Preparing for the Future: Physician-Assisted Death in Canada

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Assistant Professor, Department of Medicine, University of Toronto
Objectives

- Describe the current legal status of PAD in Canada
- Review the literature from other jurisdictions that already practice PAD
- Frame the potential challenges for ICU physicians
- Clarify the status of conscientious objection
Disclaimers

• I have an opinion (we all do)
• Co-chair of Physicians’ Advisory Committee of Dying with Dignity

• PAD = Physician-Assisted Death
  • Physician-Assisted Suicide
  • Euthanasia
The Data: What is the effect on...

- ...vulnerable populations?
- ...non-voluntary ending of life?
- ...Palliative Care?
Can we protect the vulnerable?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Washington</th>
<th>Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>255</td>
<td>935</td>
</tr>
<tr>
<td>Age 85+</td>
<td>15%</td>
<td>11.9%</td>
</tr>
<tr>
<td>White</td>
<td>95.2%</td>
<td>97.6%</td>
</tr>
<tr>
<td>High school graduate</td>
<td>94.1%</td>
<td>93.2%</td>
</tr>
<tr>
<td>No health insurance</td>
<td>2.7%</td>
<td>1.7%</td>
</tr>
<tr>
<td>EOL concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of autonomy</td>
<td>90.6%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Inability to engage in enjoyable activities</td>
<td>88.6%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Burden on family</td>
<td>38.6%</td>
<td>36.1%</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>4%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Can we protect the vulnerable?

• Demographics of Swiss receiving Assisted Death
  – Higher income
  – Higher education
  – Non-institutionalized

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Logistic Regression Odds Ratio (Age 65-94)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Compulsory</td>
<td>1</td>
</tr>
<tr>
<td>Secondary</td>
<td>1.74</td>
</tr>
<tr>
<td>Postsecondary</td>
<td>2.71</td>
</tr>
<tr>
<td><strong>Type of Household</strong></td>
<td></td>
</tr>
<tr>
<td>2+ People</td>
<td>1</td>
</tr>
<tr>
<td>1 Person</td>
<td>1.44</td>
</tr>
<tr>
<td>Institutionalized</td>
<td>0.84</td>
</tr>
<tr>
<td><strong>Socioeconomic Position</strong></td>
<td></td>
</tr>
<tr>
<td>Lowest Quartile</td>
<td>1</td>
</tr>
<tr>
<td>Second Quartile</td>
<td>1.36</td>
</tr>
<tr>
<td>Third Quartile</td>
<td>1.90</td>
</tr>
<tr>
<td>Highest Quartile</td>
<td>2.68</td>
</tr>
</tbody>
</table>

Steck et al. *Int J Epidemiol* e-published Feb 18, 2014
Non-voluntary ending of life

- Assisted Death in the Netherlands

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Euthanasia</td>
<td>1.7%</td>
<td>2.4%</td>
<td>2.6%</td>
<td>1.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Assisted Suicide</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Life-terminating acts without explicit request (LAWER)</td>
<td>0.8%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total</td>
<td>2.7%</td>
<td>3.3%</td>
<td>3.5%</td>
<td>2.2%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Does prohibition of PAD prevent LAWER?

<table>
<thead>
<tr>
<th>Country</th>
<th>LAWER</th>
<th>Assisted Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>Belgium (pre-legal)</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Belgium (post-legal)</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>0.67%</td>
<td>1.82%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>0.42%</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>0.23%</td>
<td>0.23%</td>
</tr>
<tr>
<td>Italy</td>
<td>0.06%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Does PAD replace PC?

• Assisted death as a percentage of all deaths
  – Oregon – 0.2% (2012)
  – Holland – 3% (2010)
  – Belgium – 3.8%* (2007)

  • * lower than pre-legalization levels

Does PAD replace PC?

**Physician Assisted Death**

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>2001</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>7.4%</td>
<td>5.1%</td>
<td>7.6%</td>
</tr>
<tr>
<td>CV Disease</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>1.2%</td>
<td>0.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2.8%</strong></td>
<td><strong>1.8%</strong></td>
<td><strong>3.0%</strong></td>
</tr>
</tbody>
</table>

**“Intensified Alleviation of Symptoms” (Netherlands)**

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>2001</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>33.4%</td>
<td>37.1%</td>
<td>47.7%</td>
</tr>
<tr>
<td>CV Disease</td>
<td>11.1%</td>
<td>14.3%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Other</td>
<td>17.1%</td>
<td>24.1%</td>
<td>36.0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>20.1%</strong></td>
<td><strong>24.7%</strong></td>
<td><strong>36.4%</strong></td>
</tr>
</tbody>
</table>

Effect of PAD on EOL Care

Economist Intelligence Unit, 2010
Effect of PAD on EOL Care

- **Availability of PC in US hospitals**

1. Vermont (100%) - A
2. District of Columbia (100%) - A
3. Nebraska (93%) - A
4. Maryland (90%) - A
5. Minnesota (89%) - A
6. Oregon (88%) - A
7. Rhode Island (88%) - A
8. Washington (83%) - A
9. South Dakota (78%) - B
10. Virginia (78%) - B

http://www.capc.org/reportcard/topten
Current paths to legalization

• Statute
  • Federal- Bill C581
  • Provincial- Bill 52 (Quebec)

• Court Cases
  • Rodriguez (1993)
  • Carter vs. Canada

• Does it matter?
Bill 52

- **Indication**
  - At EOL, serious and incurable illness
  - Advanced state of irreversible decline in capability
  - Constant and unbearable physical or psychological pain
- **Adult, resident x3 months**
- **Competent written request, confirmed orally after “reasonably spaced interval”**
- **Confirmed by independent physician (witnessed)**
- **MD must be present throughout PAD**
Bill C-581

- Indication
  - Illness, disease or disability (including traumatic)
  - Intolerable physical/psychological suffering
  - Weakening capacities, no chance of improvement

- Competent requests 14d apart
- Confirmation with 2 independent witnesses
- PAD (PAS and Euthanasia)
Rodriguez v. Canada (1993)

- Woman with ALS - wanted PAS
- Launched charter challenge to s.235 of CC
  - Section 7: Everyone has the right to life, liberty and security of the person
  - Section 12: Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.
  - Section 15: Everyone has the right to the equal protection and equal benefit of the law without discrimination... based on physical disability.
- But, Section 1:
  - The Charter... guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.
The Supreme Court Responds

- Majority (5-4) felt that breaches were justified based on threat of harm to vulnerable
- Sue Rodriguez committed suicide with help of MD in 1994
Carter vs. Canada (2012)

- Gloria Taylor granted exemption from CC by BC Supreme Court
- Overturned by BCCA
  - The majority (per Newbury and Saunders JJ.A.) found the trial judge was bound by stare decisis (or “binding precedent”) to apply Rodriguez.
- But....
Carter vs. Canada (BCCA)

• “In the event that the SCC does review Rodriguez... consideration should be given to the remedy of a ‘constitutional exemption’ in favour of persons on whom an otherwise sound law has an extraordinary and even cruel effect.”

• “... a constitutional exemption for those who are clear-minded, supported in their life expectancy by medical opinion, rational and without outside influence, might not undermine the intention of the legislation.”

*Carter v. Canada (Attorney General), 2013 BCCA 435*
Carter vs. Canada (BCCA)

• “The majority also suggested that… court approval of some kind should be sought in addition to the bare requirement of two medical opinions …”

• “A court could provide a perspective and a safeguard from outside the often overstressed healthcare regime in which patients and physicians find themselves.”

Carter v. Canada (Attorney General), 2013 BCCA 435
Physician-assisted death: time to move beyond Yes or No

James Downar MDCM MHSc (Bioethics), Tracey M. Bailey BA LLB, Jennifer Kagan MD, S. Lawrence Librach MD

Physician-assisted death, which includes both euthanasia and assisted suicide, is legal in four countries and five US states. It is not yet legal in Canada, but the National Assembly of Quebec was close to passing Bill 52 before the Apr. 7 election call,¹ and a private member’s bill that would allow physician-assisted death under specific circumstances has recently been introduced in the House of Commons.² The Supreme Court of Canada is set to hear an appeal of Carter v. Canada³ in October 2014, when it will decide whether Canada’s laws prohibiting physician-assisted death violate the Canadian Charter of Rights and Freedoms.

Physician-assisted death poses a distinct challenge in Canada. Palliative care is available to only 30% of Canadians,⁴ with long wait times even for urgent referrals. Such a requirement would be as much a barrier as a safeguard.

Depression may be common among those requesting physician-assisted death,⁵ and it can render patients incapable of providing consent if it prevents them from being able to understand and appreciate the consequences of physician-assisted death and alternative treatments. In the Netherlands and the United States, two physicians must use clinical judgment to determine whether a patient is capable of making decisions regarding death.

³¹ Competing interests: None declared.
This article was peer reviewed.

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What are indications for PAD?

- Physical suffering?
  - What is “intolerable”?

- Psychological suffering?
  - Indication or contraindication for PAD?
  - Rational suicide?

- Terminal illness?
  - PAD in Oregon usually requested for loss of independence rather than symptoms (90%)
  - When is patient “terminal” or at “end of life”?
What safeguards should we use?

- How many physicians should ensure capacity?
- How do we ensure persistence of request?
  - 14-15 days (Oregon, Bill C-581)
  - “Reasonably spaced intervals” (Bill 52)
- Other therapeutic possibilities?
  - Palliative care consultation?
  - Psychiatric assessment?
- Judicial oversight- constitutional exemption
Preventing involuntary PAD

- Persistent, voluntary requests from capable patient
- Prospective oversight
- Patient advocate
- Institutional
Oversight

- Review committees
  - Rate of reporting?
  - Feedback?
  - Notification of authorities?
- Reporting mechanism
  - Voluntary submission
  - Monitoring of prescription
  - Monitoring of dispensing medication
  - Inpatient facility
- Empowerment of committee?
Oversight

• Judgment of Commissions
  – Belgium- 8 MDs, 4 lawyers, 4 PC practitioners
  – Holland- 1 MD, 1 lawyer, 1 ethicist
  – Bill 52- 11 representatives appointed after consulting college of physicians, nurses, pharmacists, social worker/marriage therapists, notaries, plus representatives from institutions, ethics community, and patient advocate

Oversight – Bill 52

- 2/3 vote would trigger feedback to MD, notification of institution and/or College des Medecins for “appropriate measures”
  - 0 cases referred in Belgium
  - 16 cases (0.2%) in Netherlands from 2003-6
  - Medical act vs. Criminal act

Conscientious Objection

- Capacity of patient to advocate for his/her own needs
- Duty to refer
- Duty to transfer?
- Duty to raise the issue?
Conscientious Objection

- CMA’s position on induced abortion
  - “a physician should not be compelled to participate in the termination of a pregnancy.”
  - “a physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another physician.”

Blackmer J. Clarification of the CMA’s position concerning induced abortion. CMAJ 2007;179:1310.
Induced abortion [CMA policy]. Ottawa (ON): Canadian Medical Association; 1988
Conscientious Objection

- CMA’s position on induced abortion
  - You should therefore advise the patient that you do not provide abortion services... [and] you will not initiate a referral to another physician who is willing to provide this service (unless there is an emergency).
  - At the patient's request, you should also indicate alternative sources where she might obtain a referral. This is in keeping with the obligation spelled out in the CMA policy: “There should be no delay in the provision of abortion services.”

Blackmer J. Clarification of the CMA’s position concerning induced abortion. CMAJ 2007;179:1310.

Induced abortion [CMA policy]. Ottawa (ON): Canadian Medical Association; 1988
Conscientious Objection

- CPSO- MDs must arrange alternative services OR give “reasonable opportunity to arrange alternative services”
  - Policy under revision
- Discussion about “duty to refer”
  - Ontario Human Rights Commission

Specific Concerns for ICU

• Likely rare
  • 2.2% of all ICU deaths in Europe**
  • Confusion between PC and PAD

• Incapable patients

• Should PAD be part of advance care planning?

• How to distinguish from WDLS?
  • Moral agency
  • Lethal physiology

Chambaere et al. CMAJ Open in press.
Final thoughts...

• Regardless of whether you support PAD...
  – Effective safeguards
  – Clear communication
  – Policies, protocols and guidelines
  – Oversight and monitoring
• Overly stringent/unreasonable restrictions could backfire
• Society is moving forward, with or without MDs.
Objectives

- Describe the current legal status of PAD in Canada
- Review the literature from other jurisdictions that already practise PAD
- Frame the potential challenges for ICU physicians
- Clarify the status of conscientious objection
“I'm not afraid to die, I just don't want to be there when it happens.”
Hippocratic Oath

• Original Hippocratic Oath...
  • ...swears by the original Greek gods
  • ...bans giving a “deadly drug”
  • ...bans giving women “an abortive remedy”
  • ...suggests that only males be taught medicine.

• Tradition, modified to reflect modern beliefs

• CMA Code of ethics revised 19 times since 1868