

Informed Consent

Do we understand the risks associated with legalizing physician assisted suicide and euthanasia?

SUMMARY

IN THE 1993 *RODRIGUEZ* DECISION, the Supreme Court of Canada decided not to legalize physician assisted suicide or euthanasia (PAS/E) in part because of the risk of wrongful death to our patients. In her 2012 decision in *Carter*, BC Supreme Court Justice Smith held that those risks could be minimized because of the capacity of doctors to make proper determinations in individual cases.¹ The Canadian Medical Association brief to the Supreme Court in *Carter*, however, questioned the court's assurances.

The trial judge placed great reliance on the ability of physicians to assess the competency of patients requesting medical aid in dying and the voluntariness of their wishes. The CMA submits that the challenges physicians will face in making these assessments have been understated, especially in the end of life care context where the consequences of decisions are particularly grave and in a public medical system in which

This brief was hand delivered and presented to each member of the CMA ethics committee in the fall of 2014, and was discussed at the CMA Board level. Unfortunately, its advice was not followed. It serves as a sobering reflection on the challenges faced by government agencies in Canada who will need to develop a regime of legalized euthanasia and assisted suicide while at the same time attempting to protect the vulnerable. It was written by Larry Worthen with assistance from Dr. Margaret Cottle and Dr. Will Johnson, among others.

resource constraints are a pressing issue.²

It is entirely possible that the whole decision in *Carter* will turn on the practical issue of whether it is possible in the current medical care environment in Canada to give physicians the legal right to kill patients, or provide patients with the means to die without at the same time endangering the lives of innocent others. It should be remembered that if the Court decides that the current law

must be struck down, Parliament will have a deadline to rewrite the law. It will likely be left to provincial governments to implement the procedures. The concerns expressed by the CMA in the above quoted paragraph should loom large in the determination of whether or not to support a change in the legislation. Once the court decides, we will be stuck with whatever system and resources the legislatures provide. Given the constraints of current health care funding, and the reality in other jurisdictions that have gone before us, we are not optimistic that striking down the law will result in a robust system that will provide the requisite checks and balances to assure patient safety. **Not only is such**

a scheme unreasonably expensive in today's health care climate, it is impossible to build.

This paper will provide you with evidence from three jurisdictions that there have been serious problems in the implementation of PAS/E that have created life and death risks for patients. These include: inadequate oversight, legislated requirements not being followed, a gradual expansion of who may qualify, and dramatic, unexplained increases in patient deaths.

We commend the CMA for the work done in the National Consultation on End of Life Care. We urge the CMA leadership to publicly acknowledge what is implicit in our brief: **Legalization of PAS/E will pose serious risks to the safety and well being of our patients.**

PUBLIC ATTITUDES TO PAS/E

As the CMA consulted with the public from coast to coast a variety of strong feelings were represented. This is because the general public can readily identify with high profile individuals who would like the means to die who have been in the Canadian media recently. But what about the faces of our patients who may "fall between the cracks" if PAS/E is legalized in Canada? They are the ones who may fall victim to a plan that masks a lack of societal caring and support with rhetoric about autonomy.

Public opinion polls are frequently cited as evidence that Canadians support the legalization of physician assisted suicide or euthanasia (PAS/E).³ But polling numbers consistently go down when people understand exactly what has been proposed.⁴ Despite over 120 attempts at legalization in various states in the US, only three states have actually approved PAS/E. Most people do not understand that everyone in society assumes a clear risk of wrongful death if PAS/E becomes legal. As this becomes apparent in the midst of a public debate on legalization, people's opinions often change.

Many people confuse PAS/E with refusal of medical treatment. This refusal is already legal in Canada, no matter how essential the treatment may be to continued life. The important ethical difference is intention, which is the basis of our entire legal and medical code. In PAS/E the primary intention is to kill the patient, or to provide the means for the patient to kill her or himself. However, in removing or refusing treatments that represent an excessive burden, the intention is simply to allow nature to take its course at end of life.

1 *Lee Carter et. al. v. Canada*, (BCSC), 2012, para. 1240.

2 *Lee Carter et. al. v. Canada*, SCC 3559, Factum of the Intervener, Canadian Medical Association

3 On June 15, 2012 a BC judge handed down a decision in *Lee Carter et. al. v. Canada*, (BCSC) striking down the *Criminal Code* provisions against aiding or abetting a suicide. While the appeal court overturned the decision it is now going to the Supreme Court of Canada on October 15, 2014. On June 12, 2013 the Quebec National Assembly introduced Bill 52 that tries to legalize "medical aid in dying" or euthanasia in Quebec. It was passed in June 2014.

4 <http://pjsaunders.blogspot.ca/2014/07/public-support-for-falconers-assisted.html>

WRONGFUL DEATH

What is wrongful death? Many people believe that it is always wrong to kill a fellow human being. Proponents of PAS/E suggest that there should be exceptions to that rule, and that it is possible to regulate the practice so that only those people who “qualify” for PAS/E will die. However, even if that were true, one can argue that it is not practical since there is always a danger that a mistake can be made. The concern that a single innocent person might be killed was sufficient to halt the practice of capital punishment in Canada.

Mistakes can be made in a variety of ways, such as when a patient consents to PAS/E and . . .

- there are therapies that could be offered (like palliative care), but are not, due to lack of health care funding or the lack of trained health care professionals. Patients may then choose PAS/E because they do not have alternatives. Currently, palliative care options are only available to 16-30% of Canada’s population who need them.⁵
- the patient succumbs to subtle or overt coercion by family, or the health care team
- the patient goes along with the societal normalization of PAS/E, thinking that society is sending the message that he or she is no longer valued or wanted and would be less trouble if they were not alive
- the patient is not able to pay for an acceptable and supportive environment, and finds the alternative unacceptable
- the patient is reacting to a traumatic accident that brings about a disability like paraplegia
- the patient is responding to a significant emotional loss like the death of a spouse or another close family member or friend
- the patient lacks social support networks due to relatives living at some distance
- the medical prognosis that he or she is about to die is incorrect or overly pessimistic
- the patient is influenced by a feeling of guilt of being a burden to family and care givers
- mental illness or low self esteem is prompting the request, or
- they do not fit within the criteria proposed in the empowering legislation and are assisted in their suicide or euthanized anyway.

Unfortunately, protocols in jurisdictions that allow PAS/E leave it up to the patients’ doctors to determine when these factors are present. It is an onerous responsibility for the physician to accept in addition to their other responsibilities and data from other jurisdictions demonstrate that oversight is often absent.⁶

There are two serious problems with this approach. First, it is common for patients to want to end their lives after traumatic life events, sudden serious illnesses, mental health problems, disability or accident, and yet later change their minds. Legislation like Quebec’s

Bill 52 creates a checklist for the doctor to follow to determine who is eligible for PAS/E including criteria like age, competency, lack of ambivalence, etc. If the patient qualifies the doctor must permit the euthanasia, unless the physician is personally opposed to the practice, in which case the file is passed to a doctor who will perform the euthanasia. If it is legalized across Canada, euthanasia will become a legal medical procedure, and there will be no obligation for health care professionals to discourage the patient to choose it. In fact, discouraging a patient from choosing euthanasia may even be seen as “unprofessional” and thus may not be permitted. If patients meet the criteria, they qualify.⁷ People can be legally competent, yet influenced by the factors described above. In many cases, there would be no way for the doctor to know. Often, the patients themselves are unaware of the pressures they are experiencing, even from within themselves.

Secondly, there is a large range of attitudes among physicians about the morality of euthanasia. Some, like the members of the Dutch Euthanasia Society (NVVE) believe that any person after the age of 70 years should be able to be euthanized without any specific criteria.⁸ Some believe so strongly in the ethical value of autonomy they do not see any role for the physician in “second guessing” the patient. This leaves a huge loophole in the legislation of those jurisdictions that have legalized physician-assisted suicide and euthanasia: the practice of “doctor shopping.” Even though the consent of two physicians is often required, there are recorded cases where the patient’s family physician or psychiatrist opposed PAS/E for a patient yet the patient received it anyway after getting permission from two other doctors.⁹ In Oregon, 75% of cases of PAS are done by physicians who are members or associates of Compassion in Dying, a group promoting PAS/E.¹⁰ Because of the range of attitudes about PAS/E, some will see the limitations on the practice as a prudent safeguard, while others will see them as a needless restriction on patient autonomy. This will only increase the frequency of “doctor shopping” – and result in dramatically different responses from physician to physician as to who qualifies for PAS/E. The NVVE in the Netherlands has found a way to bypass the family physician by sending physician PAS/E services to the patient’s home.

7 Note the contrast with the request in the CMA brief. “In addition, if the law were to change, no physician should be compelled to participate in or provide medical aid in dying to a patient, either at all, because the physician conscientiously objects to medical aid in dying, or in individual cases, in which the physician makes a clinical assessment that the patient’s decision is contrary to the patient’s best interests.”(p.8) No jurisdiction permits broader discretion for the physician than the legislated criteria.

8 See http://www.loc.gov/lawweb/servlet/lloc_news?disp3_1205403034_text The associated citizens initiative, which garnered over 150,000 signatures required only that the Dutch citizen be over age 70 and “tired of life” to get assistance in dying from a friend or family member. The Dutch physician’s association went on record as suggesting that the current legislation could be stretched to allow this type of euthanasia. They did not support that a physician need not be involved in the process, however.

9 Hendin and Foley, p. 1624.

10 *Ibid.*, p. 1628

5 Parliamentary Committee on Palliative and Compassionate Care (2011), *Not to Be Forgotten: Care of Vulnerable Canadians*, pg.7

6 Hendin, H., Foley, K. (2008). Physician-assisted Suicide in Oregon: A Medical Perspective. *Michigan Law Review*, 106:1613-1640. Retrieved from <https://docs.google.com/file/d/0BwDPETL1NPnAMmFjZTNjNzctOGU4NS00MTUwLTgxZjAtM2I4NDhMjA2OTFj/edit?hl=en>

THE EXPERIENCE OF JURISDICTIONS WHERE PAS/E IS LEGAL

Requirements Not Followed

The experience of jurisdictions that have legalized PAS/E provides evidence that legislated requirements are often not followed and that physicians underreport cases of PAS/E. A study of PAS/E deaths in Flanders, Belgium, published in the CMAJ in May, 2010 found that 32% of euthanasia deaths occurred without the explicit consent of the patient, despite a strict requirement to do so in the legislation.¹¹ A 2010 article published in the British Medical Journal also dealing with the same area of Belgium documented that 47.2% of all euthanasia deaths went unreported.¹² The latest research indicates that physicians in the Netherlands did not report 23% of cases to a review committee as required in the legislation.¹³ From the very beginning of the Oregon program officials conceded that “there’s no way to know if additional deaths went unreported” because Oregon DHS “has no regulatory authority or resources to ensure compliance with the law.”¹⁴ This is particularly disturbing given that the Oregon law authorizes physicians to prescribe a lethal dose of medication to a patient, but there is no requirement for an independent witness when the patient takes the medication.

In fact in 2013, 84% of people who took the lethal medication did so without a health professional present.¹⁵ This opens the door for potential abuse by third parties who could administer the medication without the patient’s consent.

11 Chambaere, K., Bilsen, J., Cohen, J., Onwuteaka-Philipsen, B. D., Mortier, F., & Deliens, L. (2010). Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. *Canadian Medical Association Journal*, 182(9), 895–901. Retrieved from <http://www.cmaj.ca/content/early/2010/05/17/cmaj.091876.full.pdf+html>

12 Smets, T., Bilsen, J., Cohen, J., Rurup, M., Mortier, F., & Deliens, L. (2010). Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. *British Medical Journal*, 341. doi:10.1136/bmj.c5174

Retrieved from <http://www.bmj.com/content/341/bmj.c5174.full.pdf+html>

The conclusions of this study: “One out of two euthanasia cases is reported to the Federal Control and Evaluation Committee. Most non-reporting physicians do not perceive their act as euthanasia. Countries debating legalization of euthanasia should simultaneously consider developing a policy facilitating the due care and reporting obligations of physicians.”

13 Onwuteaka-Philipsen, B., Brinkman-Stoppelenburg, A., Penning, C., Jong-Krul, G., Delden, J., & Heide, A. (2012). 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*, 380(9845), 908–15. doi:10.1016/s0140-6736(12)61034-4

14 Prager, Linda. (1998, September 7). Details emerge on Oregon’s first assisted suicides. *American Medical News*. <http://www.sciencedirect.com/science/article/pii/S0140673612610344>

15 Oregon Public Health Division. 2013 Death With Dignity Act Report. p.6. Retrieved from: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>

An Expansion of the Mandate

When jurisdictions legalize PAS/E the intention is most often to focus on end of life situations. Based on the experience of the permissive jurisdictions, this goal is elusive. Categories of persons permitted to end their lives have continued to expand. In Belgium, twin brothers who were deaf and had the possibility of becoming blind within five years were legally killed. Recently, a patient was killed who had experienced a failed sex change operation. An inmate in a correctional facility was killed in 2012.¹⁶ One patient in Oregon waited over 1,000 days after receiving the lethal prescription to take it, despite the legislated requirement that the person be terminally ill and have only six months to live.¹⁷

The national legislature in Belgium has legalized PAS/E for children under the age of 18. The Netherlands has developed the Groningen protocol for the euthanasia of infants.¹⁸ In fact, in the Carter case itself, the judge expanded the category of persons who could end their lives prematurely beyond what was necessitated by the facts of the case. Both plaintiffs in the case suffered from a terminal illness, yet the protocol proposed by the judge did not require that the patient suffer from one.¹⁹

In the Netherlands, the first country to legalize euthanasia (2002), there has been a shift in the types of patients who are euthanized. While hardly any patients with psychiatric illnesses or dementia appear in the reports in the early years of the program, those numbers are on the rise. According to Dutch ethicist Dr. Theo Boer, who sat on a euthanasia review committee for nine years in the Netherlands, “Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades.”²⁰

A comprehensive study published in the Lancet in 2012 has brought to light the huge increases in deaths due to intensified alleviation of symptoms in the Netherlands since legalization of euthanasia.²¹ In the 5 years between 2005 and 2010 the number of patient deaths due to continuous deep sedation rose from 8.2% of all

16 *Lee Carter et al v Canada*, SCC 3559, Affidavit of Etienne Montero for the respondents.

17 Oregon Public Health Division. 2013 *Death with Dignity Act*. p.7.

18 Verhagen, E., & Sauer, P. J. (2005). The Groningen protocol – euthanasia in severely ill newborns. *New England Journal of Medicine*, 352(10), 959–962. doi:10.1056/NEJMp058026. Retrieved from: www.nejm.org/doi/full/10.1056/NEJMp058026

19 *Lee Carter et al v Canada*, (BCSC) 2012, para. 384.

20 Boer, Theo. (2014, July 17). Boer: I was wrong – euthanasia has a slippery slope. *Calgary Herald*. Retrieved from: <http://calgaryherald.com/opinion/boer-i-was-wrong-euthanasia-has-a-slippery-slope>

21 Onwuteaka-Philipsen, B., Brinkman-Stoppelenburg, et al. 2012. 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. *The Lancet* 380:908–15

deaths in the Netherlands to 12.3% (est. 16,500 deaths). Compare this to a rate of palliative sedation in Canada estimated to be between .1 and 1%. In an associated comment published in that same issue, Dr. Bernard Lo stated:

First, the line between euthanasia and the less controversial, much more common practice of palliative sedation can be blurred in clinical practice. . . . But physicians who say they are undertaking palliative sedation sometimes cross the line to euthanasia.²²

In fact according to the Lancet article, in about 20% of cases the investigators classified as euthanasia or physician-assisted suicide, the physicians viewed the case as alleviation of symptoms (1.5%) or palliative or terminal sedation (18.1%). This demonstrates that it is very hard to maintain clear categories and that without the clear boundary of no killing, doctors may commit euthanasia while considering it to be something else.

Furthermore, there seems to be an overall lack of communication between the physicians and patients at end of life. In the ten years between 2001 and 2010 the number of deaths due to “intensified alleviation of symptoms” rose from 20.1% to 36.4% (est. 49,500 deaths). Intensified alleviation of symptoms means increased pain medications. Shockingly, in 49.2 % of cases the physician did not discuss this decision with the patient, relatives or another colleague. This is of real concern for patient safety, because without physician self-disclosure there is no way for officials to realize that euthanasia has occurred.

In some of these cases euthanasia is being implemented outside of the restrictions described in the legislation and without adequate consultation with patients. This must of necessity lead to a weakening of the ethos of respect for the human life of each patient.

Lack of Proper Oversight

In most permissive jurisdictions, physician self-reporting provides the only oversight mechanism to review committees. There is no agency with the mandate to independently audit and investigate cases to see if physicians are in fact reporting all of their patient deaths and reporting them honestly. In fact the most revealing statistics were provided through the studies in Flanders Belgium where physicians we invited to respond anonymously and were given amnesty from prosecution. The startling results are recorded above. The sanction of the criminal law, which today protects vulnerable citizens, would be gutted and unlikely to produce a prosecution, much less a conviction, even in the most extreme cases. Crown prosecutors are often unwilling to wade into matters of a sensitive nature like this. Frequent concerns

about patient deaths are uncovered in permissive jurisdictions but none has resulted in a successful prosecution. A proper program of comprehensive audit and investigation would be so costly that jurisdictions would find the costs and legalization prohibitive in an age of tight health care budgets. Failure to provide funding for such an agency demonstrates a lack of respect for the value of human life.

In her decision in the *Carter* case, Madame Justice Lynne Smith of the BC Supreme Court acknowledged that legalization of PAS/E would result in an increased risk of wrongful death.²³ She stated the standard of “one wrongful death” was not a realistic measure to determine whether the needs of those wanting PAS/E should outweigh the right to life protections in the *Charter* for everyone else.²⁴ Unfortunately, legalization along the lines of current permissive jurisdictions will not provide the accurate statistics required to determine whether more people were harmed or helped by legalization. At any rate, this determination sounds like a bizarre and macabre calculus.

Legalization means that physician assisted suicide and euthanasia will no longer be murder or aiding and abetting a murder but part of a “continuum of end of life care” as foreseen in Bill 52. They will be regulated as such – and their proper regulation will be subject to the same bureaucratic challenges as other procedures, along with the risk that some patients will “fall between the cracks.” If it is determined to be a matter of health care, then it will be administered at a provincial level and subject to the potential challenge that services are available inconsistently across the country. *In this case a mistake is a matter of life and death.*

Do we really trust our Departments of Health to create systems of checks and balances to ensure that wrongful death never occurs? On what basis could investigators question a physician’s judgment? Will they create a special Medicare code to cover the lengthy discussions required for a physician to determine competency and suitability in these cases? Or will they support this initiative because of the health care funding saved from not having to help people in these difficult situations? Given the severe crisis in healthcare funding, bed and personnel shortages the temptation may prove too great. In a generation, societal values could shift to the point that the acceptable response would be for a patient to cut short their lives through PAS/E so that another patient can get the services they require. The right to euthanasia could become a duty to undergo it. Is this the cultural heritage we want to leave for our children and grandchildren after striving so hard for so long to provide universal access to health care for all our citizens?

Societal values could shift to the point that the acceptable response would be for a patient to cut short their lives through PAS/E.

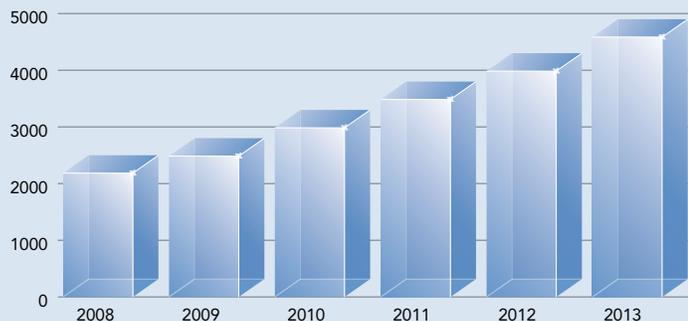
22 Lo, B. 2012. Euthanasia in the Netherlands: What Lessons for Elsewhere? The Lancet, Vol. 380, No. 9845, p869–870 September 8, 2012 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61128-3/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61128-3/abstract)

23 *Lee Carter et. al. v. Canada*, (BCSC), 2012, para. 1240.

24 *Ibid.*, para. 1352

Disturbing growth in the number of patient deaths

NETHERLANDS



The largest numbers of patients killed through PAS/E have occurred in the Netherlands, where the practice has been permitted since the early 70's. Legislation took effect in 2002 that has attempted to regulate the practice. The annual report of the Euthanasia Committees for 2013 has reported 4,829 deaths compared with 1,815 in 2003 (the first full year of the program). This represents an increase of 166%. After 2008, the number of euthanasia deaths increased an average of 15.7% each year.²⁵ According to Dr. Boer, "I expect the 6,000 line to be crossed this year (2014) or the next. Euthanasia is on the way to become a 'default' mode of dying for cancer patients." The Dutch Right to Die Society has established a network of mobile euthanasia doctors.²⁶

25 Netherlands Report of the Regional Euthanasia Review Committees, 2002-2013. Retrieved from <http://www.livinganddyingwell.org.uk/publications/research/dutch-regional-euthanasia-review-committees-2011-annual-report>

26 Boer T. Calgary Herald: "Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or sending the patient away. On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic. The NVVE shows no signs of being satisfied even with these developments. They will not rest until a lethal pill is made available to anyone over 70 years who wishes to die. Some slopes truly are slippery."

BELGIUM

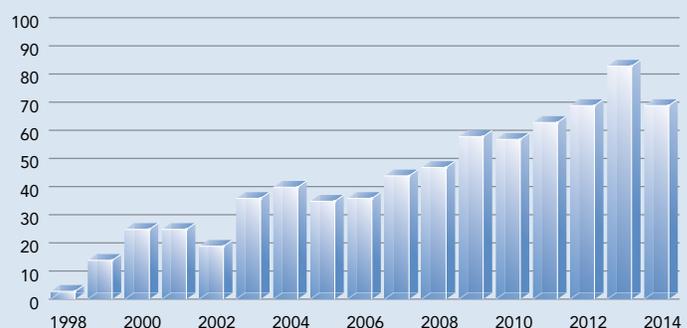


Belgium has also seen dramatic increases in the numbers of patient deaths from PAS/E. There has been an increase from 235 patients euthanized in 2003 (the first full year of implementation) to 1432 patients who died in 2012 (500% increase).²⁷

27 Data from Belgium Federal Government publications: <http://www.health.fgov.be/eportal/Healthcare/Consultativebodies/Commissions/Euthanasia/Publications/index.htm?fodnlang=fr#.VRwYDVxYhbx>

See also Hamilton, Graeme. (2013, November 24). 'Suicide with the approval of society': Belgian activist warns of slippery slope as euthanasia becomes 'normal'. *National Post*. Retrieved from <http://news.nationalpost.com/2013/11/24/suicide-with-the-approval-of-society-belgian-activist-warns-of-slippery-slope-as-euthanasia-becomes-normal/>

OREGON



In Oregon, patient numbers have shown a steady increase since inception of PAS in both the number of lethal prescriptions written (400 % increase) and the number of patients killed by ingesting lethal medications (345% increase).²⁸

28 Oregon Public Health Division. 2013 *Death with Dignity Act*. p.7.

Lethal prescriptions written have increased from 24 to 122 and reported deaths have increased from 16 to 71.

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>

 Number of reported deaths from physician assisted suicide or euthanasia

LOSS OF RESPECT FOR PEOPLE WITH DISABILITIES

Disability rights advocates express concern about a kind of reverse discrimination that would come about if these proposals go ahead. A fear of disability is shared by many in our society. In a world in which PAS/E is legalized, a non-disabled person who had suicidal thoughts would be treated to prevent suicide and to help them get some relief. If a disabled person had the same suicidal thoughts, however, they might receive the same treatment, but PAS/E might also be accepted by the health care professional and raised as an option. Suicide is an action of an individual while PAS/E requires the assent of at least one other person and of the society that permits it and pays for it. The society is therefore sanctioning killing based upon the physical or mental characteristics of the person. In this sense PAS/E requires an acknowledgement that certain lives are not worth living, which is problematic even if the person himself feels his life is worthless. If PAS/E were legal would there be as much of an incentive to press government for increased resources for people living with disabilities or for palliative care?²⁹ It is certainly true that a “choice” between living without proper supports or independence and death is not a choice at all.

ARE THESE RISKS REALLY NECESSARY?

The most recent statistics from Oregon indicate that lack of pain control is not the primary reason people seek PAS. Loss of autonomy (93%), fear of being a burden on family and friends (49%) are all much larger factors than worries about pain (28%).³⁰ In fact, the Canadian Association of Palliative Care Physicians indicates that pain is rarely the reason patients ask for hastened death – it more often comes out of a desire to control the circumstances surrounding death.³¹

75% of palliative care physicians in Canada are opposed to legalization. Their association says that end of life pain can be dealt with if the proper tools of modern medicine are available. The fact that 16 – 30% of the Canadian population has access to appropriate palliative care resources raises a significant social justice concern: we should not resolve the problem of our tight health care budgets at the expense of those who have lost hope.

PRACTICE OF MEDICINE

A final concern is how these proposed changes may impact the practice of medicine. Bill 52 makes “medical aid in dying” part of end of life care. s. 31 of this proposed legislation requires that any

physician who refuses a patient’s request for PAS/E for reasons of conscience must forward the request form to the director of professional services of the local health authority who will find a physician to process the request. All hospitals and nursing homes would be required to participate in PAS/E, even if their organization was morally or ethically opposed to the practice. This deprives patients of the peace of mind of living out their final days in an institution where they have no risk of wrongful death.

Physicians, nurses, pharmacists and other health care workers could find the willingness to participate in this practice part of their job requirements if PAS/E is legalized across Canada. Many physicians would object to being required to forward the request for PAS/E to the appropriate official on conscience grounds. A referral means that the referring physician is recommending PAS/E or its consideration for the well being of the patient.

Under the *Charter of Rights and Freedoms*, Canadians enjoy freedom of conscience and religion. However, Bill 52 does not explicitly protect physicians from discrimination in the event that they apply for a position that requires the administration of “medical aid in dying.” We could see a time when all palliative care positions require the willingness to perform PAS/E. This requires health professionals to make an impossible choice – go against your conscience or do not apply for the position. Many doctors have a predictable reaction – their role is to heal – not kill their patients.

How can we create a medical system that values both saving life and ending it? Will both responses continue to be valued in the profession or will those who refuse to be involved in PAS/E gradually have their rights eroded and their position devalued? Once killing patients is seen as a virtuous and professional activity by the majority of the profession, will the minority be forced to conform?

CONCLUSION

The acceptance of PAS/E into Canadian health care and society will have wide reaching effects on the lives of every day Canadians and the practice of medicine. Clearly, while a minority of patients might be able to die according to their wishes, everyone else in Canadian society will be subjected to the risk of wrongful death should they have the misfortune of falling into one of the categories listed above. Doctors inherently understand the demands of the system, and the insurmountable challenges of trying to “draw a line” once patient autonomy trumps all other values including malfeasance. We ask that in light of the facts above that the CMA resist the temptation to allow the courts or public opinion to set medical ethical standards. Let us continue our stand to protect the well being of our most vulnerable patients, which is our primary responsibility as a profession and as citizens. 

**Supporting documents can be found here:*

https://www.dropbox.com/sh/vrd8ijuxmwx5dq/AABlNEhIBKmfEtp9B2_7Up2qa?dl=0

29 Golden, M., & Zoanni, T. (2010). Killing us softly: the dangers of legalizing assisted suicide. *Disability and Health Journal*, 3(1), 1630. doi:10.1016/j.dhjo.2009.08.006

Retrieved from www.disabilityandhealthjournal.com/article/S1936-6574%2809%2900073-9/fulltext

30 Oregon Public Health Division. 2013 *Death with Dignity Act*. p.6

31 Golden, M., & Zoanni, T. (2010). Killing us softly: the dangers of legalizing assisted suicide.