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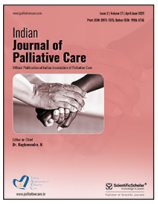

Short Communication

Regulating Death: A Brief History of Medical Assistance in Dying

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ABSTRACT

Unique reports of suicide and euthanasia date back more than 2 millennia, reflecting evolving philosophies of death and dying as expressions of the mores dominating a given era. One longstanding theme in the history of decisions to die has been staunch opposition founded in religious claims that one's body is a trust from the divine (and therefore not wholly in their ownership). The role of the physician has also been traditionally estranged from participation in such decisions, dating back to rudimentary conceptions of medical ethics in the Hippocratic notion *primum non nocere* ('first, do no harm'). However, fundamental principles in the modern philosophy of medicine lend support to the idea that physicians can be justified in actions which cause some harm, in so far as they are acting to fulfil a greater ethical imperative. This brief historical review explores the inception of modern North American medical assistance in dying (MAiD) policy through a series of critical case studies in the unfolding of its practice. Medically assisted dying has presently been legalised in Canada and some United States jurisdictions, but with critical caveats surrounding circumstances of mature minors, advance directives and mental illness as participants' sole underlying medical condition. While the modern regulations surrounding MAiD continue to take shape, the palliative care community is well-positioned to both guide and scrutinise the ethics of this practice.

Keywords: History, Medical assistance in dying, Philosophy of dying, Euthanasia, Suicide

In Athens, 399 BCE, the Greek philosopher Socrates – imprisoned and sentenced to death by hemlock on the charges of impiety and corrupting Athenian youth – famously raised a cup of the poison to his lips.[1] Descriptions of Socrates' equanimity at the end of his life, and of his refusal to escape this fate when the opportunity presented itself, have invited the question of whether Socrates' death was a case of euthanasia or suicide.[2] The distinction may seem peripheral, but we can imagine it likely to have been an important consideration for both Socrates and the jailer who provided his poison.

Medical assistance in dying (MAiD) is a modern name for an ancient idea, which has been a source of enduring contention for ethicists since the days of hemlock. The tools for suicide, euthanasia, and the expansive grey area between the two (ostensibly including MAiD) have evolved dramatically, but many fundamental questions have remained the same: who owns a life, and what are the ethical implications in advancing (or otherwise choosing not to delay) a death? The present article cannot, given its commitment to brevity, claim to offer a complete history of MAiD. Instead, it aims to introduce some of the answers to these questions through a historical lens by presenting a background for the philosophies of assisted dying, followed by several landmark cases in MAiD's development. This abbreviated history of MAiD's practice portrays how we can appreciate medical decisions regarding death and dying as expressions of the mores dominating any given era.

The Hippocratic Oath appears to contain a specific condemnation of MAiD: '(…) I will not give a drug that is deadly to anyone if asked (for it), nor will I suggest the way to such a counsel.'[3] Ancient Greek and Roman physicians did, nevertheless, sometimes offer such drugs to their patients for the purpose of euthanasia.[4] However, in the centuries to follow, many major religions opposed euthanasia for a variety of reasons. Among these were notions that life was a trust from God, and to shorten or prolong it would interfere with God's plan; that artificially shortening life could preclude admission to the afterlife or reincarnation; and that suffering may have a divine purpose which ought to be accepted.[5] St. Thomas Aquinas condemned suicide on behalf of the Christian church in the 13th century, claiming that its completion interferes with the natural inclination of self-perpetuation, injures communities, and violates God's authority.[6] Common Law similarly forbade suicide and physician-assisted suicide (PAS) in the British

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and French colonies that spread West to the Americas and, although Renaissance philosophers had begun to challenge ecclesiastical authority in Europe, several centuries would pass before the legalisation of human euthanasia developed widespread interest.[7]

The middle ages did supply a philosophy which would later find application in medical and ethical decision-making, coopted into arguments justifying PAS. For example, the Rule of Double Effect (ironically first appearing in Aquinas's *Summa Theologica*) describes how – in situations where one cannot possibly avoid all harmful actions – an action that intends to prevent harm may be justified even if the outcome is harmful.[6,8] In medicine, this has been applied in scenarios where a physician might act to pharmacologically treat a patient's suffering, knowing that the intervention may inadvertently hasten the end of life. The Danish philosopher Søren Kierkegaard developed a similar concept in 1843, describing granular conceptions of human ethics which are broadly applicable to the discussion of MAiD although not specifically applied to euthanasia in the canon. Kierkegaard's 'Tragic Hero' character type would customarily abandon one ethical commitment in favour of another with a higher ethical imperative, therefore retaining social justification despite forgoing the former.[9] Applying this reasoning to MAiD: a tragic physician could forego the traditional ethical commitments to a patient – which include preserving life – in favour of imperatives to alleviate suffering and defend patient autonomy.

Neither formulation resolves the question of whether or not voluntary death could ever represent a higher ethical imperative, and several historical anecdotes poignantly illustrate uncertainty about this, even within the medical firmament. Samuel Williams petitioned in 1872 for euthanasia (using the term 'mercy killing') in medical cases of untreatable illness through analgesic medications, which were undergoing revolutionary developments at the time; a contemporaneous editorial in the *Journal of the American Medical Association* protested the suggestion that doctors 'don the robes of an executioner.'[10,11]

In 1915, Dr. Harry Haiselden (Chicago, IL) recommended that the parents of a newborn with severe physical abnormalities not consent to a potentially life-saving surgery – presenting arguments tied to the eugenics movement – and, with the agreement of the parents, the baby died without treatment.[12,13] Public support for euthanasia waxed and waned in North America throughout the mid-20th century, increasing during the Great Depression (1930s) and decreasingly sharply in the immediate aftermath of World War II (1940s) when euthanasia raised fears of association with National Socialism.[14] Suicide was decriminalised in Canada in 1972, but the involvement of another party remained criminal.[15] Jack Kevorkian, known also as 'Dr. Death,' was one of the most prominent supporters and enactors of assisted suicide at this time in the United States: After reportedly assisting over 100 terminally ill patients to affect their own death, Kevorkian administered a lethal injection to a consenting patient unable – due to advanced amyotrophic lateral sclerosis (ALS) – to administer it to himself. The case was videotaped and broadcast by Kevorkian to advocate for voluntary euthanasia but, because his actions violated Michigan law, he was imprisoned for 8 years on the charge of second-degree homicide.[16] Amidst evolving controversy about euthanasia, a Canadian doctor writing under the pseudonym Dr. Gifford-Jones argued in 2013 that because Switzerland has long been recognised as provider of euthanasia for those who desire it (and meet Swiss regulatory standards), the only real barrier presented to North American patients by anti-euthanasia laws was the purchase of 'a one-way ticket to Zurich.'[17,18]

In the early 1990s, a Canadian named Sue Rodriguez received a diagnosis of ALS, which would be fast progressing and fatal. Rodriguez became a national leader in the right-to-die debate while seeking a physician to help her end her own life once she had lost the ability to do so herself. Rodriguez asked Canadian parliament, 'If I cannot give consent to my own death, whose body is this? Who owns my life?'[19] The Supreme Court ruled against her 5–4.[20] The case came down to a conflict within Canada's Charter of Rights and Freedoms: Section 7 describes individuals' rights surrounding their own person, while Section 1 states that rights in other sections may be limited for the broader social good.[21] This is the Rule of Double Effect or Kierkegaard's 'Tragic Hero' applied in opposition to assisted dying: foregoing individual liberty in favour of broader public safety or social good. Rodriguez took her own life in 1994, in British Columbia, with the help of an anonymous physician;[22] no charges were laid.

Current ethical arguments in favour of MAiD include respect for patient autonomy and evidence that assisted dying does not impact patient views of the doctor-patient relationship.[23] Conversely, arguments against MAiD include balancing patient autonomy with a fundamental respect for human dignity and a reverence for life, as well as concerns for the stability and motivations of an individual's decision-making – with the legalisation of MAiD, many have concerns that money, guilt or coercion could play an inappropriate role in the decision to pursue assisted dying.[23] Recently, non-profit organisations such as Dying With Dignity have increased the public awareness of MAiD in North America through persistent advocacy campaigns. Although healthcare delivery is under provincial jurisdiction in Canada, the federal government is implicated in discussions of assisted suicide as murder is a federal offence. The Canadian province of Quebec declared itself in favour of MAiD in December 2015, anticipating the federal Bill C-14 (June 2016), which became the first Canadian legislation to legalise MAiD, albeit

with several caveats.[24] Specifically, Bill C-14 does not allow MAiD in circumstances of mature minors, advance directives, or mental illness as the sole underlying medical condition – all three scenarios remain controversial issues. However, it does provision an impending 5-year review to revisit these circumstances with new evidence when it is available.[24]

Current MAiD legislation mixes a common language of its practice with certain geographical nuances, and international debate continues with a focus on universally defining the term and determining the exact circumstances under which it will and will not be permitted. These explorations attempt to address the ambiguity inherent in determining what conditions constitute a life so unbearable that the option of euthanasia can be ethically justified. They also raise the question of how much demand there would be for MAiD if there was greater accessibility of quality palliative care. While MAiD is legally recognised in Canada, its practice remains uncommon but not insignificant: as of June 2018, almost 4000 Canadians have chosen MAiD (accounting for <1% of deaths in Canada).[25] This has been partially attributed to a 'Disability Paradox,' wherein patients with severely limiting disease report a higher quality of life than others might expect them to have.[26] Nevertheless, to think critically about the ethics of MAiD while its regulations and limitations continue to take form, we must continue to engage with the core questions of who may decide which lives are and are not 'worth living,' and what rights and obligations should be recognised for both patients expressing an interest in MAiD and the physicians committed to caring for them.

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Disclosure

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Declaration of patient consent

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There are no conflicts of interest.

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