ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

CMA POLICY

EUTHANASIA AND ASSISTED SUICIDE (UPDATE 2007)

This policy replaces two previous policies, *Physician-Assisted Death 1995* and *Euthanasia and Assisted Suicide (1998)*. Euthanasia and assisted suicide, as understood here, must be distinguished from the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life. The CMA does not support euthanasia or assisted suicide. It urges its members to uphold the principles of palliative care. The following policy summary includes definitions of euthanasia and assisted suicide, background information, basic medical ethical principles and physician concerns about legalization of euthanasia and assisted suicide.

Definitions

The CMA defines aid in dying, euthanasia and physician-assisted suicide as follows.

Aid in dying is a generic term that encompasses both euthanasia and physician-assisted suicide.

Euthanasia means knowingly and intentionally performing an act that is explicitly intended to end another person's life and that includes the following elements: the subject has an incurable illness; the agent knows about the person's condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.[1]

Assistance in suicide means knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.

Euthanasia and assisted suicide are often regarded as morally equivalent, although there is a clear practical distinction, as well as a legal distinction, between them.

Background

Euthanasia and assisted suicide are opposed by almost every national medical association and prohibited by the law codes of almost all countries. A change in the legal status of these practices in Canada would represent a major shift in social policy and behaviour. For the medical profession to support such a change and subsequently participate in these practices, a

[1] Three types of Euthanasia are identified; the divisions are premised on whether the subject has and expresses a desire to end their life. *Voluntary euthanasia* is limited to situations where the subject is a competent, informed person who has voluntarily asked for his or her life to be ended. *Non-voluntary euthanasia* means the person has not developed or expressed his or her preference regarding aid in dying or is decisionally incapacitated and is unable to make or exercise an informed choice. *In-voluntary euthanasia* means the person made an informed choice and expressed his or her refusal for aid in dying.

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fundamental reconsideration of traditional medical ethics would be required.

Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide. Because of the controversial nature of these practices, their undeniable importance to physicians and their unpredictable effects on the practice of medicine, these issues must be approached cautiously and deliberately by the profession and society.

Basic ethical principles

Although euthanasia or assisted suicide are not mentioned explicitly in the CMA Code of Ethics, the code has traditionally been interpreted as opposing these practices. The following articles of the code are relevant to CMA policy on this issue.

1. "Consider first the well-being of the patient." This means that the care of patients, in this case those who are terminally ill or who face an indefinite life span of suffering or meaninglessness, must be physicians' first consideration.

2. "Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support."

3. "Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability."

4. "Respect the right of a competent patient to accept or reject any medical care recommended."

5. "Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment."

6. "Recognize the profession's responsibility to society in matters relating to . . . legislation affecting the health or well-being of the community . . ."

7. "Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants."

These principles cannot, by themselves, determine whether euthanasia and assisted suicide should be permitted. Nevertheless, they are relevant to the debate. The first five emphasize the importance of patient well-being and autonomy, the sixth balances this with responsibility to society, and the seventh defends physician autonomy if the law were to be changed.

CMA policy on physician participation in euthanasia and assisted suicide

Canadian physicians should not participate in euthanasia or assisted suicide.

Physician concerns about legalization of euthanasia and assisted suicide

The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues.

Before any change in the legal status of euthanasia or assisted suicide is considered, the CMA urges that the following concerns be addressed.

1. Adequate palliative-care services must be made available to all Canadians. The 1994 CMA General Council unanimously approved a motion that Canadian physicians should uphold the principles of palliative care.

The public has clearly demonstrated its concern with our care of the dying. The provision of palliative care for all who are in need is a mandatory precondition to the contemplation of permissive legislative change. Efforts to broaden the availability of palliative care in Canada should be intensified.

2. Suicide-prevention programs should be maintained and strengthened where necessary. Although attempted suicide is not illegal, it is often the result of temporary depression or unhappiness. Society rightly supports efforts to prevent suicide, and physicians are expected to provide life-support measures to people who have attempted suicide. In any debate about providing

assistance in suicide to relieve the suffering of persons with incurable diseases, the interests of those at risk of attempting suicide for other reasons must be safeguarded.

3. A Canadian study of medical decision making during dying should be undertaken. We know relatively little about the frequency of various medical decisions made near the end of life, how these decisions are made and the satisfaction of patients, families, physicians and other caregivers with the decision-making process and outcomes. Physicians are involved in making decisions concerning whether to withhold or withdraw treatment and whether to administer sedatives and analgesics in doses that may shorten life. It is alleged that some Canadian physicians are providing euthanasia or assistance in suicide. Hence, a study of medical decision making during dying is needed to evaluate the current state of Canadian practice. This evaluation would help determine the possible need for change and identify what those changes should be. If physicians participating in such a study were offered immunity from prosecution based on information collected, as was done during the Remmelink commission in the Netherlands, the study could substantiate or refute the repeated allegations that euthanasia and assisted suicide take place.

4. The public should be given adequate opportunity to comment on any proposed change in legislation. The law should be determined by the wishes of society, as expressed through Parliament, rather than by court decisions.

5. Consideration should be given to whether any proposed legislation[2] can restrict euthanasia and assisted suicide to the indications intended. Research from the Netherlands and Oregon demonstrate that a large percentage of patients who request aid in dying do so in order to maintain their dignity and autonomy.

If euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges, based on the Canadian Charter of Rights and Freedoms, to extend these practices to others who are not competent, suffering or terminally ill. Such extension is the "slippery slope" that many fear. Courts may be asked to hear cases involving euthanasia for incompetent patients on the basis of advance directives or requests from proxy decision makers. Such cases could involve neurologically impaired patients or newborns with severe congenital abnormalities. The "Groningen protocol," which sets out five criteria for the provision of euthanasia to incurably ill babies, was adopted in Holland. Psychiatrists recognize the possibility that a rational, otherwise well person may request suicide. Such a person could petition the courts for physician-assisted suicide.

Conclusion

This statement has been developed to help physicians, the public and politicians participate in any re-examination of the current legal prohibition of euthanasia and assisted suicide and arrive at a solution in the best interests of Canadians.

[2] *E.g.*, Oregon Revised Statutes. *The Oregon Death with Dignity Act.* § 127.800 - §127.995.