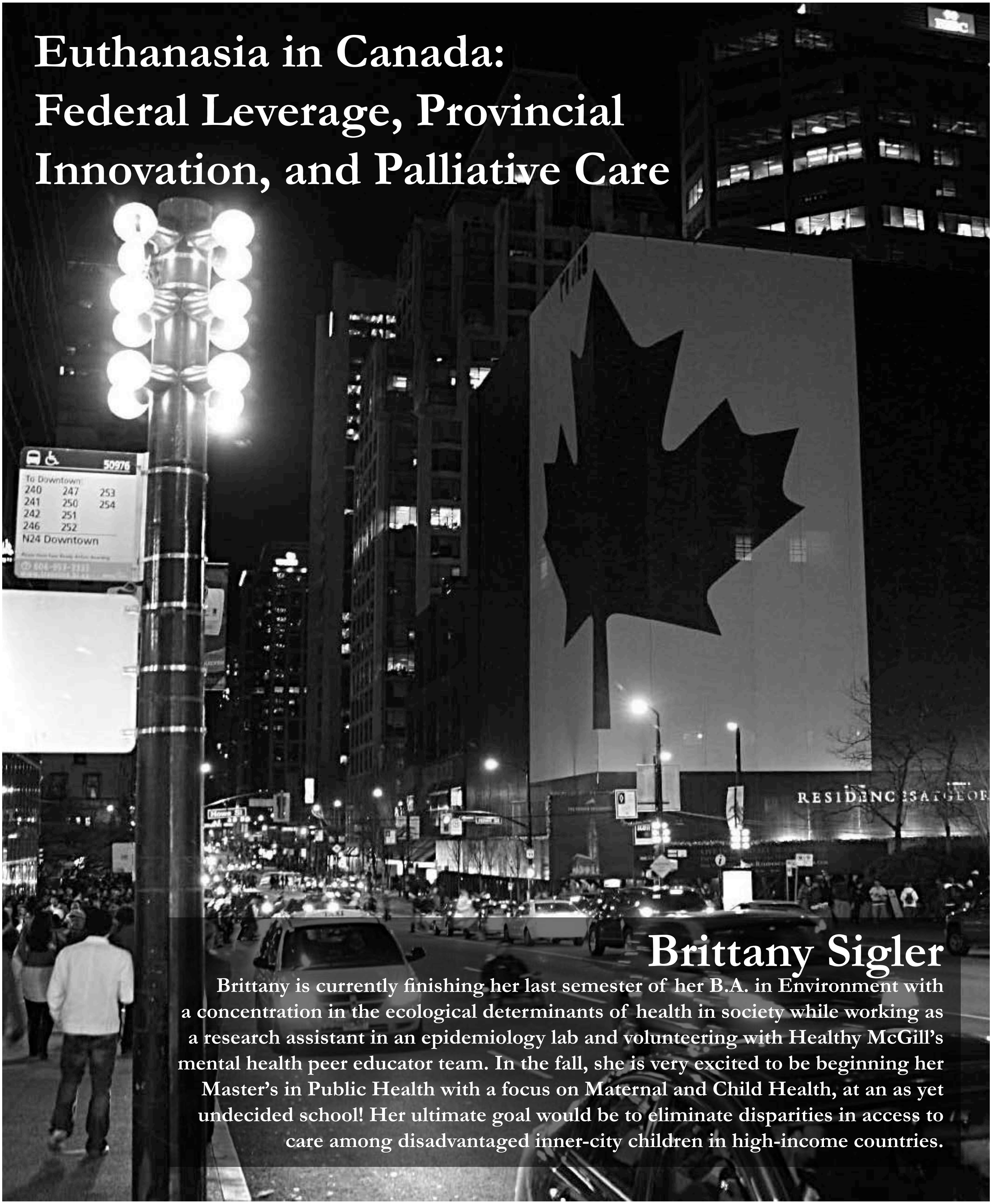
Euthanasia in Canada: Federal Leverage, Provincial Innovation, and Palliative Care



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Introduction

In 2010, Canadians older than 65 represented slightly more than 14% of the population, yet they consumed 45% of provincial and territorial government health care dollars (Canadian Institute for Health Information [CIHI], 2012). While CIHI's National Health Expenditure Trends show consumption has been growing slowly, more importantly, it is growing consistently. Due to the aging of baby boomers, the largest demographic in Canada, in the near future the health care system will have to cope with a senior population that is larger than all other age groups combined, a challenge that has never been met before (CIHI, 2012). One consequence is that there will be a greater number of people vying for limited palliative care beds in insured hospitals. Having foreseen this problem, the Honourable Michael J. L. Kirby's authoritative 2002 report tenaciously advocated for an expansion of public health insurance coverage to benefit palliative home care, catastrophic prescription drugs, and post-hospital home care (Canada. Parliament, 2002).

While in-hospital palliative care services are required to be covered by public health insurance, the Honourable Senator Sharon Carstairs noted in her detailed report pushing for palliative care reforms and improvements that at least 70% of Canadians do not have access to palliative care, and that when there is access, it is not equitable (2010). Significantly, Carstairs wrote that: "There are still Canadians dying in needless pain because health care providers do not know what a good death is" (2010). Provinces responded to her call for change very differently- the Western provinces developed palliative drug care programs, while Quebec is currently proposing a bill that regards euthanasia as an expansion of palliative care (Canadian Virtual Hospice, n.d.).

While both responses aim to make the end of life as comfortable as possible by expanding available treatment options, euthanasia, the act of purposefully ending a person's life to eliminate suffering , has been considered highly politically and ethically contentious. Opponents to euthanasia typically ascribe to one, some, or all of these lines of reasoning: killing is wrong and disregards the fundamental social value of respect for life; euthanasia requires subjective judgment on quality of life; society's most vulnerable are at risk of abuse; euthanasia can become an option when other resources are absent; euthanasia of competent people can lead to a slippery slope of assisted suicide for the incompetent, (i.e., without appropriate informed consent); and practice of euthanasia could obviate advances in palliative care (Butler et al. 2013). As of now, euthanasia, often discussed in tandem with doctor-assisted suicide, is illegal in all of Canada. However, in Belgium, the Netherlands, and Luxembourg it is part of medical care and therefore considered an issue of health, not of crime (NHS, 2012). Indeed, the greatest challenge inherent to the legalization of euthanasia is success in categorization of the practice as health-related.

Due to the federal involvement in previous efforts to pass laws similar to Quebec's, the issue of euthanasia – hotly debated in mass media as well as political circles – is a fascinating embodiment of the persistent power struggle between Ottawa and the provinces, especially in the realm of health care decision-making and accountability. Moreover, this issue presents the opportunity to examine whether the historical precedent will persist – especially after the institution of the Canada Health Act – of provinces individually undertaking innovative health reforms without national backing, yet prove so popular and successful that they are eventually adopted by the rest of the country with federal support to boot.

Policy Alternatives

There is a feeble delineation between euthanasia and assisted suicide, whereby an act of euthanasia requires the physician, or another designated individual, to administer the lethal therapy, while assisted suicide – sometimes considered within the realm of passive euthanasia – implies that the patient administers the therapy that a physician has prescribed for them. Quebec is the midst of legalizing the former, while Oregon has permitted the latter for sixteen years.

Quebec is the most recent province to challenge the reigning Canadian position on euthanasia – which was securely established by the case of *Rodriguez v. British Columbia (Attorney General)* [1993] – by tabling the radical Bill 52, "An Act respecting end-of-life care" (2013). This heavily controversial piece of legislation is trying to bypass previous opposition (based on the criminality of assisted suicide) by making health care and the administration of justice its central focus, both domains are distinctly under provincial control (CIHI, 2013). Although Bill 52 has bipartisan political support, it also receives much opposition: Catholic and other religious groups are vehemently against it; the Canadian Medical Association is officially opposed despite mixed member opinions regarding euthanasia; and Rhona Ambrose, the representative of the federal government on the topic on account of her positions as federal Health Minister and head of Health Canada, has issued unsupportive statements based on the principles of the Criminal Code, especially after the rejection of a similar federal bill (Canadian Medical Association, 2013; Canadian Medical Association, 2007; Perkel, 2013).

This bill is intriguing for its proposal to embed euthanasia within a framework of improved palliative care. Given the aforementioned complaints in Canada about inadequate end-of-life care, the purpose of this bill is: "to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy and to recognize the primacy of wishes expressed freely and clearly with respect to end-of-life care" (Bill 52, 2013). Through the establishment of a continuum of care from 'cradle to grave,' as it is so often demanded, this piece of legislation aims to prevent and relieve suffering up until a patient's death. Bill 52 (2013) does this by setting forth precise conditions for terminal palliative sedation and "medical aid in dying," including requirements which must be met before the physician's administration of a lethal treatment; the rules for an advance medical directive to have binding force; and establishing a council to oversee such decisions. Significantly, such treatment can only be provided if a capable, informed patient suffers from an advanced, incurable, serious illness that is inflicting "constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable" and the patient voluntarily submits an oral and written request for medical assistance to die ("Bill 52," 2013). The bill therefore establishes an entire framework for euthanasia within the confines of palliative care, after all other methods for alleviating such pain have proven futile, short of unnecessary aggressive treatment.

A parallel American policy proposal that brings euthanasia into the medical sphere is Oregon's Death with Dignity Act, originally proposed in 1994. This law allows terminally ill, competent, informed adult Oregon residents to self-administer physician-prescribed lethal doses of medication. This can only take place after such a patient voluntarily voices his desire to die, subsequently makes a "written request for medication for the purpose of ending his or her life in a humane and dignified manner" in accordance with this Act, a prognosis of life expectancy of six months or less is confirmed by a consulting physician, and a minimum of 15 days later the patient orally expresses this wish a second time ("Oregon's Death with Dignity Act," 2005). The goal of Oregon's Death with Dignity Act (DWDA) is to promote patient autonomy to the greatest possible extent by providing the opportunity to choose how and when to die given that the aforementioned conditions are met. Securing this right for Oregon residents is portrayed as the means to the provision of all existing options to relieve suffering at the end of life. It is also a means to overcome the "beneficent paternalism" and authoritarianism that is inherent in western medical treatment, particularly with regards to current notions of consent (Hughes, 2006; Veatch, 1995).

The focus on choice has resonated with the Oregonian public. Voters passed the law in two separate referendums – with increased support in the second – yet just 0.2% of all Oregon deaths were accountable to the law in 2012, the year with the greatest amount of prescriptions for lethal doses of medication (Proposition 16, 1994; Proposition 51, 1997; Oregon Public Health Division, 2013). While religious-oriented groups like Physicians for Compassionate Care have opposed the Oregon law based on the "slippery slope" argument, several initial opponents have admitted that the predicted abuses have not emerged (Schwartz and Estrin, 2004). Consequently, the 9th Circuit Court ruled against the claim by former Attorney General John Ashcroft, the law's most vocal dissident, that the law did not hold a legitimate medical purpose and that doctors were illegally prescribing federally-controlled drugs (Gonzales v. Oregon, 2006). In fact, no referrals were made to the Oregon Medical Board in 2012 for failure to comply with DWDA requirements (Oregon Public Health Division, 2013).

Policy Analysis

Quebec's Bill 52 and Oregon's Death with Dignity Act have the common aim of viewing euthanasia as a viable component of end-of-life medical care. The key difference is that Quebec is emphasizing the expansion of what a doctor can do for their patients and Oregon is focusing on increasing the power of patients themselves. This distinction, however, is very nuanced and very much a matter of semantics. While both policies 'medicalize' such treatments and both provide ample safeguards to avoid abuse of the laws, which historically have been the biggest obstacles to acceptance, there is a more obvious distinction to be made. Oregon's successful implementation of its program occurred in a jurisdiction dominated by private health insurance and considered the sixth best palliative service provider in the United States in terms of hospitals offering end-of-life care, while Quebec has an inclusive political landscape that struggles to ensure equitable access to its publicly funded and universally covered palliative care (Center to Advance Palliative Care, 2011; Santé et Services sociaux, 2004; Canadian Cancer Society, 2013). Because a physician is not required to be present when a patient ingests the lethal drug cocktail according to DWDA, there are no barriers to dying at home, which was the locale of choice for 95% of all DWDA users and is considered the best possible scenario for one's death as stated by 69% of Quebecers (Oregon Public Health Division, 2013; Canadian Cancer Society, 2013). Given that palliative care encompasses "whole-person health care that aims to relieve suffering and improve the quality of living and dying" in all settings as of the diagnosis of a fatal condition, fulfilling the desires of the dying would be integral to successful palliative care (Carstairs 2010). Quebec's decision to implement a euthanasia policy prior to revamping its existing palliative health care sector seems drastically rash: 82.7% of Quebec deaths occur in hospitals, and at best, 1 in 2 people have access to palliative care (Statistics Canada, 2013; Canadian Cancer Society, 2013). That is to say, most Quebecers die in a hospital, but they are not receiving adequate end-of-life care despite eligibility. Bill 52's promise of universal funding through provincial Medicare is irrelevant in the absence of palliative care, as there is effectively no other environment where a patient can discuss the concept of euthanasia given it is far from the scope of acute care. In complete contrast, 90.4% of all DWDA patients who died were enrolled in hospice programs at the time of their death, exposing them to the notions of managing one's own death and developing one's ability to cope with it (Oregon Public Health Division 2013, Carstairs 2010).

Assuming access to quality palliative care services, the health care system would stand to greatly benefit from either of the policies presented above. In Carstairs' most recent report on end-of-life care in Canada, she explained that effective palliative care can lead to less stays in the intensive care unit and lower pharmacy costs; decreased hospital costs through decreased lengths of stay and unnecessary tests; and efficiently coordinated care transitions (2010). Indeed, in a literature review on the cost-effectiveness of palliative care by the Canadian Hospice Palliative Care Association, it was found that hospital-based palliative care can save the health care system an average of between $7,000 and $8,000 per patient relative to the cost of dying under acute care, which is the usual scenario (2012). Moreover, savings were found to be greatest for patients dying from a terminal disease (Canadian Hospice Palliative Care Association, 2012). Considering this enormous financial drain on limited healthcare funds, palliative care has the potential to significantly reduce consistently growing health expenditures; this could garner widespread political support as more of the population moves into the older age groups (CIHI, 2012; Butler et al., 2013). Although there is an extraordinarily delicate balance to be made between sustaining life and cost-containment in the health care sector, it is inarguable that euthanasia and/or physician-assisted suicide will contribute to the expenditure-reduction inherent in improved palliative care. Quite bluntly, if a patient decides they would like to pursue euthanasia or physician-assisted suicide, and is eligible according to the law to do so, they will no longer require the numerous other interventions that were previously required to make their life more comfortable. Furthermore, in addition to the cost-containment advantages of these policies, Canada stands to reap further gains from the introduction of either policy considering its health care system is currently notorious for its paternalism (Veatch, 2006). Since the Canadian health care system struggles to respond to the demands of its users, like all publicly insured systems funded through general taxation, presenting euthanasia and physician-assisted suicide as choices for the dying has the capacity to inject much coveted responsiveness into Canada's health care system (Fierlbeck, 2011).

Analysis

Despite several federal recommendations for improved palliative care, and the Senate's critique of the lag in development of the principles, expertise, and medical infrastructure needed to care for people facing death, euthanasia and physician-assisted suicide laws are liberal policies for a progressive society that has the infrastructure to support it (Parliament. Canada, 2000; Canada. Parliament, 2002; Carstairs, 2010; Canadian Medical Association, 2007). Euthanasia cannot be a viable solution to this problem in a jurisdiction without established quality palliative care services (Canadian Medical Association, 2007; Carstairs, 2010). Currently neither policy is logistically feasible in Canada due to the state of its palliative care, especially due to the absence of a pan-Canadian framework for end-of-life services. Yet this can be achieved, according to the Honourable Senator Sharon Carstairs, through the development of: "a culture of care, building capacity, support for caregivers, integration of services, and leadership" (2010).

Both policies are politically feasible given the strong incentives of improved cost-containment and responsiveness, two qualities that rarely are found within the same healthcare system. Conditional upon strong regulation against feared abuses by both physicians and relatives towards vulnerable individuals, the political will is present in Quebec and elsewhere in Canada. British Columbia already passed legislation supporting euthanasia that was subsequently overturned by the courts, demonstrating that euthanasia is a resonant issue across the country (*Carter v. Canada (*Attorney General), 2013). A notable setback to the adoption of policies that permit intended death as a medical practice is that there has not yet been a policy that can act as a benchmark for further cross-country development, as has been the case with Oregon's Death With Dignity Act in the United States. Given the political history, especially the rejection of federal bill C-384 proposing the legalization of euthanasia in 2009, Quebec's bill appears to be more feasible than Oregon's Act because it safely ensconces euthanasia as a medical issue in the hands of physicians, as opposed to a criminal one in the hands of the courts, and is pointedly trying to change the Medical Act and not the Criminal Code. Based on past Canadian efforts, a clause similar to that of the Oregon Act that allows patients to ingest their prescription without medical supervision would be enough to have such a proposed policy overturned. Still, before Quebec or any other province could implement a policy that allows intended death, the jurisdiction in question would need to ensure widespread public support due to its highly controversial nature, as Oregon was forced to accomplish with its referendums.

In a secular society, law and medicine are the institutions that determine the main societal values. If one of these policies were to be implemented in Canada, it would prompt questions of whether these institutions value life, as they permit doctors to kill their patients. The public would need to agree that the decision to include euthanasia within palliative medical care is about providing in the words of the Minister spearheading Quebec's Bill 52, an "'exceptional answer to exceptional circumstances of exceptional suffering that cannot be alleviated'" (Hamilton 2013).

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