

## The Great Canadian Euthanasia Debate: learning from history

Arthur Schafer

Parliament will be voting soon on a private members bill to legalize euthanasia and physician assisted suicide, subject to safeguards. Meanwhile, the Quebec College of Physicians has just endorsed euthanasia in some circumstances and is calling for Criminal Code amendments to protect doctors who hasten the death of suffering patients when those patients face “imminent and inevitable death”.

If Canadians decide to take time out from debating who should be first in line for the flu vaccine, we might find our attention captured by this latest round of a debate about ethics at the end of life.

Historical perspective may help. When I began teaching ethics to undergraduate medical students, in 1970, the “hot button” issues were passive and indirect euthanasia. “Passive euthanasia” referred to the withholding or withdrawal of life support, from the motive of mercy, usually at the request of a dying patient. Doctors used to worry about both the ethics and the legality of hastening a patient’s death by “pulling the plug”. “Indirect euthanasia” was the term then in use to describe the administration of large, sometimes very large, doses of analgesia with the direct aim of relieving pain but in the knowledge that indirectly this pain relief was likely to depress the patient’s respiratory system and thereby bring on death more quickly.

“Passive euthanasia” is now called “appropriate care”. Today it is universally practiced in Canadian hospitals and no physician has ever been charged with a criminal offence for withholding or withdrawing life support, whether at the request of a dying patient, in compliance with the patient’s living will or at the request of the patient’s family when the patient herself was no longer competent. In January of 1992, Nancy B, quadriplegic since 1988, told Quebec Superior Court Judge Jacques Dufour “I am fed up with living on a respirator. It’s not a life”. The court ruled in her favour. She was disconnected from life support and got the quick and painless death she sought. This case helped to establish that in Canada a competent adult patient has the right to refuse life-prolonging treatment.

“Indirect euthanasia” is now seen as merely a form of palliative care. A physician who denies adequate pain relief to a dying patient because of fears that the analgesic might cause death would be considered unprofessional. Today, many Canadian hospitals have palliative care wards in which the overall treatment goal is to keep the patient comfortable rather than to prolong life. In these wards and in hospices for the dying there is little hesitation in administering whatever dose of painkiller is required for comfort, even when the foreseeable consequence is hastened death.

One important lesson to be learned from these historical debates is that not all slopes are slippery. Opponents of so-called passive euthanasia balefully predicted that if doctors were allowed to withhold or withdraw life support we would immediately find ourselves

on a slippery slope. Doctors who pulled the plug on dying patients would become desensitized or even brutalized. Hospitals would become cruel and dehumanized places. Patients would come to think of their doctors as executioners. The fundamental social value of respect for life would be debased. The old and the vulnerable would be at high risk of merciless killing. However, experience has shown that what happened in reality was exactly the opposite of what was predicted by the nay-sayers: doctors and hospitals have become kinder and gentler; patients' wishes are better respected than previously; and society has come to accept the importance of individual autonomy at the end of life.

With this brief *tour d'horizon* as context, let's consider where the euthanasia debate stands today. When palliative care doesn't provide needed relief from severe and intractable suffering, a growing number of hospitals now offers "sedation to unconsciousness": the patient is rendered terminally unconscious and food and fluids are then discontinued. For many people, however, terminal sedation seems an undignified way to end one's life. Instead, they seek physician assisted suicide [PAS].

PAS has been legal in the State of Oregon for 11 years and accounts for about one out of every thousand deaths per year. But, although it's not used often, one in six patients discusses this option with their family and one in fifty raises it with their doctor. In other words, the safeguards appear to work. Few people opt for physician-assisted suicide but many people take comfort from the knowledge that if their lives become unbearable they can request and will be given assistance to die. Of course, as physicians sometimes acknowledge, euthanasia and assisted suicide are practiced secretly in every state of the USA and in every Canadian province; but, where these practices are illegal, they are practiced in the dark and are therefore much more likely to result in mistakes and abuse.

Critics widely predicted that legalizing PAS would be a slippery slope to cut-backs in palliative care. Society would reason: Why offer expensive comfort care to suffering patients when it's cheaper simply to hasten their deaths? In practice, the opposite has occurred. Oregon legislation requires that dying patients be offered a full range of options and the state has become a leader in palliative and end-of-life care.

Is it too much to hope that our legislators might learn from recent history? When it comes to end of life care, Canadians should be able to choose from among a full range of options, including first rate palliative care and physician-assisted suicide. With proper safeguards in place to ensure openness and accountability there is no reason to deny people the help they want and need.

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