



Canadian Geriatrics Society

**Michael Gordon
MD, MSc, FRCPC**

*Baycrest Health Sciences,
Toronto, Canada: Division
of Geriatric Medicine,
Department of Medicine,
University of Toronto,
Toronto, Canada*

**Tammy Vu Bach
MD, CCFP (COE)**

*Baycrest Health Sciences,
Toronto, Canada: Division
of Palliative Medicine,
Department of Family and
Community Medicine,
University of Toronto,
Toronto, Canada*

Corresponding Author:

Dr. Michael Gordon
MD, MSc, FRCPC
Geriatric Consultant to
Palliative Care
Medical Ethicist
Baycrest Health Sciences
Professor of Medicine
University of Toronto
3560 Bathurst Street
Toronto, ON M6A 2E1
416 785 2500 ext. 2613
mgordon@baycrest.org

Key words:

assisted suicide, supreme
court ruling, canadian
legislation

MEDICAL ASSISTANCE IN DYING: AN ONGOING SAGA OF CONFLICTS AND CONCERNS

Introduction

Within the world of clinical practice there are always issues that occur, which result in major changes in clinical care. The evolution of medical practice over time has been remarkable. Many physicians are old enough to recall the introduction of new medications or surgical treatments that have had such an impact on clinical practice that whatever happened changed forever what had previously been the standard of practice and care.

The same occurs with public policy, even though the course through which it occurs may not be as readily appreciated as, for example, a new medication for a common but serious illness. If one looks at the last few decades of public policy in North America and the western world, one might categorize the introduction of end-of-life care, including medical assistance in dying (MAID), as being among the most profound shifts in public policy, and one that has slowly evolved across countries and cultures.^{1,2,3}

Using a prototypical case, we will attempt to address the many issues currently being discussed as MAID becomes law in Canada and will likely continue even once the law is proclaimed.

This article has been peer reviewed.

Conflict of Interest: None

This article was published in December 2016.

Prototypical case

Mr. G, an 81-year-old retired physician well until three years previously, was admitted on a palliative care unit (PCU) in Ontario. He had metastatic prostate cancer that progressed despite surgery and chemotherapy. With curative treatments no longer available, he chose to focus on comfort measures. Four weeks into his PCU admission, he decided that he no longer wanted to pursue any further ongoing therapy, even though it did result in some degree of pain relief. His goals of care changed due to the gradual loss of his independence and ability to participate in meaningful aspects of his life. He also recently lost his last living sibling, a brother in Ottawa. His only remaining significant family member was a daughter with whom he was always very close.

Mr. G raised the issue with his daughter on one of her visits. "I think I want to die sooner rather than later. I feel there is nothing left for me to live for, and I want to apply for assistance in dying – or whatever they are calling it." She did not try to talk him out of it, but told him, "I understand why you might choose this path. I will support you whatever you decide, but will miss you even for the extra weeks or months we might have. Are you having pain?" "These medications are helping me a lot, but there is still this existential anguish I feel and a desire to end it all. After all, I have done it all. I had a great career and a wonderful family. I think enough is enough and that is how I feel now. I need your support if I am going to do this." With tears welling in her eyes, she agreed to support whatever he wanted. "You know how much I love you, and with that love comes support for whatever you want. What you have given me throughout my life will always be with me and I am forever grateful for it."

When he shared his decision with his physician, she attempted to figure out how she was failing him in terms of symptom management. He assured her that was not the issue. Because of her concern about clinical depression influencing his decision, she asked if he would agree to a psychiatric consultation. He agreed, despite knowing that a psychiatric consultation was not a requirement to have his wishes carried out under the new MAID guidelines. The psychiatrist felt that Mr. G's wishes were not the result of a clinical depression but rather an existential decision he made, and had no suggested interventions to alter his wish.

The above scenario in its various iterations has already occurred and is likely to occur with increasing frequency as the new legislation on MAID takes effect.^{4,5,6} From the experience in other jurisdictions, it is likely that in the beginning there will be a flurry of requests and then there will be a steady state or equilibrium as physicians and other health care providers become more adept at providing the care necessary to obviate physical, emotional and existential suffering so that the motivating forces that might lead individuals to seek MAID will be less pressing.^{2,3 6,7} Finding a reason to live, even for a short period separate from religious or cultural prohibitions against such an act, may be the key to reducing the perceived need for MAID in those patients who cannot find a compelling reason to continue with their lives, however truncated it might appear.

With requests, such as illustrated in this prototypical case, there was a range of responses from the staff involved. There were those who completely "understood" the patient's desire to "end it all," and those that could not fathom why someone who in fact was getting good pain management would not want to stay alive, even if only for the sake of his daughter. There were those, especially among some of the physicians on the PCU and in the rest of hospital who felt that although they could "understand" the desire of the patient, they did not feel that they could participate in the act of providing the lethal dose of medications either for "professional" reasons or for very deep cultural or religious reasons. Among the latter were those who felt so strongly about the issue that the provincial regulatory colleges' (e.g., College of Physicians and Surgeons of Ontario) dictum of requiring a physician to refer to another physician was an intrusion onto their "conscience"

and “religious beliefs”.⁸ They claimed they were prepared to accept censure or even punishment rather than comply with what they felt was aiding and abetting an act that they felt was abhorrent to their belief systems.

In several organizations across the country, attempts were made to find ways to abide by the new legislation while trying to respect the sensibilities of physicians who refused to participate due to what they deemed to be their “autonomous” rights of conscience.^{8,9,10} Some protocols were considered, such as a referral to a committee rather than directly to a physician willing to carry out assistance in dying, and appeared to potentially adequately answer the requirements of the regulatory colleges while clearing the conscience of those physicians who strongly oppose the act and were against being accomplices to an act abhorrent to them.

Discussion on ethics, law, personal choice, and professional duties and obligations

How a physician acts under conditions of moral demands is in many ways a foundational indication of what it means to be a true professional. When one undertakes to be a physician, there are certain duties and obligations that one accepts that are not necessary in other fields of work – some of it is part of the concept of true professionalism.^{11,12} The welfare of the patient supersedes the wishes, needs and one might say values of the physician. This may sound extreme but it is in many ways a necessary underpinning of the idea of medical professionalism. If this is not the case, any physician might choose to not provide certain care or not treat certain individuals because of personal values or beliefs including, for example views on same-sex marriage or deep-seated religious beliefs.

The priority to patients is not unique to medicine in that in principle the priority of responsibility to serve the public by public employees in many ways reflects this same principle that we apply in medicine. Although not necessarily defined as “public employees” the reality remains that our purpose is to serve the public and this has been a basic tenet of medicine from its earliest days. How we are remunerated or what our relationship is to the structure of licensing and practice is irrelevant to the concept of our duties and obligations to our patients.

The issue of professional duties and obligations is well illustrated in the recent case where a municipal office clerk in Arkansas, United States refused to provide marriage certificates to gay couples that the federally mandated law deemed lawful.¹³ The clerk reported her personal belief system prevented her from carrying out her employee duties and responsibilities. The case made national and international headlines. She spent time in prison – ultimately a compromise but a less than ideal resolution was found that allowed gay couples to fulfill their marriage certificate acquisition without her being able to prevent the process from occurring despite her personal beliefs. The implications of this case are profound as what if her personal beliefs extended to people of religions, colour or ethnic origins alien to her beliefs. When one undertakes activities that affect the public it has to be clear what one’s duties and responsibilities are to the public that you have agreed to serve.

Concept of physician autonomy

It is of historical interest that when the ethical framework for care decisions was developed by the scholars from Georgetown University, which came to be known as *principlism*, the focus was on decisions related to patients/clients of health care professionals.¹⁴ The four tenets, often called the Georgetown mantra, consisted of autonomy, beneficence, non-maleficence and justice – with the big change being the introduction of autonomy.¹⁴ The result was a huge shift in the decision-making focus from what had been century-old

beneficence counterbalanced by non-maleficence to what in essence became a new paradigm – patients could decide on their health care decisions even in the face of opposition by their physicians or in the face of inordinate health care risks or poor outcomes, as long as the patient was capable of such decisions.

There was nothing in the initial formulation of the four tenets that gave physicians a separate autonomous framework for deciding what medical care they would provide outside of the usual professional and currently touted evidence-based formulations. The idea of autonomy of physicians had more to do with choice of type of practice, specialty, hours and associations, but not to whom one would provide health care services other than as part of one's specific clinical focus, i.e., geriatrics, paediatrics or adolescent psychiatry. However, arguments were put forth by the group at Georgetown University supporting the concept of physician autonomy and objection to certain acts.¹⁵ The idea of physician autonomy in the sense of what in essence is conscientious objection stems from an old historical construct of participation in war and its subsequent risk of killing. For example, in the United States where rules are stringent, objectors can be assigned to non-combat roles that continue to help the war effort. While the risk of killing an enemy combatant is much reduced, these roles, such as being a medic in a war zone, often still pose a major personal risk to the objector.

As an alternative option for physicians who feel that the referral process to a physician who might implement MAID is unethical, a more sophisticated and potentially more acceptable referral process can be adopted where the person making the MAID request is referred to a committee that discusses and reviews the options, and only then makes recommendations as to the suitability of the referred person for MAID. This might remove the immediacy of the referral process from the actualization of the MAID intervention.

Projection of MAID legislation

In P. Taylor's *Can you describe a 'typical' assisted death?* piece from The Globe and Mail, the author described the range of options potentially available to the federal government that would be compliant with the requirements of the Supreme Court ruling by using the information and experience gleaned from other jurisdictions.¹⁶

His summary at the time included the following options for administration of MAID:

- In the Netherlands, a physician administers a combination of drugs either through an IV needle or by mouth, following the patient's request for the lethal substance. This is known as *voluntary euthanasia*. (The Quebec approach, in which a physician must be present, is partly based on the Netherlands model.)
- In the U.S. state of Oregon, a physician writes a prescription for the patient who can then pick up the oral medication at a local pharmacy. The patient is basically in control, and decides when and where to take the lethal dose (100 or more capsules). It is often mixed into a sweet drink such as juice to mask its bitter taste. The patient is also instructed to take an anti-emetic medication beforehand to prevent vomiting up the toxic drink. In the older terminology, this is referred to as *physician-assisted suicide* or *physician-assisted death* where the physician provides the means to the patient but does not undertake the action of administration.

After a lengthy period of deliberations, the Canadian legislation on MAID came into force in June 2016. The legislation is an amalgam or combination of the experiences in other jurisdictions, and also incorporates some Canada-specific recommendations advocated for by various Canadian working groups and expert panels on the subject.^{4,5} There are those who have expressed objections to some components of the law and

province-specific regulations but, as with all new legislations, there will likely be modifications of the law over time. Of note, the federal government has yet to address the issue of MAID access for vulnerable populations, such as mature minors, persons with psychiatric illnesses and persons with dementia. With time and experience, components that prove unworkable or public and legislative opinion that gathers in one direction or another will lead to change. This has been the experience in other jurisdictions.^{17,18}

Conclusion

Like many changes that occur in society, when there is an interface and impact on health care delivery and those responsible for providing such care, it is not surprising that there will be multiple opinions and an array of “stakeholders” who either support or oppose the policy or legislation in question. What appears to be the case in all the jurisdictions in which MAID has been implemented, is that over time, it finds an appropriate place within its health care system and society. It may undergo steps of evolution and fine-tuning with experience. Ultimately, it will likely meet the needs of most people for whom it is reasonable for it to be considered, and those who are offended by it will likely continue to lobby against and avoid participating in its implementation, at least on a personal basis. This too will presumably occur in Canada.

REFERENCES:

1. Gordon M. Ethical perspectives on end-of-life care: euthanasia, assisted suicide and the refusal of or withdrawal of life-sustaining treatments in those living with dementia. In: *The Law and Ethics of Dementia*. 1st ed. Oxford, United Kingdom: Hart Publishing; 2014. p. 197-214. Available from: <http://www.bloomsburyprofessional.com/uk/the-law-and-ethics-of-dementia-9781782254300/>
2. Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J: Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada and Europe. *JAMA* 2016;316:79-90. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/27380345>
3. Steck N, Egger M, Maessen M, Reisch T, Zwahlen M: Euthanasia and assisted suicide in selected European countries and US states: a systematic literature review. *Med Care* 2014;51:938-44. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23929402>
4. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (formerly Bill C-14), 1st Sess, 42nd Leg, Canada, 2016 (assented to June 17, 2016). Available from: <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014>
5. Government of Canada. Medical assistance in dying (2016) [Internet]. 2016 [cited 2016 Sept 8]. Available from: <http://www.healthycanadians.gc.ca/health-system-systeme-sante/services/end-life-care-soins-fin-vie/medical-assistance-dying-aide-medicale-mourir-eng.php>
6. Cullen C. More than 100 Canadians have opted for assisted death since law passed (2016) [Internet]. 2016 [cited 2016 Sept 8]. Available from: <http://www.cbc.ca/news/politics/assisted-dying-tracking-numbers-1.3744347>

7. Zimonjic P. Only 1 in 10 requests for a medically assisted death granted, Toronto doctor says (2016) [Internet]. 2016 [cited 2016 Sept 8]. Available from: <http://www.cbc.ca/news/politics/medical-assisted-death-toronto-rodin-1.3747136>
8. College of Physicians and Surgeons of Ontario. Medical Assistance in Dying (2016) [Internet]. 2016 [cited 2016 Sept 5]. Available from: <http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Assistance-in-Dying>
9. Alberta Health Services. Medical Assistance in Dying 2016 [Internet]. 2016 [cited 2016 Sept 5]. Available from: <http://www.albertahealthservices.ca/info/page13497.aspx>
10. Canadian Medical Protective Association. Online module on medical assistance in dying (2016) [Internet]. 2016 [cited 2016 Sept 5]. Available from: <https://www.cma.ca/En/Pages/online-module-medical-assistance-dying.aspx>
11. Kirk LM: Professionalism in medicine: definitions and considerations for teaching. *Proc (Bayl Univ Med Cent)* 2007;20:13-16. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1769526/>
12. Canadian Medical Association. CMA policy: medical professionalism (2016) [Internet]. 2016 [cited 2016 Sept 5]. Available from: <http://policybase.cma.ca/dbtw-wpd/Policypdf/PD06-02.pdf>
13. Ennis D. Kim Davis is back in court, defiant as ever (2016) [Internet]. 2016 [cited 2016 Sept 5]. Available from: <http://www.advocate.com/marriage-equality/2016/1/20/kim-davis-back-court-defiant-ever>
14. Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;309:184-88. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2540719/>
15. Pellegrino ED: Patient and physician autonomy: conflicting: rights and obligations in the physician-patient relationship. *J Contemp Health Law Policy* 1994;10: 47-68. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/10134815>
16. Taylor P. Can you describe a 'typical' assisted death? (2016) [Internet]. 2016 [cited 2016 Sept 5]. Available from: <http://www.theglobeandmail.com/life/health-and-fitness/health-advisor/how-does-assisted-dying-work/article29572737/>
17. Koopman JJ, Boer TA: Turning points in the conception and regulation of physician-assisted dying in the Netherlands. *Am J Med* 2016;129:773-5. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/26992560>
18. Legemaate J, Bolt I: The Dutch Euthanasia Act: recent legal developments. *Eur J Health Law* 2013;20:451-69. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/24437331>

The publisher and the Canadian Geriatrics Society shall not be liable for any of the views expressed by the authors published in Canadian Geriatrics Society Journal of CME, nor shall these opinions necessarily reflect those of the publisher.

Every effort has been made to ensure the information provided herein is accurate and in accord with standards accepted at the time of printing. However, readers are advised to check the most current product information provided by the manufacturer of each drug to verify the recommended dose, the method and duration of administration, and contraindications. It is the responsibility of the licensed prescriber to determine the dosages and the best treatment for each patient. Neither the publisher nor the editor assumes any liability for any injury and/or damage to persons or property arising from this publication.