



Thou shalt not kill

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The Supreme Court of Canada has just struck down a section of the Criminal Code prohibiting physicians from helping patients to die:

Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.¹

In a unanimous decision, the highest court in the land ruled that a total prohibition of physician-assisted death was an infringement of the Canadian Charter of Rights and Freedoms and, therefore, unconstitutional. It ruled that the Criminal Code, in its current wording, infringed upon the right to life, liberty, and security of certain individuals. The ruling will apply to adults who are deemed competent within the meaning of the law, who are able to clearly give consent, and who are enduring intolerable suffering due to a grievous and irremediable medical condition.

This decision raises many issues and questions, one of which is that of determining which patients will be eligible for physician-assisted death. One immediately thinks of patients suffering from chronic, debilitating, and irreversible diseases such as amyotrophic lateral sclerosis, multiple sclerosis, or Parkinson disease. These patients become progressively bedridden and their condition inevitably leads to a terrible death. Suffering, despairing, and exhausted, by the end, they often want only one thing: to end it. Surely, these patients deserve help to die with dignity.

But what about patients with other illnesses that are just as grievous and irremediable? Will patients with severe respiratory failure be allowed to ask for help if they are suffering from chronic obstructive pulmonary disease, heart failure, or pulmonary fibrosis? If, in spite of all the treatment and care they receive, in spite of oxygen at full concentration and optimal doses of corticosteroids, they have no quality of life and wish that this calvary would end, will these patients be authorized to ask for help to die? Will quadriplegic patients who are bedridden with huge bed sores and uncontrollable phantom limb pain, and who refuse treatment with a clear intention to die, be allowed to ask for help? And

what about patients who suffer from severe, chronic, treatment-resistant depression, who have made many unsuccessful suicide attempts and who are letting themselves die slowly? Could these people ask for help? And what about individuals who have committed an abominable crime—perhaps the unspeakable crime of infanticide—who cannot forgive themselves, whom society will never forgive, and who have stopped eating in order to end their lives? Will they be able to ask for physician-assisted death?

Hence, a legislative framework for physician-assisted death does exist. In Quebec, for example, *An Act Respecting End-of-Life Care* states that in order to obtain medical aid in dying a person must be insured within the meaning of the *Health Insurance Act*; be of age and capable of giving consent to care; be at the end of life; suffer from a serious and incurable illness; be in an advanced state of irreversible decline in capability; and experience constant and unbearable physical or psychological pain that cannot be relieved in a manner he or she deems tolerable.² The act also states that the patient must request medical aid in dying themselves, in a free and informed manner, by means of the form prescribed by the health minister.

These conditions are indeed fair and laudable; however, do not all of the patients in the examples provided above meet all of these criteria? Have they not all reached the end of life, suffering from a serious and incurable illness, in an advanced state of irreversible decline in capability, in which they are experiencing constant and unbearable physical or psychological pain?

Yet the further down the list of examples we go, the more uncomfortable most of us feel about offering help in dying.

How and by whom will the decision be made?

Who will decide who is eligible for medical aid in dying? Will it be the attending physician, another physician whose job it is to make such decisions, the ethics board, the person responsible for the institution, or the health minister? Sections 29, 30, and 31 of the act address this by means of a set of rules.²

And what will be the procedure? Will it only be necessary for a patient to demonstrate that he or she meets all 6 of the criteria? If so, what about cases in which it is hazardous to decide that an illness is serious and incurable? Consider the cases of patients with emphysema who are admitted to intensive care with respiratory distress and intubated because they are dangerously lacking in oxygen and who, after a few days, ask to be

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extubated so that they can die in peace. It is not uncommon to see these patients miraculously survive the process and continue to rally. Will more weight be given to physical suffering than to psychological suffering? It seems highly unlikely that a chronically depressed patient or a mother who has killed her children will receive help in dying, in spite of their immeasurable suffering. A patient for whom no relief is effective and who is writhing in despair will be more likely to receive medical aid in dying.


And who will actually carry out the act? Will this task fall (yet again) to the family physician or the attending physician? Beyond the issue of individual conscience, we need to ask whether the family physician—who has accompanied the patient throughout the illness, doing everything in his or her power to provide care and help—is the right person. Such a role reversal creates a paradox, does it not? Perhaps the task of medical aid in dying will fall to a new group of specialists: anesthesiothanatologists.

Palliative sedation

But what is paradoxical about the change in the legislation is that patients have received medical care and aid with dying for years. In the presence of a patient

who is experiencing extreme suffering or who presents with untreatable symptoms such as respiratory distress, excessive agitation, or psychological suffering (or any other symptom), physicians have a moral and ethical obligation to offer relief, up to and including palliative sedation. This practice is common in palliative care. The critical distinction between palliative sedation and medical aid in dying is intention. In the first case, the primary goal is to provide relief and make the patient comfortable, even if death might occur. In the second, the primary goal is the patient's death. It seems as though the framer of the legislation and society at large has minimized these long-standing practices.

Conclusion

Whether or not we agree with its ruling, the highest court in the land has determined that a physician cannot be prevented from helping a patient to die. But does this mean that physicians will have to cut patients' lives short at their request, when other forms of help are available? 

References

1. *Carter v. Canada (Attorney General)*. 2015. 5 S.C.C. 35591.
2. *An Act Respecting End-of-Life Care*, RSQ c S-32.0001. Available from: www.canlii.org/en/qc/laws/stat/rsq-c-s-32.0001/latest/rsq-c-s-32.0001.html. Accessed 2015 Feb 25.