Legalization of assisted suicide and the risk of non-voluntary or involuntary euthanasia among vulnerable persons

[Excerpted from *Carter v Canada (Attorney General)*, 2012 BCSC 886 (CanLII)]

2. Do the safeguards effectively prevent abuse of vulnerable individuals?

[661] Professor Battin's opinion with respect to the efficacy of safeguards is captured in this statement:

> In the past, debates about the risks and benefits of legalization have been based on theory and conjecture. However, we now have years of empirical knowledge about the effects of legalization in Oregon and the Netherlands in practice. The empirical data collected from these jurisdictions demonstrates that a legal process can be contained. The empirical data demonstrates that no or little substantive abuse has occurred. None is reported in Oregon, and much, much less than has been claimed occurred in the Netherlands. In my opinion, the opposition to legalization of physician-assisted dying based on "slippery slope" arguments that predict wholesale abuse of assisted dying legislation is utterly unfounded; the objective data available from jurisdictions where legalization has taken place simply do not support these predictions. Further, in my opinion, opponents' presentation of data from Oregon and Netherlands is generally incomplete, frequently filled with factual inaccuracies and distortions, and often meant to construct a false empirical foundation for what is essentially a moral opposition to the practice of physician-assisted death.

[662] With respect to the Netherlands and Oregon, the Battin et al. Study provides evidence (with varying degrees of strength) that the availability of assisted death in those jurisdictions has not inordinately impacted persons who might be seen as "socially vulnerable": elderly, female, uninsured, of low educational status, poor, members of racial or ethnic minorities, physically disabled or chronically but non-terminally ill, minors or mature minors, or psychiatrically ill (including depression). Their data show that people with AIDS exhibit a heightened risk, but the data pre-date the development of highly active antiretroviral therapies.

[663] The study, however, does not address the question of persons who are "situationally vulnerable" due to the factors identified by Baroness Finlay, such as: personality, emotional distress, untreated symptoms, coercion or the desire not to be a burden.

[664] The Battin et al. Study was also criticized by some of the defendants' witnesses. Dr. Pereira spoke from his deep and sincere conviction that assisted death is wrong and unnecessary in the light of the availability of modern palliative care. He was straightforward but he did not have the benefit of having conducted empirical research of his own; he basically relied on the work of others, including that of Baroness Finlay. She is a very well-respected palliative care physician who has taken a leading role in the debate about assisted suicide and euthanasia in the United Kingdom. So far as I am aware, she and her collaborators in the critique have not themselves conducted an empirical study. Dr. Hendin is a psychiatrist and a leader in suicide prevention, but has not done the same kind of empirical work. Further, his testimony on cross-examination, and his passion on the topic, left me in some doubt as to his impartiality.

[665] I have carefully reviewed the critique made by Baroness Finlay and others of the Battin et al. Study, and I find that the study withstands that critique.

[666] I have considered the study, the critique and the cross-examinations, as well as other evidence (such as that of Ms. Jackson, Dr. Bentz and others) bearing on whether the experience in Oregon and the Netherlands supports the fears of those who argue that the availability of consensual assisted death will lead to the imposition of assisted death on vulnerable persons.

[667] I accept that the conclusions stated in the Battin et al. Study are soundly based on the data. I find that the empirical evidence gathered in the two jurisdictions does not support the hypothesis that physician-assisted death has imposed a particular risk to socially vulnerable populations. The evidence does support Dr. van Delden's position that it is possible for a state to design a system that both permits some individuals to access physician-assisted death and socially protects vulnerable individuals and groups.

[668] No conclusion can be drawn from that study with respect to situational vulnerability. However, there is some evidence bearing on that question.

[669] First, depression is a factor that may enter into decision-making about assisted death. Although many patients are screened out because of depression, Dr. Ganzini acknowledges that it is virtually impossible to guarantee that a person whose decisional capacity is affected by depression will not slip through the safeguards designed to reduce that risk.

[670] It seems unlikely that persons suffering from Major Depressive Disorder or depression causing impaired judgment would both have the persistence and will-power to work their way through the approval process for assisted death, and escape detection by the reviewing physicians. However, the evidence (from the Ganzini Depression Study) suggests that up to three persons in Oregon may have done so.

[671] Second, patients may have received assistance in death after experiencing subtle or overt pressure, facing unconscious suggestions by caregivers that their circumstances are hopeless, or sensing that they are a burden on their families. It is impossible to know from statistical evidence whether this has occurred, or how often. However, the evidence from both Oregon and the Netherlands about actual decision-making practices does not support the conclusion that pressure or coercion is at all wide-spread or readily escapes detection. Dr. Ganzini, for example, who studied the decision-making process, said that the involvement of family members was usually to try to dissuade rather than persuade patients from seeking assisted death. That most patients in Oregon are in hospice care and that the decision-making process in the Netherlands involves extensive deliberation with a long-term family physician suggest that it is unlikely that many patients successfully obtain a physician-assisted death because of outside pressure to do so. The incidents referred to by Dr. Hendin and others cannot be disregarded, but, on my reading of the evidence, are highly isolated.

[672] With respect to Belgium, it is difficult to reach any firm conclusion. In cross-examination, Professor Deliens acknowledged that patients who do not have a psychiatric disorder but who have some level of depression might be vulnerable to being euthanized. He

also acknowledged that patients with cognitive impairments such as dementia might be vulnerable. However, I note Professor Deliens's evidence that the Chambaere et al. Population Study does not show elderly patients or patients dying of diseases of the nervous system (including dementia) to be proportionately at greater risk of LAWER than other patient groups.

3. What inferences can be drawn with respect to the likely effectiveness of comparable safeguards in Canada, given different cultural contexts?

[673] I will discuss in the next section of these Reasons the feasibility, in general terms, of safeguards based upon the application of criteria such as a patient's competence and the voluntariness of a request for physician-assisted death. At this point, however, having spent some time reviewing the evidence about the experience in permissive jurisdictions, I will note some of the reasons why it is necessary to be cautious about drawing inferences for Canada.

[674] The utility of considering the experience in other jurisdictions depends upon whether there are sufficient similarities between those jurisdictions and Canada to permit inferences to be drawn.

[675] Oregon, Washington, the Netherlands and Belgium are all relatively prosperous Western democracies.

[676] However, though Oregon and British Columbia are geographically proximate, their cultural contexts and methods of health care delivery differ in some ways.

[677] The evidence suggests that palliative care practices in Oregon differ from those in Canada. According to Dr. Ganzini, hospice care is delivered in patients' homes in Oregon. The evidence of Dr. McGregor and Carolyn Tayler (the Director, Clinical Programs End of Life Care for Fraser Health Authority) is that such care, in British Columbia at least, is provided in a broader range of settings, whether in the home, in hospitals, in hospice or in residential care. However, I do not view the differences between Oregon and British Columbia, including the differing ways of delivering palliative care, as very significant in this specific context. Indeed, it may be easier to achieve compliance when most palliative care patients are in an institutional setting (permitting greater monitoring) rather than in their homes.

[678] The overall practice of medicine is different in the Netherlands and in Belgium than in Canada, with a much greater likelihood in those countries that a patient will have a long-term relationship with a family physician. I do view that as a significant difference, and will return to it in the next section of these Reasons when discussing assessment of competence and voluntariness.

[679] One of the striking aspects of the evidence is that the practice of what could be called non-voluntary euthanasia (LAWER) continues in both the Netherlands and Belgium. Dr. Hendin, in his cross-examination, suggested that a possible explanation is that there is little or no enforcement of the law against it, and physicians have a strong position in those cultures, such that they feel able to disregard the law. He opined that it is different in the

United States, including in Oregon. As well, in the Netherlands, the judicially-developed defence of necessity continues to apply to some cases of euthanasia.

[680] The evidence suggests (I refer to Dr. Kimsma, Professor Deliens and Dr. Bernheim) that the practice of physician-assisted death existed for some years prior to the euthanasia debate in the Netherlands and in Belgium. There is no evidence suggesting a comparable history in Canada. Indeed, it appears that, with very few exceptions, Canadian medical practitioners are compliant with the current absolute legal prohibition of assisted death, suggesting that physicians would also be compliant with any regulatory regime concerning the practice. Thus, it seems particularly problematic to draw inferences about the likely level of compliance with legislated safeguards in Canada from evidence about Belgium and the Netherlands. In other words, the evidence about non-compliance and LAWER in Belgium and the Netherlands may not tell us much about what would happen in Canada if physician-assisted death were made legal. This is because, in Canada, it would not be a question of attempting to regulate a pre-existing and fairly prevalent practice.

[681] It must also be recognized that the way that regulations are drawn will affect their effectiveness and enforceability. For example, in Oregon, the regulation prohibits issuing a prescription if the patient may be suffering from a psychiatric or psychological disorder or depression <u>causing impaired judgment</u>. Dr. Ganzini's evidence suggests that a more cautious approach would have been to prohibit lethal prescriptions for anyone who is depressed, without qualification.

[682] Overall, the evidence permits the following conclusions.

[683] First, cultural and historical differences between the Netherlands and Belgium, on the one hand, and Canada on the other, mean that possible concerns about the level of compliance with legislation in those countries do not necessarily transpose into concerns about Canada. The experience of compliance in Oregon is more likely to be predictive of what would happen in Canada if a permissive regime were put in place, although even there only a weak inference can be drawn.

[684] Second, the expert opinion evidence from persons who have done research into the question is that, with respect to all three jurisdictions, the predicted abuse and disproportionate impact on vulnerable populations has not materialized. Again, inferences for Canada can only be drawn with caution.

[685] Third, although none of the systems has achieved perfection, empirical researchers and practitioners who have experience in those systems are of the view that they work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths.

[…]

a) Elderly people

[844] The existence of elder abuse in Canada has been noted by the Parliamentary Committee on Palliative and Compassionate Care, which called it “Canada’s hidden crime”. Dr. Donnelly testified that between 4% and 10% of Canadian seniors experience some form of abuse or neglect from someone they trust or rely on. Abuse can be physical, psychological or financial, and can impact a person’s emotional and social well-being. She agreed on cross-examination that an abusive living situation could influence a patient’s medical decision making, and that it could do so in a manner that escapes detection by a physician.

[845] As well, as has been described, assessing cognitive impairment and accurately diagnosing depression in elderly people is challenging. In Professor Heisel’s opinion, family physicians have difficulty identifying late-life depression and typically do not assess suicide risk in older adults. He says that many clinicians fail to recognize that expressing a desire to hasten death can reflect underlying emotional distress or suicidality that can be palliated by mental healthcare. On cross-examination, Professor Heisel agreed, however, that MDD could be diagnosed in the context of a physician-assisted dying decision so long as a relationship was established and a thorough assessment conducted.

[846] Professor Bernheim says that in Belgium the majority of those whose lives are terminated without consent are over 80 years of age. Professor Deliens and his co-authors wrote in the Chambraere et al. Trends Study:

> Third, however, our findings show that some patient groups are particularly at risk of substandard decision-making. Especially for older patients, hospital patients, and non-cancer patients with unpredictable disease prognoses, advance care planning is recommended, either with the patient before she or he becomes incapacitated or with relatives in case of patient incompetence.

The authors suggest that protocols or professional practice standards for advance care planning are likely to improve end of life decision making.

[847] I accept that elderly persons are vulnerable to abuse and that the assessment of voluntariness of elderly people must incorporate an understanding of that reality. As discussed earlier, however, there is no evidence that the elderly access physician-assisted dying in disproportionate numbers in permissive jurisdictions (Professor Battin, Dr. Ganzini, Dr. van Delden, Professor Deliens), and Professor Deliens observed that the number of patients over the age of 80 whose deaths resulted from LAWER in Belgium was not disproportionate.

b) People with disabilities

[848] Professor Frazee, David Martin and Rhonda Wiebe provide evidence, based upon research and upon their personal experience, supporting the concern that persons with disabilities would face particular risks if physician-assisted death were to be permitted. For example, Ms. Wiebe deposes:

> It is not uncommon for me to hear people without disabilities, and people who have recently acquired a disability, express the belief that they would rather be dead than live with a disability.
>
> In my experience, the idea that it is better to be dead than disabled is an able-ist perception that is deeply embedded in our social conscience. ...
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> People with disabilities are often, in my experience, pitied and considered to be powerless and helpless. Furthermore, such able-ist social conditioning equates disability with pain, sickness, frailty, incapacity, de-humanization, and poor quality of life.

[849] Professor Frazee's extensive work in human rights and disability rights has included research in the particular area of the risks that physician-assisted dying poses for people with disabilities. She notes that the disability community has struggled with the question whether the availability of physician-assisted death would be of benefit to disabled persons. She states her opinion that the availability of that option would put many disabled people at risk.

[850] Professor Frazee also believes that the discourse of physician-assisted dying reinforces public prejudice and stereotypes about disability. She says that support for physician-assisted dying is linked to a fear of disability and the devaluation of the lives of disabled people. Yet, she says, the discourse does not necessarily reflect the subjective reality of a disabled person's experience:

> Disability prejudice and stereotype are embedded in the discourse around physician assisted suicide. Loss of control of bodily fluids is repeatedly and emphatically represented as a catastrophic assault of *suffering and indignity*, such as to render life no longer worth living. Loss of mobility and diminished capacity for independent self-care are consistently described as a *stripping away of dignity*. Despair and surrender are uncritically accepted as the only possible response to a hopeless predicament – a predicament invariably associated with social shame. Yet the link between dignity and instrumental physical autonomy is not absolute. It is subjective and highly variable.
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> [Emphasis in original.]

[851] She states the opinion that disabled persons face significant challenges within the medical system, including those posed by physicians who lack exposure to a disability perspective on fundamental questions of ethics and practice. Thus, physicians in particular, and medical professionals in general, consistently and dramatically underestimate disabled patients' quality of life. She says that the ambivalent relationship between the medical professions and people with disabilities would not become less difficult, ambivalent or troubled if medical professionals could legally terminate disabled persons' lives. She expresses concern that disabled persons may not be supported to resist suicidal tendencies:

> Most people who express suicidal wishes are strongly supported to resist self-destructive impulses. I have little confidence that would be the case for persons whose quality of life has been judged by others to be unacceptable. Moreover, I have concerns that the cultural scripts that narrate disabled lives as heroic will be transformed to hold out an elusive promise of esteem, for

persons willing to sacrifice their own lives so that others will be spared the burden of caring for them.

[852] However, there is no evidence that persons with disabilities are at heightened risk of accessing physician-assisted dying in jurisdictions where it is permitted. The Battin et al. Study found that there was no evidence of heightened risk of physician-assisted death in Oregon or the Netherlands for individuals who were physically disabled or chronically ill (except for, possibly, persons with stigmatized diseases, specifically AIDS). Professor Deliens testified that although the survey of physicians in Belgium did not specifically ask about disabled patients, the information was available from the coding on the death certificates and the researchers saw no cases of euthanasia of disabled persons.

[853] I accept that persons with disabilities face prejudice and stereotyping and that there is a risk of unconscious bias about the quality of life of a person with a disability. However, while I accept Professor Frazee's evidence and take into account the submissions of the defendants and the Euthanasia Prevention Coalition, I am not persuaded that the risks to persons with disabilities are such that they cannot be avoided through practices of careful and well-informed capacity assessments by qualified physicians who are alert to those risks.