Unanimity on Death with Dignity — Legalizing Physician-Assisted Dying in Canada

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In February 2015, Canada legalized physician-assisted dying — a first among countries with common-law systems, in which law is often developed by judges through case decisions and precedent. The Supreme Court of Canada issued the decision in *Carter v. Canada*,[1] and its reasoning and implications for clinical practice bear examination.

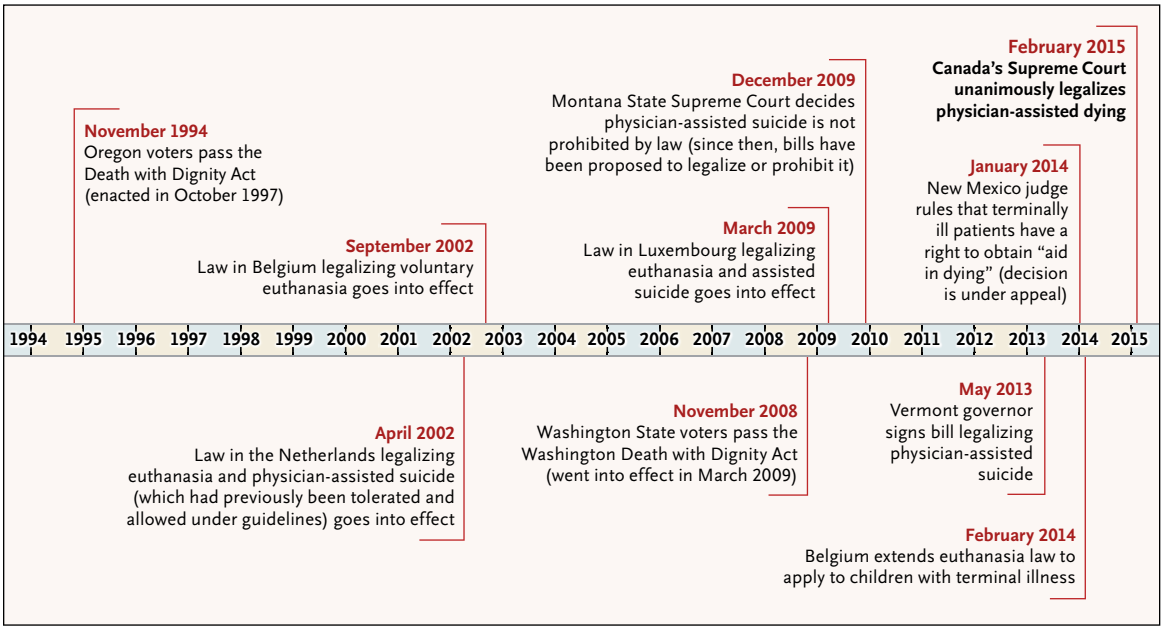
Canada's path to this point has not been short. In 1993, the Court rejected legalization of physician-assisted dying on a 5-to-4 vote, and Parliament has since considered the issue several times but demurred — though the province of Quebec passed a "medical aid in dying" law in 2014. The *Carter* judgment triggered a year-long grace period during which Canada's federal and provincial governments and the medical profession must arrange for an orderly transition so that by early 2016, Canadian patients can choose to die with a doctor's help.

Physician-assisted dying is ethically and legally controversial, and few countries or states have embraced it (see timeline). Yet Canadians apparently overwhelmingly believe that its time has come. Strikingly, the Court's nine justices ruled unanimously, without dissent. Fully 78% of Canadians polled after their decision agreed, 60% "strongly" so, with only 9% strongly opposed.[2] Anticipating the Court's ruling, the Canadian Medical Association dropped its opposition to physicians aiding in death. So what is it about the Court, or Canada's medical, legal, and social tapestry, that has rendered a typically flammable proposition so acceptable?

The Criminal Code of Canada protects life sedulously. It forbids counseling, aiding, or abetting a person in committing suicide, and if such help even indirectly causes death it is considered homicide, even if the person consented. But Canada's constitution, which is higher law, emphasizes autonomy and dignity. Under the Canadian Charter of Rights and Freedoms, everyone has the "right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice," although society can impose reasonable limits on such rights. When a mentally competent person freely wills to die and wants a physician's help in doing so, it's unclear whether the Criminal Code's prohibition or the Charter's rights take priority.

Societies are changing, and in coming decades aging populations with growing affluence and incidence of chronic illness will increasingly question the medical and legal orthodoxies regarding the end of life.

In considering physicians' involvement in a patient's death, medical practice usually distinguishes between causes of omission (adhering to a "do not resuscitate" order is allowed) and causes of commission (administering excess barbiturates is prohibited). This distinction is applied daily in critical and palliative care wards, but many legal scholars and judges have long considered it illogical. In 1993, for instance, England's top court considered whether doctors could, with the family's consent, lawfully stop nasogastric tube feeding of a patient in a persistent vegetative state.[3] The court struggled over the questions of whether extubating the patient was a homicidal act of commission, whether ceasing to feed the patient was a humane act of omission, and whether leaving the patient intubated but starving somehow made a moral difference — questions that devolve into "intolerably fine distinctions," as one judge complained. Ruling for extubation, Lord Goff of Chieveley rightly foresaw "a charge of hypocrisy, because it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal



Legal Milestones in Physician-Assisted Dying, 1994–2015.

injection, rather than let him linger on in pain until he dies."

In public health, this would be called a harm-reduction argument. And Canada's Supreme Court is fond of harm reduction. Since 2011, unanimous judgments have invoked the Charter's right to "life, liberty and security of the person" in legalizing supervised injection centers for drug addicts and brothels for prostitutes, because evidence showed that injecting drugs and selling sex are safer with oversight and shelter than without. Similarly, regarding physician-assisted dying, the Court reasoned that traditional methods of suicide infringed patients' "security of the person" more than clinical methods pursued under a physician's watch.

The justices then went further, observing that when the Criminal Code thwarts a person's ability to make decisions about something so personal as his or her own death or bodily integrity, this deprivation of autonomy causes psychological harm and distress, infringing the Charter's right to liberty. "An individual's response to a grievous and irremediable medical condition," the Court writes, "is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition or hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty."

The justices avoided the omission–commission distinction, concluding that as long as a patient in grievous and irremediable straits can give informed consent, it doesn't matter whether a physician assists actively or passively, because the patient's dignity and autonomy demand control in either case. Although the Court did not cite the concept of "patient-centered care," it was clearly on the same wavelength as modern medicine in giving patients choice, whether for palliative care or physician-assisted dying. Viewed through this lens, the Court's decision seems not radical but modest.

Canada's government argued that giving patients choice would create a dangerously slippery slope for "decisionally vulnerable" patients — such as those who are coerced, cognitively impaired, disabled, or mentally ill — who might end up dead if physician-assisted dying were not criminal. The Court was unpersuaded. Risks for such patients at the end of life "are already part and parcel of our medical system," it wrote, and it credited physicians with generally assessing those risks wisely. The justices said that familiar methods of gauging in-

formed consent — relying on advance directives or surrogate decision makers, for example — should suffice.

Nobody yet knows how physician-assisted dying will unfold in practice; that's what the grace period is for. Canada's justice minister discounted the option of overriding the Court's judgment using the Charter's "notwithstanding clause" — a controversial trump card that Parliament has never used — and in an election year, the federal government has higher priorities than regulating physician-assisted dying. It could even leave physician-assisted dying unregulated, as it did abortion, which it has never reregulated in the decades since the Court struck down the Criminal Code provisions governing it.[4]

It would then fall to Canada's 10 provincial governments either to generate legal guidance, as Quebec has done, or to do nothing and let the medical profession delineate its own practice. Two unanswered questions are especially challenging: first, how to define the type of "grievous and irremediable medical condition" for which the Court insists physician-assisted dying be offered, since controversially, this category might apply to some persons who are neither terminally nor physically ill, such as those with treatment-resistant depression; and second, how to organize the profession to accommodate the rights of doctors with religious or conscientious objections to physician-assisted dying without interfering with patients' rights. The Canadian Society of Palliative Care Physicians says that most of its members do not want to aid patients in dying; they will not take the lead in answering these questions.[5] Time will tell who does lead, or whether a new subspecialty in physician-assisted dying emerges. Meanwhile, it is striking that even in the face of so much uncertainty, Canadian society generally seems trustful rather than fearful, and the Court's decision has hardly triggered a culture war.

The judgment probably portends changes outside Canada. Imitation is a feature of the common-law world, and if physician-assisted dying is litigated in England, India, or South Africa, for example, odds are high that judges would draw on the Canadian Court's reasoning. Societies are also changing, and in coming decades aging populations with growing affluence and incidence of chronic illness will increasingly question the medical and legal orthodoxies regarding the end of life. Given the flow of legal ideas and shifting demographics, change and convergence around physician-assisted dying as a standard of care seem inevitable.

These developments will trouble people who instinctively find legalized physician-assisted dying repellent. But increasingly, society is acknowledging that denying people the right to die with dignity and safety is even more repellent.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. Carter v. Canada (Attorney General), 2015 SCC 5.
2. Vincent D. Most Canadians support assisted death ruling, poll shows. Toronto Star. February 13, 2015 (http://www.thestar.com/news/canada/2015/02/13/most-canadians-support-assisted-death-ruling-poll-shows.html).
3. Airedale NHS Trust v Bland [1993] 1 All ER 821 (H.L.).
4. R. v. Morgentaler [1988] S.C.R. 30.
5. Eggerston L. Most palliative physicians want no role in assisted death. CMAJ 2015; 187(6):E177.

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