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From Canada

Dr Jose Pereira The University of Calgary and the Foothills Medical Centre, Calgary, Canada

Dr Pereira is Alberta Cancer Foundation Professor of Palliative Medicine at the University of Calgary, Canada, and at the Foothills Medical Centre in Calgary.

In Canada, euthanasia and physician-assisted suicide are both illegal acts. The former is regarded as an act of murder and subject to a mandatory life sentence, while the latter is punishable by up to 14 years of imprisonment.

A public debate regarding 'euthanasia' was prompted approximately 10 years ago by a case that made its way to the Supreme Court of Canada. It involved a 43-year-old woman named Sue Rodriguez who was significantly incapacitated by ALS.[1] By a majority, the court declared that the provision against assisted suicide does not contravene the Canadian Charter of Rights and Freedoms, thereby upholding the illegality of physician-assisted suicide and euthanasia.

Following the ruling, a committee of the Canadian senate was set up to review the issue of euthanasia and physician-assisted suicide. In its final report, the committee highlighted the need for high quality palliative care and emphasized that the euthanasia and physician-assisted suicide debate can not be addressed appropriately without first providing access to high quality effective palliative care services to all patients requiring it.[2] In 2000, a follow-up committee of the Senate made specific recommendations on how to improve palliative care clinical services, education and research in Canada.[3] The approach taken by the Canadian Senate's reports resonates in the EAPC's call for the inclusion of palliative care as an integral component of the healthcare systems of all European countries.

In Canada, the attitudes of the general public and physicians appear to differ. In one large Canadian study, 51% of physicians stated that the law in Canada should be changed to permit patients to receive euthanasia, although only 28% of physicians reported that they would be willing to personally participate in such practices.[4] A slight majority of the public and terminally ill patients (50–60%) appear to support it.

Several Canadian studies have explored the determinants for desire for death.[5–7] Feeling hopeless and being depressed are important factors in predicting a patient's desire for death. About 60% of patients who had a genuine desire for death met criteria for clinical depression. Depression was a more important factor than pain. The 'will to live' is not a static construct and often fluctuates according to the patient's clinical progress and subjective experience of his/her symptoms. As a result, there is growing support for physicians to ask patients directly about suicidal thoughts or the desire to die. Such inquiry will be likely to decrease the patient's sense of psychological isolation and will demonstrate the care provider's willingness to engage in a frank discussion of the issue.

The euthanasia debate can be divisive. Opponents and proponents alike often make compelling and passionate arguments against or in support of euthanasia or physician-assisted suicide. The EAPC Task Force's views, rather than falling into the quagmire of 'right' versus 'wrong', are pragmatic, clear and appropriate. They set out clear guidelines but encourage ongoing informed debate. The challenge to the frequently used expressions 'passive', 'voluntary', 'involuntary' and 'non-voluntary' euthanasia is particularly welcome since these terms have lead to much confusion in the debate.

The Task Force's views regarding terminal or palliative sedation in the context of the 'euthanasia' debate are particularly timely in the Canadian context. Guidelines for the control of pain and for terminal sedation in intensive care units (ICUs) were recently published by an Ontario-based group of intensive care specialists.[8] This report has generated debate in healthcare and public circles. The Task Force's report distinguishes between palliative sedation and euthanasia and affirms the ethical justification for palliative sedation, provided certain conditions are met. (While the guidelines highlight the need for palliative care in the ICU setting, many in the Canadian palliative care community have expressed concern with some of the specific recommendations.)

References

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