throughout history.

The medical cloak

The pro-euthanasia lobby derives advantages by aligning itself tightly with medicine and physicians. The history of physician involvement in capital punishment is illustrative of this strategy. Juries in the USA, who had seen horrific footage of convicted murderers being executed in the ‘electric chair’, became reluctant to convict persons accused of

capital offences or to vote for a death sentence for felons convicted of a capital offence. Most physicians and the American Medical Association adamantly opposed medicine's involvement in administering capital punishment by lethal injections. Nevertheless, some physicians participated. By virtue of their involvement and in concocting a method of execution that makes a convicted criminal appear serene during final moments, enhanced acceptability was conferred on the procedure. It has been suggested that 'the law turned to medicine to rescue the death penalty'.¹³

It is germane to point out that the word 'doctor' is linked etymologically to 'teacher'. The Oxford English dictionary's definition is: 'one who gives instruction in some branch of knowledge, or inculcates opinions or principles'.¹⁴ Medical doctors can influence public opinion, much as teachers contribute to the socialization of their pupils. The recruitment of doctors, both as a collectivity and as individuals, to undertake a procedure, can greatly modify the public's view of that procedure.

Language is critically important in not only reflecting, but also creating reality. For example, the field testing conducted prior to the passage of the Oregon Death with Dignity Act demonstrated that when the intervention was described as 'suicide' or 'euthanasia', popular support declined by 10–12%.¹⁵ The phrase 'death with dignity', by avoiding the negative connotations of suicide, was perceived as less alarming. It was able to create a halo of benignity and to generate greater support for and muted opposition to the proposed law. For similar reasons, the euphemism 'physician assistance in a dignified death' is reassuring. It would be rare indeed for an individual to wish explicitly for a gruesome death or want to banish a benevolent healer from the sickroom. Research shows that emotions,¹⁶ which we would qualify as 'examined emotions', and we would add, moral intuition, are important in making good ethical decisions. Choice of language affects both these human ways of knowing what is morally right and morally wrong.¹⁷

Jill Dierterle, a member of the Department of History and Philosophy at Eastern Michigan University, denigrates the validity and power of words in order to claim that none of the anti-PAS arguments hold merit and concludes that 'we have no reason not to legalize it'.¹⁸ She turns a blind eye to any potential harm and conveniently overlooks the lacuna in current data-gathering procedures or impact assessments. This stance flies in the face of the golden rule of medicine: *primum non nocere*. Hence, it is anathema to the vast majority of practicing physicians. Few of us, presented with a new and relatively untested therapeutic instrument, would conclude, 'we have no reason to doubt its safety; let's forge ahead'. Her nonchalant dismissal borders on the offensive. Note how

she handles an important deontological argument against PAS: ‘...if PAS is wrong, its wrongness cannot be constituted by its conflict with the Hippocratic Oath. After all, the Hippocratic Oath itself is just a bunch of words’.¹⁸ With the phrase ‘just a bunch of words’ Diertele implies that the oath is hollow and meaningless. But ethical precepts and laws are also just a ‘bunch of words’, yet they establish our metaphysical reality—what can be called our metaphysical ecosystem—which, depending on its nature, determines whether or not we have a society in which reasonable people would want to live.

It is critical to the euthanasia debate to consider what role, if any, physicians may, should or must not play. It is not a ‘given’ that, were euthanasia to be legalized, it would be inextricable from the medical mandate. We propose that it is in the best interests of individuals and society to remove the medical cloak from euthanasia in order to lay bare fundamental arguments against it. The stakes are too high to have the veneer of doctoring obscure the essential core of what is involved and its potential harms and risks.

Collaborators in euthanasia

The commentary previously mentioned, ‘Redefining Physicians’ Role in Assisted Dying’, suggests that a non-physician group could be made responsible for the ‘active’ role in euthanasia.³ The label ‘thanatologist’ has been suggested for such a group.¹¹ The possibility that a new discipline might emerge raises a set of intriguing questions: What would be the scope of practice of thanatologists? Where would one draw the line between ‘active’ and ‘passive’ roles? Of what might their education consist? We want to make it clear that we believe euthanasia is inherently wrong and, therefore, should never be undertaken, but, it is important to consider what such a proposal could involve if it were put into practice.

It is reasonable to speculate that the training could be offered in a program at a technical level and that the duration of training period would be modest. The act of terminating someone’s life is thought to be fairly straightforward—at least, the execution of it is not overly complicated. The experience in the UK of recruiting and training hangmen can provide useful clues.¹⁹ Executioners were trained in the late 19th to mid-20th century with a 5-day course that included lectures, a practical component—‘applicants to pass pinioning in the presence of the Governor’—and ended with a written examination that included simple algebra—the applicant was required to calculate the length of drop (i.e. stretch of the rope) for men of varying weights. Given the complexity of drug-based protocols used in euthanasia,

5 days of instruction would likely be insufficient. A program in the order of 24 weeks, as is the case for cadet training in many police academies, might allow for core objectives to be adequately covered and relevant abilities to be tested and credentialed.

A provocative essay on the topic suggests that lawyers could be trained in euthanasia, practicing a new specialty called *legistrothanasia*.²⁰ Although admittedly implausible, the proposal serves to foreground pragmatic issues relevant to the debate. It rests on two fundamental assumptions: (i) that lawyers are trained to interpret laws and regulations accurately, to apply them strictly and to act on the basis of implementing patients' values and (ii) that carrying out the required tasks does not require sophisticated technical expertise. The authors state, 'Attorneys who wish to provide this service would require only a small amount of additional training'.²⁰ An appropriate educational blueprint could include the following cognitive base: the physiology of dying, basic pharmacology and an overview of the historical, ethical and legal aspects of natural and requested/assisted death. The toolkit of required skills would likely include: communication, verification of decision-making capacity and informed consent, securing of intravenous access, supplying and/or administering of lethal drugs, management of complications, accurate recognition of death and completion of death certificates. The desired attitudinal substrate would include: personal resolve (that is, stick-with-it-ness), respect for individuals' rights to autonomy and self-determination, and, ideally, a calm demeanour.

Although the tone of the previous discussion may be—and should be—rather 'chilling', the substance it addresses has clearly gained a foothold in the current medical literature. A description of procedures for successful euthanasia has been published; one is entitled 'Euthanasia: medications and medical procedures'.²¹ It includes protocols for dealing with terminal dyspnea or agitation in the terminal phase, euthanasia, and the induction of 'controlled sedation'. Controlled sedation is placed in inverted commas by the author, presumably because he feels that it needs qualification; in his opinion, it represent a hypocritical response to suffering and is undertaken with the aim of muzzling the patient while he dies. We note, but will not discuss here, the ethical issues raised by 'palliative sedation', sometimes called 'terminal sedation', in which the dying patient is sedated in order to relieve otherwise unrelievable suffering. We suggest that the former term should be used when sedation is the only reasonable, medically indicated, way to relieve the patient's suffering (when it is *not* euthanasia); the latter term is appropriate when those conditions are not fulfilled and the doctor's intention is to hasten the patient's death (when it *is* euthanasia).

The epigram to the euthanasia guidelines cited above is fascinating. It states: 'One summer evening, Mr J-M L, suffering from Charcot's Disease, passed away peacefully after having asked for and obtained the assistance of a physician. Upon leaving the home, the latter did not ponder: 'What did I do?' but rather, 'Did I do it well?' (Translation by author JDB)²¹ This formulation reveals a unique mindset. The affective and moral stance expressed in that quote is closely aligned to a technical perspective, one where the emphasis is on accomplishing tasks with self-efficacy as opposed to one embellished with critical reflection. Meta-reflection is an important aspect of doctoring. What we do and the conversations we routinely engage in forge who we become; they become a habitus. Even the clothing we wear can influence our thought processes. For example, a recent article documents the impacts on cognition of donning a lab coat.²² If the simple habitual act of wearing a white lab coat can affect thinking and action, one can easily imagine the harmful impacts of regular discussions of euthanasia as they insinuate themselves into the ethos of medical care.

'The Executioner's Bible', a story of England's executioners in the 20th century, describes the work of the hangman as a 'cold, clinical operation'.¹⁹ The epigram we have chosen for our essay, extracted from that textbook, is a quote from James Billington, the UK's Chief Executioner from 1891 to 1901. It is intended to evoke calculated efficiency. The author of 'Euthanasia: medications and medical procedures' is similarly categorical, prescriptive and unrestrained by self-doubt. For example, he advises the physician not to propose suicide without medical assistance; to do so is considered incompatible with the role of the physician. He warns the physician against using 'violent options' (such as injecting potassium chloride) as this is considered contrary to medical ethics. Leaving aside a disregard for the value of respect for life, the punctilious euthanizer can be seen as behaving with professional dignity and serenity, within *a priori* defined limits. As the Home Office stated in 1926, when describing the work of hangman William Willis, '...even an executioner can remain humane and decorous'.¹⁹ Our purpose in making this historical link is not to denigrate advocates of euthanasia. Rather, through this analogy we are endeavoring to focus on the act itself and not just the actor. The latter is often well meaning.

Thanatologists, given the narrow focus of their field of expertise would, over time, almost certainly develop clinical practice guidelines; these might be tailored to different illness categories, for instance, neurodegenerative diseases and the various cancers with poor prognosis. This process seems to be well underway. For example, a recent paper explores euthanasia requests and practices in a highly particularized context, namely, patients in Belgium dying of lung cancer.²³ If euthanasia is

accepted as integral to 'medical care', this sort of disease-specific focus will surely expand. One can envisage the emergence of guidelines delineating the complementary roles of physicians and thanatologists. Most physicians (we hope) would eschew any involvement in euthanasia and confine themselves to traditional roles such as diagnosing, estimating prognosis and providing supportive care and symptom control, that is, excellent palliative care—which does not include euthanasia, as some advocates argue it should.

The extent to which principled opponents of euthanasia would be legally 'excused' from participating in the steps leading up to fulfilling a patient's request for assisted death is a contentious aspect of the debate. How would the profession balance the requirement for individual physicians to fulfill specific social roles and the need to respect the freedom of conscience of those who, on moral grounds, reject certain options? Physician-philosopher Edmund Pellegrino argues that physicians can refrain from entering into professional relationships that have the potential to erode their moral integrity; he offers strategies to assist the physician in navigating potential conflicts.²⁴

Psychiatrists and medical ethicists who do not reject euthanasia would be expected to focus on soliciting patient perspectives, exploring options and assessing comprehension, competence and voluntariness—that in making her decision, the patient is free from coercion, duress or undue influence, assuming this is possible. The profession has begun to equip itself with tools to deal with this incipient new clinical reality in jurisdictions which allow euthanasia. Physicians in the USA have been provided with an eight-step algorithm to assist them in discussing assisted suicide with patients who request it.²⁵ These guidelines were developed immediately after the legalization of PAS in Oregon. It is reasonable to expect that additional decision-making tools will emerge should the practice gain wider societal acceptance. Also, the possible consequences on undergraduate medical education, should it have to include protocols for ending patients' lives, have been explored.²⁶

Again, we note that the above discussion is included for the sake of comprehensive coverage of the issue of physicians' involvement in euthanasia, were it to be legalized, and whether it could be ethically acceptable 'medical treatment' or even 'therapy'. It is not meant to signal that we see euthanasia as ethically acceptable.

Healing and euthanasia

It has been repeatedly found that of all separately identified groups in Western societies, physicians are among the most opposed to involvement in euthanasia. There is substantial indirect evidence to support

this claim, even in jurisdictions in which doctor-assisted death is legal. For example, in Oregon, there is a suggestion that some patients have to resort to 'doctor shopping' to obtain their lethal medications. The Oregon Public Health Division's annual report for 2011 shows that one physician was responsible for 14 of the requisite prescriptions out of a total of 114 that year.²⁷ Also, the Netherlands recently approved the launching of mobile euthanasia clinics. A stated reason for this development was that patients' goals in self-determination were being thwarted by physician resistance to providing euthanasia. Not all physicians, including many Dutch colleagues, are on-side with having euthanasia become a medical act.

A questionnaire-based study comparing the opinions of the Dutch general public with that of physicians revealed some marked differences. With respect to the active ending of life for patients with dementia, the level of acceptance was 63% for the public and 6% for physicians.²⁸ With respect to terminally ill cancer patients, the figures were much higher and less divergent; this may be a consequence of the prolonged experience of euthanasia in cases of terminal illness in the Netherlands. Or, it might be that often survey questions are phrased as, 'If a person is in terrible pain, should they be given access to euthanasia?' The respondent must choose between leaving the person in pain and euthanizing them. But this choice is wrongly constructed. The person should be able to choose fully adequate pain management—that is, the 'death' of the pain—without having to endorse the intentional infliction of death on the patient.²⁹ Despite high levels of acceptance by physicians of euthanasia for cancer patients in the Netherlands, recent reports reveal persistent ethical concerns.³⁰ It is also noteworthy that physicians involved in palliative care, including in Britain, appear to be particularly concerned about legalizing euthanasia.³¹

What underlies the medical profession's reluctance to accept euthanasia? There are multiple explanations. Aside from ethical, moral and religious beliefs, one of the most salient and compelling has to do with one's conception of the medical mandate, especially as it relates to healing. Healing is a challenging term to define. Many in our institution (the Faculty of Medicine, McGill University) consider it to be 'a relational process involving movement towards an experience of integrity and wholeness'.³² It has been operationally defined as 'the personal experience of the transcendence of suffering'.³³ A feature of healing important to our thesis is the notion that healing does not require biological integrity. Although it may seem counter intuitive at first glance, it has been pointed out that if a sick person is able to construct new meaning and is able to achieve a greater sense of wholeness, that individual may 'die healed'.³² It is undeniably a vastly different concept

than curing, although they are not in opposition one to the other. Most physicians accept the healer role as a fundamental and enduring characteristic of the profession.³⁴ In our undergraduate medical program, this concept is taught using the term 'physicianship'; it refers to the dual and complementary roles of the physician—the physician as healer and professional.³⁵ It could be argued that one can remain 'professional' even while serving as a collaborator in requested death. On the contrary, many commentators—the American Medical Association is a prime example³⁶—believe that it is impossible to do so as a 'healer', one who is focused on accompanying the patient on a transformational journey towards personal integrity that transcends the embodied self.

The process of healing in the doctor–patient relationship is poorly understood. We do not have a complete picture of how it is initiated or which clinical skills or abilities are essential in fostering a healing relationship. The literature suggests that healing resides in the quality of interpersonal connections and that it requires a deep respect for the agency of the physician in the therapeutic process.³⁷ An appreciation of the placebo effect, or in more poetic terms, the 'doctor as the medicine', is required.^{38,39} It is almost certainly linked to the phenomena of transference and counter-transference and it may utilize the power differential for salutary purposes, even if these phenomena operate largely at a covert level.

The patient–doctor relationship is marked by intense ambivalence. Any physician who has initiated a discussion with a patient on the issue of resuscitation or desired level of technical intervention will realize how easily it can be misinterpreted, how quickly it can catalyze existential angst and how thoroughly it can overwhelm hopeful sentiments. Affective turmoil and cognitive dissonance can rapidly ensue. These sorts of cross-purpose exchanges would surely be magnified in the context of discussions regarding euthanasia. Although there may be a productive 'meeting of the minds' in any specific doctor–patient dyad, the risks of emotional derailment, self-effacing dependency and irremediable miscommunication should not be minimized. It is inconceivable to us that deep layers of existential suffering would not be activated and exposed by such a discussion. A healing space that can support patients would be unnecessarily deflated. Admittedly, this belief is based on incomplete understandings of the clinical encounter, yet the axiomatic foundation of that encounter is anchored in a 2400-year old tradition. We must consider why we have so jealously guarded that tradition. We could always have abandoned it by accepting euthanasia. Unlike many other current medical–ethical dilemmas, neither death nor euthanasia is a novel issue presented by new technoscience.

Recent developments

Many proponents of euthanasia like to claim that opponents rely on two types of unsound arguments: one based on empirical data and the other anchored in axiology. In the first instance, they allege that the outcomes data available from jurisdictions where euthanasia or assisted suicide has been legalized, suggest that our fears of potential abuse are groundless. They deny that there is a 'logical' slippery slope—that the situations in which euthanasia will be available will expand over time—or a 'practical' slippery slope—that euthanasia will be used abusively. Pro-euthanasia advocates claim that evolving legislation does not pose a threat to persons with a disability, does not lead to euthanasia without consent, does not invite extension of the practice to vulnerable populations—in short, that it has not become a 'run-away train'. They usually express satisfaction with individual clinicians' professional restraint and integrity as well as with administrative safeguards. Some suggest that the acceptance of euthanasia results in improvements in traditional palliative care. This belief that it represents a positive force for changing prevailing clinical practices is not based on robust evidence. Moreover, the evidence for the existence of a practical slippery slope is very convincing. This was very recently affirmed by the High Court of Ireland, in a judgment we discuss shortly, in deciding whether prohibiting assisted suicide contravened the Irish Constitution, which it held it did not.⁴⁰

A recent dramatic example of the logical slope's gravitational pull is the euthanizing, in December 2012, of 45-year-old twins in Belgium. Deaf since childhood, Marc and Eddy Verbessem were facing the additional disability of blindness. Accepting that they were irremediably suffering, their physician euthanized them.⁴¹ Euthanizing patients with non-terminal conditions, even though it can be legal in Belgium, will surely meet with the disapproval of most physicians. Even within the pro-euthanasia movement, this development may be considered an aberration. Nonetheless, there are increasing numbers of commentators who subscribe to the following philosophy: 'If a patient is mentally competent and wants to die, his body itself constitutes unwarranted life-support unfairly prolonging his or her mental life'.⁴²

There are two arguments, both warranting careful scrutiny, frequently advanced in support of physician involvement in euthanasia. The first is that physicians have privileged access to information about their patients' unique perspectives and circumstances, including personal resources and frailties, as well as complex family dynamics. That argument has been undermined by evolving practices. The 'Oregon Public Health Divisions' report for 2011 reveals that the median length of the

doctor–patient relationship for those who died by PAS was merely 12 weeks (with a range of 1–1379 weeks).²⁷ It is highly unlikely that a physician would have acquired a sophisticated understanding of a person's values, hopes and fears in the matter of a few weeks. It is even less plausible in the case of the mobile euthanasia units currently being deployed in the Netherlands. The second argument is that physicians are inclined, by temperament and experience, to accompany their patients throughout the illness trajectory, including death. That too is not defensible on the known facts. For example, in Oregon, in the first 3 years of the administration of Oregon's 'Death with Dignity Act', physicians were present at approximately half of assisted deaths. By 2005, it was 23%. In 2011, it was a mere 9%.²⁷ The behaviour of these prescribing physicians is not congruent with the image of physicians represented in that iconic painting by Sir Luke Fildes, bearing the title 'The Doctor', and often used to portray empathic witnessing. Pro-euthanasia advocates can come across as rather intrepid in their defense of personal autonomy. Autonomy is the overriding principle that is used to buttress arguments in favor of euthanasia; indeed, it generally runs roughshod over all other considerations. Many pro-euthanasia commentators are disposed to brush off concerns about the impact of accepting 'radical autonomy' as always being the overriding value—especially concerns about the risks and harms to vulnerable people and to important shared values, in particular, respect for life at the societal level. A 2012 case in British Columbia manifests all these issues; it involved vulnerable persons, values conflicts and shows the preferencing by the court of the value of individual autonomy in relation to euthanasia. The case originates in a challenge to the Canadian *Criminal Code's* current prohibition of assisted suicide.⁴³

Gloria Taylor, a plaintiff in the case, *Carter v Canada (Attorney General)*⁴⁴, was a person with ALS who requested assisted suicide arguing that as her illness progressed she would be incapable of committing suicide, unaided, due to her physical disability. The judge, Justice Lynn Smith, ruled in the plaintiff's favour on the basis that the prohibition was unconstitutional on the grounds that it contravened both Ms Taylor's constitutional 'right to life, liberty and security of the person' (under section 7 of the *Canadian Charter of Rights and Freedoms*)⁴⁵ and her right not to be discriminated against as a physically disabled person (under section 15 of the *Charter*); and that the prohibition could not be saved (under section 1 of the *Charter*), as a reasonable limit on constitutionally protected rights. Consequently, the judge held that the law prohibiting assistance in suicide was not applicable with respect to preventing Ms Taylor and other people in similar circumstances from having such assistance. The judgment is very long

and legally complex and is now on appeal. Read as a whole, it strongly supports legalizing PAS and euthanasia.

Criticisms of the judgment include that it gives undue weight to the evidence of expert witnesses who favour legalizing euthanasia, while overly devaluing that of those who oppose it. The High Court of Ireland, in a case with similar facts to the *Carter* case, in that the plaintiff had an advanced debilitating neurological disease and, likewise, was seeking to have the prohibition on assisted suicide struck down, summed up this aspect of the *Carter* case as follows:

In that case, the Canadian court reviewed the available evidence from other jurisdictions with liberalised legislation and concluded that there was no evidence of abuse. This Court also reviewed the same evidence and has drawn exactly the opposite conclusions. The medical literature documents specific examples of abuse which, even if exceptional, are nonetheless deeply disturbing. Moreover, contrary to the views of the Canadian court, there is evidence from this literature that certain groups (such as disabled neonates and disabled or demented elderly persons) are vulnerable to abuse. Above all, the fact that the number of LAWER ('life-ending acts without explicit request') cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide (Switzerland, Netherlands and Belgium) – ranging from 0.4% to over 1% of all deaths in these jurisdictions according to the latest figures – without any obvious official response speaks for itself as to the risks involved'.⁴⁰

One can also question Justice Smith's conclusions that PAS is not inherently unethical; that individuals' right to autonomy takes priority over the value of respect for life; that sanctity of life is only a religious value; that there is no relevant ethical or moral difference between refusals of life-support treatment that result in the death of the patient and euthanasia; and, that the availability of legalized PAS is necessary 'medical treatment' for some.

Is euthanasia medical treatment?

Justice Smith's justification for allowing euthanasia is largely based on a selective application of *Canadian Charter of Rights and Freedoms* jurisprudence⁴⁵ and depends upon her being able to distinguish the binding precedent set by the Supreme Court of Canada in the *Rodriguez* case.⁴⁶ The latter held, in a four to three split among the judges, that the *Canadian Criminal Code's* prohibition on assisted suicide⁴³ was constitutionally valid.

Invoking the *Canadian Charter of Rights and Freedoms*, Justice Smith ruled that Ms Taylor's right to life was infringed by the

prohibition of assisted suicide because she might conclude that 'she needs to take her own life while physically able to do so, at an earlier date than she would find necessary if she could be assisted'.⁴⁴ We believe that this would strike many as a straw man argument. It is to convert a right to life to a right to assisted suicide, by accepting as a breach of a right to life that a person will commit suicide sooner, if not given access to assisted suicide. But validating assistance in committing suicide hardly upholds a right to life.

Like everybody else, Ms Taylor has a right to refuse treatment even if that means she will die sooner than she otherwise would. Justice Smith accepts the plaintiffs' argument that there is no ethical or moral difference between euthanasia and refusals of life-support treatment that result in death and, therefore, both should be legal. But a right to refuse treatment is based in a right to inviolability—a right not to be touched, including by treatment, without one's informed consent. It is not a right to die or a right to be killed. At most, people have a negative content right to be allowed to die, not any right to positive assistance to achieve that outcome. A person with Ms Taylor's illness trajectory will surely die—even more precipitously if they decline many of the interventions described in the hypothetical patient with ALS we introduced earlier on. (Subsequent to the judgment, Ms Taylor died a natural death from an infection). It is also important to underline that current medical practices enable physicians to attenuate much of the suffering that may accompany the progressive loss of function and well-being in advanced ALS.

The judge appears also to accept the argument that legalizing euthanasia enhances palliative care. This goes some way towards treating euthanasia, as some have termed it, 'the last act of good palliative care'.⁴⁷ It is also consistent with the 'no-difference-between-them approach' to a spectrum of end-of-life medical interventions. Euthanasia is confused with interventions, such as pain management and rights to refuse treatment, which are ethically and legally acceptable, and an argument is thus set up that, if we are to act consistently, euthanasia must also be ethically and legally acceptable. It is tantamount to legalizing euthanasia through confusion.⁴⁸

Justice Smith turns to the British Columbia Prosecutorial policy on assisted suicide for definitional assistance with respect to whether PAS is medical treatment. Here's what she says:

In the policy, 'palliative care' is defined as 'a qualified medical practitioner, or a person acting under the general supervision of a qualified medical practitioner, administering medication or other treatment to a terminally ill patient with the intention of relieving pain or suffering, even though this may hasten death'. The policy states that that conduct,

‘when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution’.⁴⁴

In other words, the policy’s definition of palliative care can be expansively interpreted to place euthanasia in same category as other end-of-life interventions which may hasten death.

For the sake of exploration of the issue, let us assume momentarily that euthanasia is medical treatment. What might flow from this?

Classifying euthanasia as medical treatment would affect the scope of disclosure of information necessary to obtain informed consent. A physician must disclose to the patient all reasonably indicated medical treatments as well as their risks and benefits. It would now have to include euthanasia. Even most pro-euthanasia advocates regard it as unethical for a physician to introduce the possibility of euthanasia. Currently, it is generally accepted that any discussion of it must be initiated by the patient.

It would also mean that to obtain informed consent to euthanasia, all reasonably indicated treatments would need to be offered and they would certainly include all necessary palliative care, in particular, fully adequate pain management. Many of those advocating for euthanasia posit euthanasia and palliative care as alternatives, but informed consent to euthanasia could not be obtained unless good palliative care was available. This is not available to a majority of people who die in Canada; it has been estimated that less than 30% have access to even the most minimal form of palliative care.⁴⁹

As well, Canadian psychiatrist Dr Harvey Max Chochinov, who specializes in psychiatric treatment for dying people, has shown that there are significant fluctuations in the will to live, even as death is imminent.⁵⁰ The impact of these findings, as well as conditions such as depression, on the possibility of obtaining valid informed consent to euthanasia would need to be fully addressed.

Another crucially important issue is that, if PAS and euthanasia are ‘medical treatment’, then surrogate decision-makers have the authority to consent to them for the patient. Their decisions must be based on either their knowledge of what the patient would have wanted or, if those wishes are unknown, their belief that these interventions are in the ‘best interests’ of the patient. Would mentally incompetent people and those with dementia or disabled newborn babies, as is now the case in the Netherlands under the Groningen protocol, be eligible for ‘therapeutic homicide’?⁵¹

Yet another issue is what would be the indications for euthanasia as medical treatment and who could access it if were legalized? Justice Smith, citing an expert witness for the plaintiffs, refers to ‘the end-of-life population’.⁴⁴ This is a term used in the Royal Society of

Canada Expert Panel Report on *End of Life Decision-Making*.⁵² In the report, this population is defined as those persons on a continuum beginning with any serious diagnosis or injury. This represents an expansion of a term, 'end-of-life', traditionally used for those inevitably in the last days of life, to all people with serious chronic conditions, resulting from illness or injury, that may be fatal in the course of time. And, of course, it is notoriously difficult to predict with any certainty the timing of even obviously terminal illnesses. It is precisely the type of 'slippery slope' that we fear emerging from the 'limited' exception, as defined by Justice Smith. It will likely culminate in more decisions similar to that taken in the case of the Verbessem brothers in Belgium.

It is also pertinent to point out that Canada continues to fund and promote programs that aim to prevent suicide. If suicide is conferred the status of a right or is held to be acceptable medical treatment it would be difficult to reconcile this situation with the presence of programs that aim to actively thwart it. Some resolve this dilemma by trying to banish the word 'suicide' from the debate, in favor of the phrase 'assisted dying'. Marcia Angell, erstwhile editor of the *NEJM* and a fervent proponent of PAS, endorses the notion that 'assisted dying' can be distinguished from 'typical suicide'. The latter is described as being undertaken by someone with a normal life expectancy, whereas the former is carried out in someone 'who is near death from natural causes anyway'.⁵³ They are going to die anyway, so what does it matter?! We believe that this reasoning is rather disingenuous and that it can result in a dishonouring of that segment remaining in someone's life, whether this is measured in minutes or months, and could deprive them of something as ephemeral as dreams and hopes. It certainly negates the idea of dying as our last great act of living.⁵⁴

Finally, a decision classifying euthanasia as medical treatment could have impact far outside the context of issues directly related to death and dying. For example, in Canada, the federal and provincial governments' respective powers are allocated under the Canadian Constitution. The criminal law power belongs to the federal parliament and the power to govern health and social services to the provincial legislatures. If euthanasia was defined as medical treatment, the federal parliament's prohibition of it in the *Criminal Code* could be invalid by reason of its trespassing on the provincial jurisdiction to govern health and social services. That is one reason that the Quebec College of Physicians and Surgeons, which supports legalizing euthanasia, argues that it is medical treatment. Likewise, the Quebec Legislative Assembly committee, which issued a report, 'Dying with Dignity',⁵⁵ adopts the same argument. From past experience, we expect that Quebec might challenge the constitutional validity of the *Criminal Code* prohibition on this basis. However, a legal committee, set up by the Quebec

government, has proposed another approach. It has just reported on how Quebec could operationalize giving doctors legal immunity for carrying out euthanasia, including by the Attorney General of Quebec instructing Crown Prosecutors not to prosecute them under the *Criminal Code* for doing so, provided they comply with certain guidelines.⁵⁶ In either case we could see Quebec becoming 'separate' from the rest of Canada on this critically important issue.

Conclusion

In pondering medicine's possible involvement in euthanasia, we must foreground those aspects of the medical mandate that are immutable and eternally relevant. We believe these to be the constant nature of 'illness', changeless across time, place and culture, and the resultant obligations of the healer. It is important to appreciate how illness affects persons in all spheres of their lives. Patients become intensely vulnerable, impressionable and open to abuse. Pellegrino has summarized the nature of the clinical encounter eloquently as 'a peculiar constellation of urgency, intimacy, unavailability, unpredictability and extraordinary vulnerability within which trust must be given'.⁵⁷ This vulnerability sets up an intense and enduring obligation of physicians; they must respond to the wounded person with authenticity, compassion and moral agency. The latter demands that physicians harness and deploy their unique influences and persuasive powers in a particular manner. The essential nature of physicianship has evolved over time in a direction that recognizes the extraordinary vulnerability of patients and guards ferociously against their exploitation. In part, this has been achieved by imposing inviolable limits on the physician's terrain of action. Moreover, we believe that, even if one accepted that euthanasia was ethically acceptable—which we do not—it opens up too many doors for abuse.

The medical profession has arrived at a crossroad; it must choose whether to embrace euthanasia as medical treatment, as a logical extension of end-of-life care, or it can reject the redefinition of its healing mandate that this would entail. We believe, that looking back in the future, the euthanasia events of the present time will be seen as a turning point, not only for the profession of medicine, but also for societies. Crossing the line in the sand articulated by Hippocrates, that as a physician 'I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect', would result in the 'doctor as healer' becoming the 'doctor as executioner'. In short, healing and euthanizing are simply not miscible and euthanasia can never be considered 'medical treatment'.

Acknowledgements

Donald Boudreau was an Arnold P. Gold Foundation Associate Professor of Medicine when this manuscript was written and submitted. He is grateful for the financial support the foundation has provided in the past and requests that readers appreciate the opinions expressed herein are his personal views and not necessarily reflective of the perspectives of the Foundation, its staff, affiliates or benefactors.

References

- 1 Quill TE, Battin MP (eds). *Physician-assisted Dying: The Case for Palliative Care and Patient Choice*. Baltimore: Johns Hopkins University Press, 2004.
- 2 Foley K, Hendin H (eds). *The Case against Assisted Suicide: For the Right to End-of-life Care*. Baltimore: Johns Hopkins University Press, 2002.
- 3 Prokopetz JJZ, Lehmann LS. Redefining physicians' roles in assisted dying. *N Engl J Med* 2012;367:97–9.
- 4 Somerville MA. *Death Talk: The Case against Euthanasia and Physician-assisted Suicide*. Montreal: McGill-Queen's University Press, 2001,218–30.
- 5 Young KK. A cross-cultural historical case against planned self-willed death and assisted suicide. *McGill Law J* 1994;39:657–707.
- 6 Haidt J. *The Righteous Mind: Why Good People are Divided by Politics and Religion*. New York: Pantheon Books, 2012.
- 7 Edelstein L. *Ancient Medicine*. Baltimore: Johns Hopkins University, 1967,6.
- 8 Stolberg M. Active euthanasia in pre-modern society, 1500–1800: learned debates and popular practices. *Soc Hist Med* 2007;20:205–21.
- 9 Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine's social contract with society. *Perspect Biol Med* 2008;51:579–98.
- 10 Cane W. Medical euthanasia. A paper, published in Latin in 1826, translated and reintroduced to the medical profession. *J Hist Med* 1952;7:401–16.
- 11 Brazier M. Euthanasia and the law. *Br Med Bull* 1996;52:317–25.
- 12 Bill C-384. Parliament of Canada. Bill C-385, No: 40-2, Hansard-57 (2009/5/13).
- 13 Gawande A, Denno DW, Truog RD *et al*. Physicians and execution—highlights from a discussion of lethal injection. *N Engl J Med* 2008;358:448–51.
- 14 Oxford English Dictionary. Electronic format. <http://www.oed.com/> (19 October 2012, date last accessed).
- 15 Campbell CS, Cox JC. Hospice and physician-assisted death. *Hastings Center Rep* 2010;40:26–35.
- 16 Welberg L. The Moral Brain. *Nat Rev Neurosci* 2007;8:326.
- 17 Somerville MA. *The Ethical Imagination: Journeys of the Human Spirit*. Toronto: House of Anansi Press, 2006.
- 18 Dieterle JM. Physician assisted suicide: a new look at the arguments. *Bioethics* 2007;21:127–39.
- 19 Fielding S. *The Executioner's Bible. The Story of Every British Hangman of the Twentieth Century*. London: John Blake Publishing, 2007, 26–127.
- 20 Sade R, Marshall M. Legistrotanatry: a new specialty for assisting in death. *Perspect Biol Med* 1996;39:547–9.
- 21 Lossignol D. Euthanasia: medications and medical procedures. *Rev Med Brux* 2008;29:435–40.
- 22 Adam H, Galinsky AD. Enclothed cognition. *J Exp Soc Psychol* 2012;48:918–25.
- 23 Pardon K, Descherppper R, Vander SR. Expressed wishes and incidence of euthanasia in advanced lung cancer patients. *Eur Respir J* 2012;40:949–56.

- 24 Pellegrino ED. Commentary: value neutrality, moral integrity, and the physician. *J L Med Ethics* 2000;28:78–80.
- 25 Emanuel L. Facing request for physician-assisted suicide. Towards a practical and principled clinical skill set. *JAMA* 1998;280:643–7.
- 26 Boudreau JD. Physician-assisted suicide and euthanasia: can you even imagine teaching medical students how to end their patients' lives. *Permanente J* 2011;15:79–84.
- 27 Oregon's Death with Dignity Act. Annual reports. *Report from year 14 (2011)*. Released March 2012. Available at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>. (19 March 2013, date last accessed).
- 28 Rietjens JAC, van der Heide A, Onwuteake-Philipsen BD *et al*. A comparison of attitudes towards end-of-life decisions: survey among the Dutch general public and physicians. *Soc Sci Med* 2005;61:1723–32.
- 29 Somerville MA. Death of pain: pain, suffering, and ethics. In: Gebhart Gerald F, Hammond Donna L, Jensen Troels S. (eds). *Progress in Pain Research and Management*, Vol. 2. In: Proceedings of the 7th World Congress on Pain, International Association for the Study of Pain. Washington: IASP Press, 1994,41–8. Also published in 'Death Talk', supra note 4, 215–30.
- 30 Onwuteake-Philipsen BD, Brinkman-Stoppelenburg AB, Penning C *et al*. Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. *Lancet* 2012;380:908–15.
- 31 House of Lords. Select committee on assisted dying for the terminally ill bill. First report. *Views of Health Care Professionals*. Item numbers 227–229. Published March 3, 2005. Available at <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm> (19 March 2013, date last accessed).
- 32 Mount B, Kearney M. Healing and palliative care: charting our way forward. *Palliat Med* 2003;17:657–8.
- 33 Egnaw TR. The meaning of healing: transcending suffering. *Ann Fam Med* 2005;3:255–62.
- 34 Fuks A, Brawer J, Boudreau JD. The foundation of physicianship. *Perspect Biol Med* 2012;55:114–26.
- 35 Boudreau JD, Cassell EJ, Fuks A. A healing curriculum. *Med Ed* 2007;41:1193–201.
- 36 Whitney SN, Brown BW, Brody H *et al*. Views of United States physicians and members of the American Medical Association House of delegates on physician-assisted suicide. *J Gen Intern Med* 2001;16:290–6.
- 37 Schuman AL, Matthews DA. What makes the patient–doctor relationship therapeutic? Exploring the connexional dimension of medical care. *Ann Intern Med* 1988;108:125–30.
- 38 Miller FG, Colloca L, Kaptchuk TJ. The placebo effect: illness and interpersonal healing. *Perspect Biol Med* 2009;52:518–39.
- 39 Houston WR. The doctor himself as a therapeutic agent. *Ann Intern Med* 1938;11:1416–25.
- 40 Fleming-v-Ireland & Ors [2013] IEHC 2.
- 41 Deaf Belgian twins bought new suits and shoes before killing themselves. *Mail Online*. Published January 15, 2013. Available at: <http://www.dailymail.co.uk/news/article-2262630/Brother-deaf-Belgian-twins-killed-euthanasia-describes-final-words-reveals-live-learning-going-blind.html>. (19 March 2013, date last accessed).
- 42 Shaw D. The body as unwarranted life support: a new perspective on euthanasia. *J Med Ethics* 2007;33:519–21.
- 43 Criminal Code. R.S.C., 1985, c. C-46 (as amended), s. 241.
- 44 Carter v. Canada (Attorney General). 2012. BCSC 886.
- 45 Canadian Charter of Rights and Freedoms. Part 1, The Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.
- 46 *Rodriguez v. British Columbia (Attorney General)* [1993] 3 S.C.R. 519.
- 47 Quill TE, Lo B, Brock DW. Palliative options of last resort. *JAMA* 1997;278:2099–104.
- 48 Somerville MA. Euthanasia by confusion. *Univ New S Wales Law J* 1997;20:550–75.
- 49 Raising the bar: a roadmap for the future of palliative care in Canada. Report to the Senate of Canada by the Honorable Sharon Carstairs, P.C., 2010, 12.
- 50 Chochinov H, Tataryn D, Clinch JJ *et al*. Will to live in the terminally ill. *Lancet* 1999;341:816–9.

- 51 Flegel K, Fletcher J. Choosing when and how to die: are we ready to perform therapeutic homicide? *CMAJ* 2012;**184**:1227.
- 52 Report on 'end of life decision making'. Ottawa: Royal Society of Canada (Chair: Udo Schuklenk), 2011.
- 53 Angell M. May doctors help you die? *New York Rev Books* 2012. <http://www.nybooks.com/articles/archives/2012/oct/11/may-doctors-help-you-die/> (25 October 2012, date last accessed).
- 54 Somerville MA. *Dying as the Last Great Act of Living*. The Calgary Herald, 2009. Available at <http://www.calgaryherald.com/opinion/op-ed/Dying+last+great+living/1368897/story.html>. (19 March 2013, date last accessed).
- 55 Report of the Select Committee of the Assemblée Nationale of Québec on 'Dying with Dignity, Mourir dans la Dignité' (Chair: Maryse Gaudreault), 2012.
- 56 Rapport du comité de jurists experts sur la mise en oeuvre des recommandations de la commission speciale de l'Assemblée Nationale sur la question de mourir dans la dignité. Ménard, JP, Giroux M, Hébert JC. January 2013. www.msss.gouv.qc.ca/presse.
- 57 Pellegrino ED. Trust and distrust in professional ethics. In: Pellegrino ED, Veatch R, Langan J (eds). *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects*. Washington: Georgetown University Press, 1991.