



# DEBATES OF THE SENATE

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## CRIMINAL CODE

Bill to Amend—Second Reading of Bill C-225—  
Debate Continued

Speech by:

The Honourable Larry W. Campbell

Wednesday, December 10, 2014

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### CRIMINAL CODE

BILL TO AMEND—SECOND READING—  
DEBATE CONTINUED

On the Order:

Resuming debate on the motion of the Honourable Senator Nancy Ruth, seconded by the Honourable Senator Patterson, for the second reading of Bill S-225, An Act to amend the Criminal Code (physician-assisted death).

**Hon. Larry W. Campbell:** Honourable senators, I rise today to speak to this bill. It's probably no secret that I spent the majority of my adult life investigating death as a coroner for British Columbia, and the last four years as Chief Coroner; so I think I have some understanding of not only the process of death but also the sanctity of life. I would like to address three points today with regard to this bill.

The first point I want to make is that sometimes death can be in a patient's best interest. The value of life is great, but it is not infinite. When faced with a dire prognosis, some patients or family members will find strength in an old proverb: "Where there's life, there's hope." But this proverb is best interpreted as a prayer that things will get better, rather than as a literal statement that anyone with vital signs should be kept alive by any means.

Many religious authorities endorse the vitalist notion that all life is valuable. These same authorities also feel that it is wrong to prolong a life artificially to no end and they accept the limitations of life-prolonging treatments. Most accept the principle of double effect, which holds that a patient can receive comfort medications that have the potential to shorten life, so long as that is not the intention. People who accept that lives need not be prolonged indefinitely or that a life can be risked in the interest of comfort have implicitly accepted that life is not of infinite value. They recognize that compassion can sometimes be shown only through actions that might compromise lifespan.

Death is not an optional experience, and death in Canada is usually a predictable event following a chronic incurable illness. Given the choice, many people try to delay death, and some will seek out aggressive means of prolonging life, even when faced with a hopeless situation. Other patients have limited life-prolonging options and, although they remain cognitively intact, their quality of life and function deteriorate below the threshold that they would consider acceptable. These patients usually choose comfort-based care and are happy to wait for a neutral or a natural death.

However, some patients prefer not to wait for a complication to end their suffering. Several recent high-profile cases of Canadians with brain cancer, Alzheimer's and ALS have illustrated this. The patient is comfortable with the idea that they may be forgoing some period of life in the interest of comfort. They will not avoid death and might even seek it out, and everyone will feel a degree of relief when it arrives.

There may be a conceptual difference between actively assisting death and passively assisting death by withdrawing or withholding therapies; but both approaches are justified on the same premise. Death is in the best interest of the patient. The patient's interests are not affected by whether the outcome is achieved actively or passively.

Second, capable patients are well-positioned to determine when death is in their best interests. Many Canadians die in an intensive care unit, often as a result of a decision to withdraw or withhold life-sustaining treatments. Ideally, this decision comes from the patient himself or herself, and we are sure that this is what he or she wants.

In reality, we usually cannot involve the patient directly in the decision, and instead we rely on substitute decision-makers, SDMs, who are supposed to reproduce the decision that the patient would have made by considering advance directives or best interests.

Substitute decision-making is a flawed process. SDMs are inaccurate predictors of what a patient would want. Advance directives are uncommon and usually too vague or too specific to be useful for medical decisions. SDMs also have numerous potential conflicts of interest. If a patient dies, they may inherit some wealth. If a patient dies, they will not be burdened with the emotional and physical aspects of caregiving.

Despite all of these concerns about substitute decision-making, we continue to allow SDMs to decide when a patient should be allowed to die. If we are comfortable with this arrangement, why would we feel less comfortable acting on wishes communicated directly by the patient with none of these potential inaccuracies, misinterpretations or conflicts of interest?

Indeed, we are happy to respect a capable, terminally-ill patient's desire to receive palliative care and forgo life-prolonging therapy. We don't insist that they continue their chemotherapy until they die a natural death. We don't try to convince them that a ventilator will help them to find meaning in their life. We respect their ability to know when they've had enough. If a patient is allowed to decide when a passive death is in their best interests, why would he or she not be allowed to decide when an active death would be in his or her best interests?

Third, nobody's interests are served by denying patients the right to physician-assisted death. If we want to prevent a rational person from pursuing his or her best interests, we must have a strong justification for doing so.

The common argument used against legalization of PAD is framed as concern about the effects on vulnerable people, the availability of palliative care service and physicians as a group. None of these concerns are supported by data.

Data from the United States show that among patients who receive PAD, 95 per cent are white, 93 per cent are high school graduates and 97 per cent have some form of health insurance. Data from Switzerland show that the wealthier and better educated are more than twice as likely to receive assisted death

than the poorer and less educated, while institutionalized people are less likely to receive an assisted death than those living in a private residence. The people who receive PAD are not the vulnerable; they are, in fact, the privileged.

Palliative care services appear to have done well in jurisdictions that legalize PAD. Legalization of PAD is often accompanied by a larger strategy in funding to improve end-of-life services as described in the Netherlands and Australia's Northern Territory. In the United States, the three states that have legalized PAD by statute — Vermont, Oregon and Washington — are ranked first, sixth and eighth respectively in the nation for the availability of palliative care services in hospitals.

In 2010, *The Economist* ranked the basic end-of-life health care environment of 40 nations around the globe. Countries in which PAD is legal — Switzerland, Netherlands, Belgium, Luxembourg and the U.S. — ranked first, fourth, fifth, seventh and ninth respectively. Canada ranked twentieth.

Some physicians argue that legalizing PAD would compromise the physician-patient relationship. This is a difficult argument to sustain in a country where PAD is supported by 80 per cent of the population. Data from Oregon show that patients are more likely to become upset by physicians who oppose PAD than by physicians who support it.

Furthermore, the Canadian Medical Association essentially rejected this argument at its recent annual general meeting, where 90 per cent of members voted to support the right of all physicians within the bounds of existing legislation to follow

their conscience when deciding whether to provide so-called medical aid in dying.

Some have expressed concern that PAD would be a violation of the Hippocratic oath and suggested that a new profession of euthanasia practitioners should be created. We should remember that the Hippocratic oath has been modified extensively over the years to reflect changes in the laws and sensibilities of the time. Specifically, the prohibition on abortion and the implication that only males should be trained in medicine have both been removed from the original version.

Laws, policies and codes of ethics change over time. Certainly, many physicians now feel that providing PAD would be an extension of their duty of care when other means of therapy and treating end-of-life suffering have failed. Physicians can offer ranges of therapy beyond PAD, allowing an opportunity to relieve suffering through other means right up to the last moment.

What options would a euthanasia practitioner offer? Honourable senators, we have to debate this. We have to bring it out into the public and talk about it. We need to be respectful of everybody's views. This is not an issue that you can come down on one side or the other, I would say, solidly. We need to look at it and decide how we can help Canadians. We cannot ignore good science and good medical care. The overwhelming majority of Canadians want this debate to take place. I urge that you allow this to go to committee as soon as possible.

(On motion of Senator Verner, debate adjourned.)

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