Physician Hastened Death: Seeking Substantive Safeguards and Effective Access for All Canadians

Constant H. Leung, MD, CCFP, FCFP

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Vancouver, British Columbia, Canada

Introduction

The Supreme Court of Canada decision in *Carter v. Canada* (*Carter*) made three particularly relevant declarations.

First, the courts indicated that a complete ban on physician assisted suicide was unconstitutional for: "a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition[1]"

Second, the courts indicated that "the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced.[2]"

Third, the courts decreed "nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying… a physician's decision to participate in assisted dying is a matter of conscience…we underline that the *Charter* rights of patients and physicians will need to be reconciled.[3]"

A distinct federal program with exclusive jurisdiction over physician hastened death, acting as an adjunct to our current health care system, is a logical, responsible, sensitive, respectful and practical solution that upholds rights and safety for all Canadians whether they desire a hastened death or not, enables effective access for patients who desire and are eligible for a hastened death, and protects freedom of conscience rights for health care professionals to the greatest extent possible.

Let us call our nation and society to higher and better ways. As Prime Minister Trudeau has said, "in Canada, better is always possible"[4]. It is a fundamental tenet of medical ethics that a physician must always act in the patient's best interests[5], especially in times when the patient may be vulnerable. We as a society must proactively identify people who are vulnerable, and equally protect their *Charter* rights to life, liberty, and security of person.

Palliative Care vs Physician Hastened Death

Carter used the terms physician – assisted death and physician assisted dying. These terms, along with the terms "end of life care" and "medical aid in dying", are ambiguous because they could be used to describe physician assisted suicide, voluntary euthanasia, or palliative care.

The Canadian Medical Association recognizes that assisted death as defined by the Supreme Court is a practice distinct from palliative care.[6] The World Health Organization states that palliative care:

1) "improves the quality of life of patients and their families facing the problem associated with life threatening illness;"

2) "intends neither to hasten or postpone death;" and

3) "offers a support system to help patients live as actively as possible until death." [7]

Returning to the factual circumstances in *Carter*, neither patient had a life-threatening illness; both patients desired the freedom to hasten their deaths at a time of their choice. Suicide is contrary to the concept of living as actively as possible until death. Both patients were in fact requesting an assisted suicide, not palliative care.

The Canadian Society of Palliative Care Physicians recommends using the terms physician - administered or patient - administered physician hastened death when referring to assisted death as defined by *Carter*.[8]

Physician hastened death (PHD) is neither palliative care nor is it a part of the continuum of end of life medical care. Instead, it is an autonomous decision to seek death.

Ms. Taylor said: "I live in apprehension that my death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by…What I fear is a death that negates, as opposed to concludes, my life."[9] Let us seek to address this fear. Prime Minister Trudeau has inspired us to combat fear with hope. Let us strive, as a nation, to one day conquer the fear described by Ms. Taylor with health care and palliative care of such incredible quality that no Canadian will need to request a physician hastened death.

More Risks Necessitate More Safeguards

Both the Supreme Court of British Columbia and the Supreme Court of Canada acknowledged numerous risks inherent in permitting physician hastened death. Additional easily foreseeable risks and negative implications have been identified.[10] ***Carter*** **has opened the door for Canada to be the most permissive society to date in regards to physician hastened death. The logical corollary is that Canada will soon have the greatest potential for the abuse of vulnerable patients.**

Frontline Canadian primary care is rife with potentially vulnerable patients. We have patients with a myriad of medical vulnerabilities: seniors with mild cognitive impairment, moderate to severe dementia, chronic and severe cardiac, respiratory, neurological, or renal conditions, mobility issues, or all of the above. We have children with special needs, suicidal teenagers who decline antidepressants, young adults who suffer disabling and life altering events. We have patients who have impoverished social situations, patients who lack access to education, patients who have difficult family situations. We have communities without running water, communities with limited medical care, and communities with no access to palliative care. We have patients that equate palliative care with a physician hastened death. We have seniors who feel that they are a burden to society or their families. Some of these patients in vulnerable situations may be competent to make autonomous decisions, but many may be subject to subtle coercive influences that are not readily identifiable. **To protect *all* patients, Canada needs to have more stringent and robust legal protections and safeguards than those in place in other permissive jurisdictions.**

Proposed Framework for Substantive Safeguards and Effective Access

Regulatory Framework

1. **Design the system in accordance with the Carter intention to "allow for a stringently limited carefully monitored system of exceptions"[11]**
2. **Establish "a law that can be effective throughout the country even on the assumption that there is no provincial law or territorial law in part of the country"[12]**
3. **Establish a federal program as the sole legitimate provider of physician hastened death, maintaining physician hastened death under federal and criminal jurisdiction**.
    a. "The scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil."[13]
    b. Decriminalizing physician - hastened death raises the spectre of one such "legitimate public health evil", namely the systematic acceptance of a government sanctioned means of nonculpable homicide in our health care system;
    c. A uniform national approach to physician hastened death is in the best interests of the public and the ethical practice of medicine;
4. **Within the federal program, have an oversight body that intentionally includes representation from all relevant professions and perspectives.**
5. **Establish penal and regulatory sanctions for intentionally falsifying a death certificate**, in order to maintain transparency in the process of PHD;
6. **Establish penal and regulatory sanctions for failing to meet due diligence standards in assessing competency and eligibility for PHD;**
7. **Design the federal program to strive to decrease the adverse health, social and economic consequences of introducting physician hastened death.** Precedent has been set for a similarly controversial issue which also resides under criminal and federal jurisdiction, with Insite[14], a supervised injection site in Vancouver BC.

Process

1. **Physician hastened death should only be performed by physicians who have obtained a license in a newly created separate class of "license to hasten death"**
    a. This reminds the public and the profession that PHD is to be the exception, rather than the norm
    b. Patient safety is enhanced without obstructing access.
    c. The class of license can be modeled on the methadone license in BC.
    d. Educational Programs could be jointly designed by the Canadian Medical Association, College of Family Physicians of Canada, and the Royal College of Physicians and Surgeons to provide:
        i. Extensive training in competency and eligibility assessments with a focus on patients where capacity to consent is impaired or questioned;
        ii. Extensive training in the ethics of physician hastened death as they relate to Canadian culture, recognizing the vast diversity of Canadians.
        iii. Extensive training in exploring and presenting all options and supports that are available to patients, especially where the lack of these supports may underlie the request for PHD;
        iv. Additional training in the technical aspects of assisted suicide.
2. **Professionally self regulated allied health care professionals such as pharmacists and nurses should have similarly specialized licences** while support staff can be protected under exemption by federal law if they are working under the program.
3. **Explicitly mandate the federal program for physician hastened death to work with marginalized populations and those at risk of suicide in order to reduce the risk of these populations wrongfully accessing a physician hastened death**
    a. Parliament could prohibit assisted death but allow exceptions[15]
    b. A regulated regime may be more effective at bringing suicidal people to the attention of the health care community[16]
4. **Robust and thorough protection for a physician's freedom of conscience, in combination with a system of direct access to physician hastened death, provides an excellent safeguard.** The truly competent patient would easily be able to access the federal service, while an ambivalent or vulnerable patient would have the benefit of having the physician continue to act as a health advocate.
5. **Establish a judicial review to occur during the waiting period. The Supreme Court has recently established this as a useful precedent that enhances patient safety. A posthumous report provides no protection for a dead patient.**
6. **Only permit physician-administered physician hastened death if the patient is physically incapable of patient administered PHD;**
7. **Forbid physician, team, or family initiated counsel to seek a physician hastened death.** The request must come directly from the patient.
8. **Physicians and the medical profession should never suggest a hastened death, as this will undermine the entire medical ethos and undermine trust.**
9. **Physician hastened death should only be performed by physicians.** While some interventions (e.g. immunizations, obtaining intravenous access, intramuscular injections) are appropriate to delegate to alternative health care professionals, the complexity of a delegated procedure should remain commensurate with the level of education and clinical experience of the performing clinician. Just as it would be considered unprofessional to delegate a cardiac surgery to a nurse, it is inappropriate to delegate this unique task to another health care professional.
10. **A physician must remain present at the bedside, or in the immediate vicinity, at the time of patient administered PHD.**
    a. A physician prescribing a patient administered physician hastened death without following the act through represents the ultimate act of abandoning a patient. To acknowledge and satisfy a patients' desire to choose who is present at the time of death, the physician could remain in the immediate vicinity without being at the bedside.
    b. The Provincial – Territorial Expert Advisory Group indicates "physicians should ensure that the potential risks are clearly explained to the patient and provide instructions on how to respond to them should they materialize.[17]" Just as the Provincial – Territorial Expert Advisory Group indicates that the burden of access should not fall on the patient, the burden of managing potential risks of PHD

should also not fall upon the patient. If a patient opts for patient administered PHD and complications materialize, it could be physically impossible for that patient to respond appropriately.

11. **Establish a standardized protocol of medications to be used exclusively for physician hastened death,** using a small and limited number of alternatives
    a. Medications typically used in PHD protocols should remain controlled substances.
    b. Mandate that these drugs be prescribed on a duplicate prescription, if used for PHD, as is done for opioids in BC;
    c. Mandate that copies of these prescriptions be submitted to the federal regulatory body.
    d. These medications should come in quantities only available for a single use, with a maximum of two dispensed per prescription with the unused portion to be returned to the pharmacy.
12. **Provide for meaningful rights of withdrawal and refusal throughout the process**,[18] for example by providing a confidential patient advocate.
13. **Require that a representative of the federal program attend as a witness at all deaths** in order to confirm the continuing voluntariness at time of death[19] and to properly dispose of any unused lethal substance**.**
14. Physicians with a license to hasten death will use special death certificates, issued by the Federal Authority, and these certificates must record all the necessary information, including:
    a. An indication of either patient administered or physician administered Physician hastened death as the cause of death; the coroner's version of the death certificate in BC is a possible template which captures the information required;
    b. Indicate the date and time of patient's explicit request, to be signed and dated by the patient and the physician receiving the request;
    c. Indicate date and time of offer to rescind request, to be signed and dated by the patient, and the physician making the offer to rescind;
    d. Record the name and licence number and dispensing date of the dispensing pharmacist
    e. Record the name and licence number of attending and consulting physicians, including which physician was present at the death
15. **It is critical to have a waiting period in order to allow the patient to reconsider the request and to ensure that the decision is enduring. The Canadian Medical Association document Principles Based Approach to Assisted Dying[20] provides significantly better protection for vulnerable patients than the Provincial Territorial Expert Advisory Group's recommendations.**

Eligibility

1. **Explicitly indicate that all advanced directives, including those completed prior to the diagnosis of a "grievous and irremediable medical condition" are invalid for the purposes of requesting a hastened death.**
2. **Establish a consistent and national definition of adult that is based on biological age rather than a capacity to consent, for the purposes of eligibility for a physician hastened death**.
    a. *Carter* clearly referred to "a competent adult."
    b. Our society does not legally make alcohol, prescription drugs, guns, or driver's licences accessible to children, even if they may be competent to use them.
3. **The term "grievously and irremediably ill persons" should be limited to "those who are also in an advanced state of weakening capacities, with no chance of improvement"**[21].
4. Explicitly indicate that **physicians may never authorize physician hastened death on behalf of an incompetent patient, through a substitute decision maker or without consent**, and that doing so would remain a criminal offence, with an accompanying penal sanction
    a. to protect incompetent patients from being killed without consent, and to attempt to limit the emergence of Life ending Acts Without Explicit Request (LAWER) that are currently occurring in Belgium despite the existence of legislative safeguards.
5. "The unconstitutionality …arises from its application to competent fully informed non ambivalent adult persons who (not through a substituted decision maker) request physician hastened death, are free from coercion and undue influence and are not clinically depressed.[22]"

Safeguards to society

1. **Define effective and equitable access as protecting the safety of patients who either do not qualify for or do not desire a hastened death by restricting access to PHD, without obstructing access for those who both desire and qualify for a hastened death.**
2. **Keep the practice of physician hastened death as distinct and geographically separate as possible from the delivery of regular health care delivery services, especially palliative care services.**
3. **Keep physician hastened death separate from medical schools, residency training programs and teaching curricula**.

Public Education

1. **Use the terms "patient administered" or "physician administered" – "physician hastened death".** Clarity improves understanding which can only support patient autonomy.
2. **We must present a comprehensive and balanced view to society**. The Canadian public deserves thoughtful and extensive discourse on the potential negative consequences for patients, society, future generations, and the medical profession with the introduction of physician hastened death. Societal implications of *Carter* are identifiable by observing historical precedent in the Netherlands and Belgium. In light of Section 15 of the Charter, a physician hastened death may eventually need to be made available to patients who are not currently eligible, thus increasing risks to vulnerable patients as the eligibility criteria broaden.
3. **Provide public education to distinguish physician hastened death from palliative care**.
    a. An educational course could be considered in high school.
    b. Public education about palliative care and the many alternatives to PHD should be considered in implemented in conjunction with the suicide prevention programs available publicly and in the military.
4. **State the purpose of the legislation as precisely and specifically as possible**[23]
    a. protecting vulnerable persons from being induced to commit suicide at a time of weakness;
    b. protecting vulnerable persons such as patients with dementia, or cognitive impairment from an unintended death or coercion to consent to a physician hastened death
    c. preventing the transition of Canadian society into a society where Canadians are encouraged to seek our own deaths even in the absence of a terminal or debilitating illness
    d. preserving the nature of medicine and health care as a caring and healing profession

Facilitating Access

1. Offer multiple options for a hastened death, but **keep PHD absolutely distinct and separate from palliative care:**
    a. Many patients would prefer to die at home;
    b. Dying can be offered in a mobile hastened death facility modeled after the innovative BC Mobile Medical Unit[24];
    c. Dying within separate facilities as a privately funded endeavour.
2. **Use technology and telemedicine to facilitate access and improve safety** by creating a service accessible by telephone, internet, or a smartphone. Maintain an audiovisual record of both the patient's narrative request for a hastened death, and the offer to rescind the request. These should be for documentation purposes only. Simply watching the recorded request must be considered inadequate for the purposes of assessing competency, as the competency assessment should be in the context of a physician-patient interaction. In addition, at least one of the assessments must be done in person, as telemedicine does not allow for interpretation of certain subtleties of personal interaction.
3. **To facilitate access, particularly in remote or rural areas, leverage the existing infrastructure, mobility, and medical teams available to the Canadian Forces** for deployment across the country as required.
4. It should be noted that if the recommendations under facilitating access are not taken in conjunction with the recommendation to keep PHD separate from the regular health care system and in particular palliative care, facilitating access will become an unbalanced exercise and countless patients will be placed at risk.

Keep Hastened Death a Separate Service

A separate and federally regulated system for accessing physician hastened death would protect our current health care system, is an inherent safeguard that provides protection for patients who do not seek a hastened death, and still allows access to PHD. The system's initial role should be to help patients understand the difference between palliative care and physician hastened death. By maintaining the fundamental distinction between PHD and standard health care intervention, autonomy can be supported by allowing for a better informed choice.

In contrast, the approach of integrating physician hastened death protocols into our present health care system, is unnecessary, unwieldy, unsafe, and will inevitably cause divisions in the health care system by compounding issues of conscience.

From the patient perspective, patients who seek a hastened death have indicated that the only acceptable solution to relieve their suffering is a hastened death. Those patients have thus decided that our regular health care system has no more acceptable treatments to offer, so there is no need for those patients to remain in the regular system, particularly when allowing such patients to remain in the regular healthcare system would significantly infringe upon the rights of patients who do not desire a hastened death.

A separate federally regulated mobile system could solve this otherwise divisive issue. In addition, this can address issues raised by the Provincial – Territorial Expert Advisory Group, that geography and uneven distribution of health care professionals creates a barrier to access.

Conclusion - Fairness to all Canadians

Carter indicates there cannot be a duty to live[25]. The logical corollary is there cannot be a duty to die. "The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But section 7 also encompasses life, liberty and security of the person during the passage to death.[26]" The Supreme Court has decided that for those patients who are competent adults and have a grievous and irremediable condition, rights during that time need to be protected. In accordance with Section 15 of the Charter, patients need to have protection during the transition to death so as not to experience a wrongful death. Let us protect our country from becoming a society where we euthanize babies, patients with dementia, patients who are vulnerable.

The Provincial – Territorial Expert Advisory Group places a hypothetical patient who desires a hastened death at the centre[27], but the health care system of a free and democratic society should allow for any individual patient to be at the centre. **Prime Minister Trudeau, we ask you to give the rights of vulnerable patients equal consideration before the law.** The Supreme Court said, "the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly."[28] Especially for those patients who fundamentally reject PHD as an acceptable option to them, their right to life will be breached if state action forces them to be treated in facilities or by doctors who offer or promote PHD since there is obviously an increased risk of wrongful PHD (i.e. PHD without true consent or PHD that does not meet *Carter* criteria) in facilities/doctor-patient relationships which offer PHD vs. those which do not. This patient's section 7 right to life thus requires that the state permit each doctor and medical facility to determine for itself whether it will offer PHD or not, so that patients who decide never to access PHD have available to them, if they choose, facilities and doctors whom they know do not offer PHD.

The Provincial – Territorial Expert Advisory Group contends that their approach may increase the trust in the health care system for some, presumably, those who wish a hastened death. Unfortunately it follows that the same approach may equally decrease the trust in the same health care system for others, namely, those who reject a hastened death. The diversity of the entire Canadian public must be respected and the trust in the health care system must be maintained for all patients, not just a select few who wish a physician hastened death. All patients, whether they desire or reject a physician hastened death, have equally important *Charter* rights to life, liberty and security of person in the transition to death. The freedom of conscience rights of health care providers are equally important. The solution to respect these all is to provide a separate federally regulated system that can be directly accessed.

[1] Supreme Court Judgment: *Carter v. Canada* (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para 127.
[2] Supreme Court Judgment: *Carter v. Canada* (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para 27
[3] Supreme Court Judgment: *Carter v. Canada* (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para 132.
[4] Prime Minister Justin Trudeau's acceptance speech http://www.macleans.ca/politics/ottawa/justin-trudeau-for-the-record-we-beat-fear-with-hope/ (Accessed February 1, 2016)
[5] CMA code of ethics: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf (accessed January 31, 2016)
[6] The Canadian Medical Association, at its annual meeting (General Council) in August 2015, unanimously passed a resolution stating "The Canadian Medical Association recognizes that the practice of assisted death as defined by the Supreme Court of Canada is distinct from the practice of palliative care."
[7] World Health Organization definition of palliative care: http://www.who.int/cancer/palliative/definition/en/ (accessed January 31, 2016)
[8] Canadian Society of Palliative Care Physicians written submission to the External Panel on Options for a Legislative Response to Carter vs. Canada: http://www.cspcp.ca/cspcp-submission-to-federal-panel/ (accessed February 1, 2016)
[9] Supreme Court Judgment: *Carter v. Canada* (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para. 12
[10] To receive a copy of the Submission to the Parliamentary Committee on Assisted Dying by a Network of BC Physicians, email: mdnetwrk@telus.net (note the spelling)
[11] Supreme Court Judgment: *Carter* v. Canada (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para. 29
[12] Peter Hogg, to the Parliamentary Committee on Assisted Dying January 2016
[13] RJR-MacDonald v. Canada (Attorney General), [1995] 3 S.C.R. 199, para. 32
[14] http://supervisedinjection.vch.ca/
[15] Trial Judgment: *Carter* v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 1233
[16] Trial Judgment: *Carter* v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 1262
[17] Provincial – Territorial Expert Advisory Group on Physician Assisted Dying: Final Report, December 14, 2015;
[18] Trial Judgment: *Carter* v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 873 -880
[19] Trial Judgment: *Carter* v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 880
[20] Canadian Medical Association Document: Principles-based Recommendations for a Canadian Approach to Assisted Dying https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf (Accessed February 1, 2016)
[21] Trial Judgment: *Carter* v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 1388-1392
[22] Trial Judgment: Carter v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 1388
[23] Trial Judgment: *Carter* v. Canada (Attorney General), 2012 BCSC 886, http://canlii.ca/t/frpws, Para 1189
[24] The Mobile Medical Unit: A unique program in British Columbia. BCMJ, Vol. 57, No. 9, November 2015, page(s) 382-386
[25] Supreme Court Judgment: *Carter* v. Canada (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para 63
[26]Supreme Court Judgment: *Carter* v. Canada (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para 63
27 Provincial – Territorial Expert Advisory Group on Physician Assisted Dying: Final Report, December 14, 2015;
[28] Supreme Court Judgment: *Carter* v. Canada (Attorney General), 2015 SCC 5 http://canlii.ca/t/gg5z4, Para 62