

The case for physician-assisted dying

Written by Tristan Bronca on June 3, 2016 for CanadianHealthcareNetwork.ca

Discussed: Suicide as a rational act; the betrayed family member; the depressed person; and the capacity for a patient to change their mind



Vancouver psychiatrist Dr. Derryck Smith testified in favour of physician-assisted death in the Kay Carter case

Dr. Derryck Smith's advocacy for physician-assisted dying began after he witnessed first-hand the prolonged deaths of both his mother- and father-in-law. "They both took about five years to die and it was the most miserable time in their life," he said. When he spoke to the *Medical Post* he recalled how his father-in-law had repeatedly asked him for help dying. He couldn't then, but Dr. Smith made a promise that he would do his best to help change the law.

That's how he became involved with Dying with Dignity Canada. Now a board member for the national body, he's debated anti-euthanasia advocates such as Dr. Will Johnston in several settings (read Dr. Johnston's Q&A [here](#)). He also testified against the Euthanasia Prevention Coalition before the Supreme Court in the landmark [Carter case](#).

"Euthanasia comes from the Greek word meaning 'good death' so I really have a hard time with a group that is

opposed to people having a good death,” he said of the Euthanasia Prevention Coalition. In our interview, he responded to concerns about suicide as a treatment and discussed why he believes the new legislation doesn’t go far enough.

Q. I wanted to ask you about the federal legislation that they’re trying to push through. I know it’s been criticized by a lot of assisted-death advocates as being too restrictive. What’s your position?

We want the principles outlined in the Carter decision. A person cannot be forced to take treatments they do not agree with and they get to define whether they are enduring unbearable suffering. With C-14, they’ve thrown in some language that suggests a person needs to be terminally ill or that their death is reasonably foreseeable. I have no idea what that language means. I would reflect that in 50 years, it’s reasonably foreseeable that I will be dead.

The Carter decision was also pretty clear that it should include people who were suffering from psychiatric ailments and that was recently upheld in the [Supreme Court of Alberta](#) and the Alberta Court of Appeal. C-14 is purporting to exclude psychiatric patients and study it down the road.

The final thing is that (Parliament’s) special joint committee had recommended the provision of advanced directives that would let competent individuals decide that if they developed dementia they could still take advantage of physician-assisted dying. That did not make it into C-14 either.

Q. There are a few things you mentioned there that I want to touch on, but first you took issue with some of the wording. “Foreseeable,” for example. Doctors have also said that terms like “grievous” and “irremediable” are also unclear. Just wondering if you feel some of those terms are clearer than others?

Well “grievous and irremediable” I think is pretty clear and doctors will have no difficulty adjudicating that.

We have to keep in mind, too, that this is not about doctors and doctors’ attitudes. It’s really about what patients want. Doctors are involved in this because we are the only group that has access to life-ending medication and if it wasn’t for that, doctors might not be involved at all. This is about patient autonomy, in other words the ability of individuals to have control over their life and, in these cases, over their death.

Q. That’s another point of contention. When [we interviewed Dr. Johnston](#) from the Euthanasia Prevention Coalition he suggested it was disingenuous to frame it as a question of pure autonomy because there are other factors at play. There’s the family, questions of physician conscience, the possibility of mistakes. How do you mitigate those surrounding factors?

Competent adults do not need the agreement of their family to make all kinds of decisions in life. Although a psychiatrist such as myself spends a good deal of time trying to prevent suicide in psychiatric patients, suicide in and of itself is not illegal, and people who access physician-assisted dying in jurisdictions such as Oregon have clearly stated their desire to have control over how and when they die. I think that is a principle that resonates with the vast majority of Canadians.

Q. But you just said yourself that suicide is an avenue to be avoided as a course of medical treatment. Even if it is legal.

There’s a philosophical issue over that: Can suicide ever be a rational act? I think the answer to that is yes. There’s a rich literature, at least from the field of psychiatry, noting that people can rationally decide that they no longer wish to be alive. Their desire to die is not a product of mental illness, it’s not a product of clouded judgment. They’re fully competent to make a decision and, according to Carter, they now have a charter right to do so.

Q. If psychiatric patients have a right to make that decision wouldn’t their illness affect their judgment? It seems impossible that it wouldn’t...

If the patient is competent then it really doesn’t make any difference what their diagnosis is. I’ve spent my whole life trying to make sure that psychiatric diagnoses are seen as part of medicine. They require medical treatment and those patients should have the same charter rights as those who do not have a primary disorder of the brain.

Q. Take someone who is seriously depressed and wants to die but is otherwise competent. You're not apprehensive about the possibility that they may now have access to a permanent solution for what may be a manageable condition?

It's an issue of patient autonomy versus physician paternalism. Should we as doctors take over the decision-making process for an otherwise competent individual? We let individuals make decisions, even bad decisions, because that's what autonomy is all about in our liberal society. So if the person meets the criteria from Carter—competent, grievously and irremediably ill, and suffering intolerably—I see no reason to exclude psychiatric patients from that.

Q. I want to get your thoughts on a story I heard out of Belgium that was written about in the [New Yorker](#). An elderly woman was dealing with some mental health issues after she had been widowed, and her estranged children later learned that she had ended her life with the help of a doctor. They hadn't been made aware of their mother's decision beforehand and they felt betrayed. Is it right to exclude all these other parties, assuming the patient meets all the other criteria?

This is a momentous decision and ideally family members should be involved. I can almost guarantee that if this woman wanted her family involved, the doctor would have involved them. But when this woman says to the doctor, "I really don't want my family involved," it's my view that the doctor is bound to respect her ability to make a decision herself, assuming she's competent to do so.

Q. What if she had a dependent? Does the state still have the same responsibility to abide by her wish to end her life?

The state has nothing to do with this other than setting the rules. It's the same as if someone were to refuse medical treatment, even when family members and doctors think the treatment might benefit them. It is the individual—not the family or the doctor—who makes these decisions.

Q. Palliative care. A lot of people are concerned that assisted death is going to become an alternative to good-quality palliative care. What are your thoughts on that?

I see them as being on a continuum and that's because even with the best palliative care, you're still going to die at the end. We know from Oregon there are a greater percentage of people who choose physician-assisted dying who have had palliative care than those who haven't. It's not one or the other. I'm in favour of better and better-funded palliative care but that's not going to detract from the fact that some people are going to want to die before they die of natural causes.

Now, the palliative care people are really big on something called terminal sedation and this means putting people into a coma until they die. I fail to see the real differences between that and having them die at a time and place of their choosing.

Q. I also wanted to ask about advanced directives. You have to acknowledge that it is at least possible for someone who is incapable of communicating their wishes to change their mind about a previous desire for physician-assisted death. How, if legislation is expanded to include advanced directives, could you account for such changes?

People who are in late-stage dementia do not have any capacity to make a decision or to change their minds. There is always a risk with advanced directives—which are legal and binding for all medical decisions except physician-assisted dying—that the person may change their mind. But the risk of not having advanced directives is that people will take their lives before they need to in order to avoid the risk of living with dementia. This is exactly what happened to [Gillian Bennett](#).

Q. Another concern raised by Dr. Johnston was that assisted-dying advocates have often used religion as a way to distract people from their arguments. Do you think religion is a fair target, so to speak?

I think we need to understand where the opposition comes from. The Catholic Church has been in the press on many occasions and has spent huge sums of money to defeat citizens' efforts to have physician-assisted dying brought into place in other parts of the world. I don't have any argument with the Catholics for following their own belief system. What I resent is efforts to impose their beliefs on the rest of us. That's my issue with religion.

Q. One final thing: Do you have any worries at all about this new law coming into effect, or do you feel that the safeguards that are in place are entirely adequate?

We don't have to guess. There are 11 different jurisdictions in the world that have physician-assisted death and there is no evidence of abuse of any groups. There certainly isn't in Oregon, where the people who access physician-assisted dying tend to be middle income or above and well-educated. There is no representation of so-called vulnerable groups. What's being proposed in Canada is even more stringent because you need two physicians and two independent witnesses, the witnesses being people who have no conceivable way from benefiting from the person living or dying. I believe that the vulnerable are much more likely to be taken advantage of in an unregulated environment than one in which we have legislation in place.

Edited for length and clarity
