Medical Assistance in Dying

Some ethics-based considerations

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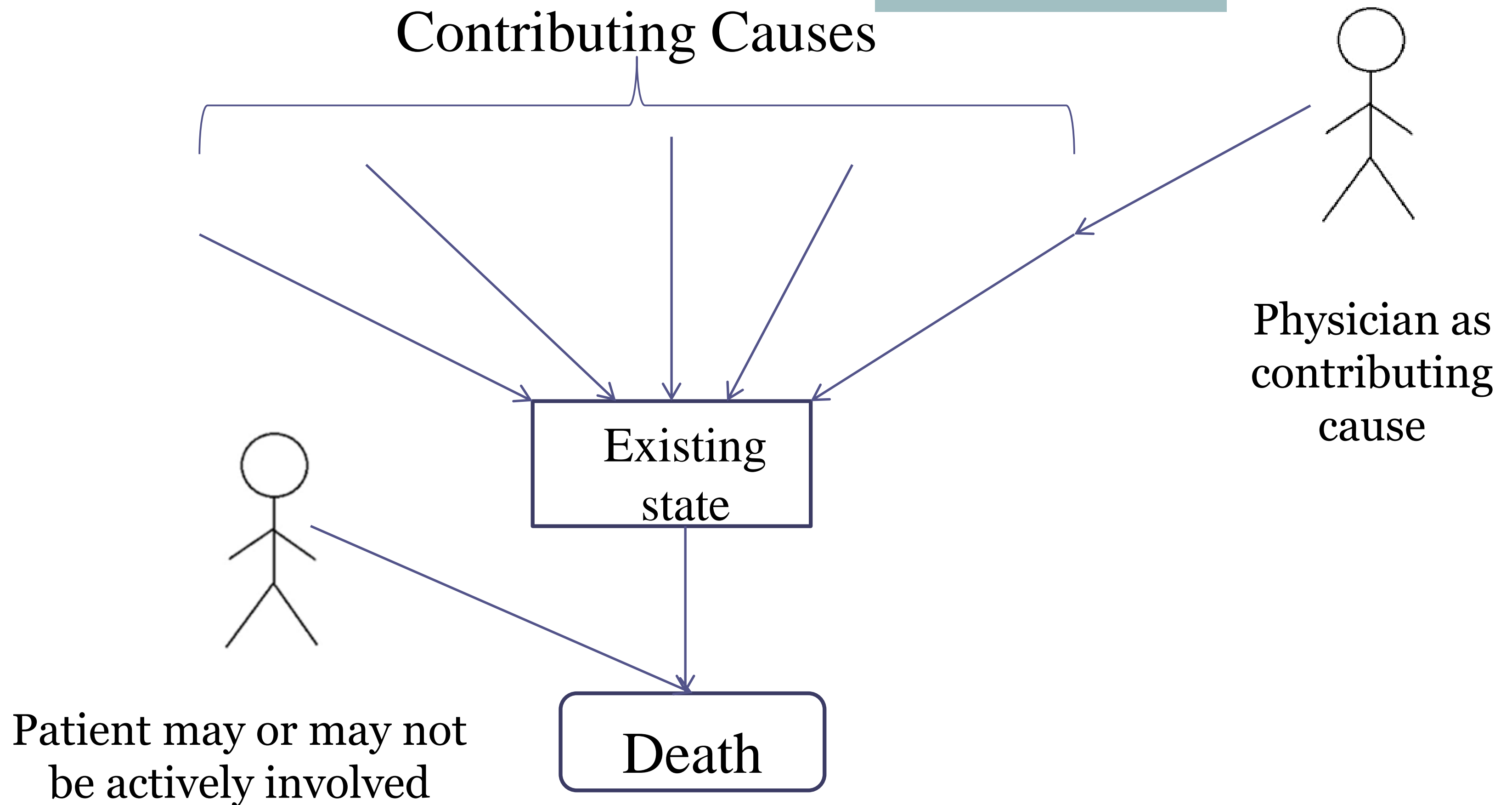
Terminological note

- For the sake of terminological brevity, I shall use the term ‘physician’ to refer to both physicians and nurse practitioners

Another terminological note

- MAiD: Medical Assistance in Dying
  - Physician intentionally participates in the death of a patient by
    - directly administering a substance, or
    - providing the means whereby a patient can self-administer a substance,

    that leads to the patient's death



Medically Assisted Death

Some background

King George V

- Euthanatized by Lord Dawson (overdose of morphine and cocaine) in 1936 so that death would be reported "in the morning papers rather than the less appropriate evening journals."

Rodriguez v. British Columbia (AG) [1993] 3 S.C.R. 519

- Argument
  - Disability prevents disabled persons from exercising freedom-right to commit suicide that was established when suicide was decriminalized in 1972
    - S. 241(b) violates s. 15 (Equality and Justice) of *Charter*
  - Forces disabled persons to exercise autonomy at price of life
    - Violates s. 7 (Security of the Person) of *Charter*
  - Rejected 5-4 by Supreme Court
    - 241(b) violates s. 15 of *Charter* **but** 241(b) is saved by s. 1 of *Charter*

Carter v. Canada (2016)

- Court maintained that facts had changed
  - Social perception
    - True for physicians
    - Questionable for public
      - 74% Angus Reid Poll 1994
  - Legal evolution of *stare decisis*
- Supreme Court unanimously ruled that ss. 14 and 241(b) are unconstitutional
  - *S. 14: No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent*
  - *S. 241(b): Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not .... aids a person to die by suicide*

Powers

Federal	Provincial

- Regulates what is criminal under *Criminal Code*,
- Stipulates conditions
  - Who may perform
  - Who is eligible to receive
  - Application conditions
- Requires Reporting
- Gives consistency

- Medical and health care aspects
- Reporting to Coroner's Service
  - Request
  - Assessments (2)
  - Medication order
  - Death certificate

Federal legislation

- Medical Assistance in Dying Act (MAiD)
    - http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html
    - Passed 7 June 2016
    - Royal assent June 17, 2016
  - Two forms
    - Directly administering a drug that causes death
      - Voluntary euthanasia
    - Prescribing a drug that is self-administered to cause death
      - Assisted suicide

Conditions apply

- Grievous and irremediable medical condition
  - Advanced state of irreversible decline
  - Reasonably foreseeable death
  - Physical or psychological suffering that is intolerable
  - Not suffering only from a mental illness
- 18 years or older
- Competent
- Voluntary consent
  - Signed and dated request
    - May be given by other person in case of inability to sign
  - Second medical opinion

Process for MAiD

- Competent patient meeting conditions set out in *Medical Assistance in Death Act*.
- Consult with independent MD/NP
  - Telehealth witnessing of eligibility
- Signed, dated and witnessed by 2 independent witnesses
- 10 day waiting period unless death or loss of competence imminent

Ethical considerations

Patient perspective
Professional perspective
Codes of Ethics
Ethically questionable issues with MAiD

Patient perspective: Ethics

- Principle of Autonomy
  - Reflected in s. 7 of Charter
- Principle of Equality and Justice
  - Reflected in s. 15 of Charter
- Issue of availability
  - Falls under s. 15 of *Charter* and *Canada Health Act*

Consent

- General rule: Patient has the right to accept or reject any intervention
  - Presumption of competence
  - Limitation of credible health threat to others
  - Medical opinion offered but not determinative
- Two parts to consent
  - Standard of disclosure
  - Standard of comprehension
    - *Reibl v. Hughes* [1980] 2 S.C.R. 880

Substitute decision making

- Arises as issue when patient lacks competence
- If anticipated, should be explored with patient as part of fiduciary duty
- Ethically and legally defined order
  - Underlying assumption that propinquity correlates with understanding of values
    - *Health Care (Consent) and Care Facility (Admission) Act;* etc.
    - When conflict arises, duty to refer to Courts

Ethical issues for profession

- Duty of Care
- Consent
- Competence
- Substitute decision making
- Medically assisted death

Duty of Care

- Entailed by fiduciary physician-patient relationship
  - *Fiduciary relationship ethically and legally mandated*
    - *Codes of Ethics*
    - *McInerney v. MacDonald* [1992] 2 S.C.R. 138.

Duty of Care
Impossibility vs. futility

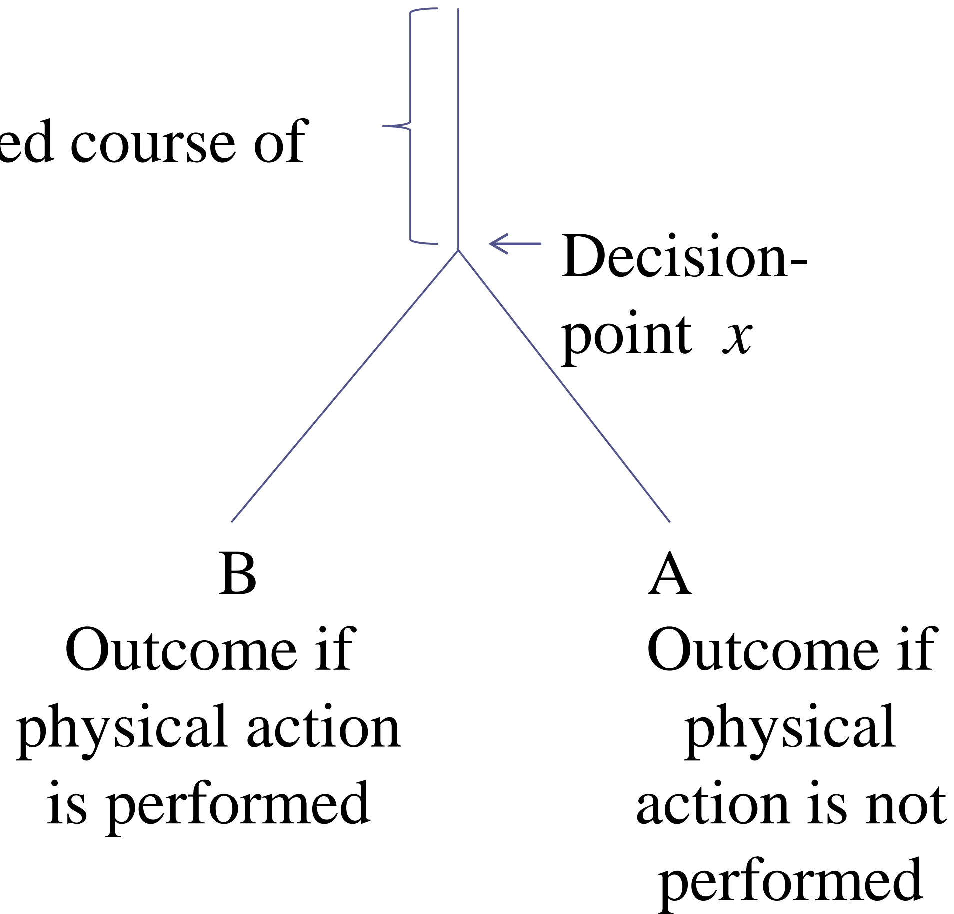
- Impossibility removes duty to act in the relevant manner
  - In ethics and in law, the existence of a duty logically presupposes possibility of carrying out that duty
  - Therefore cannot have obligation/duty to do the impossible
    - See Jecker and Schneiderman, "Medical Futility: The Duty Not to Treat" *Cambridge Quarterly of Healthcare Ethics* 2:2(1993)151-159
    - *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482
- Futility not the same as impossibility
  - Futility is goal-relative
    - Therefore is value-relative
  - Therefore governing issue is whether goal is
    - Realistically achievable
    - Ethically defensible
      - Issue of values

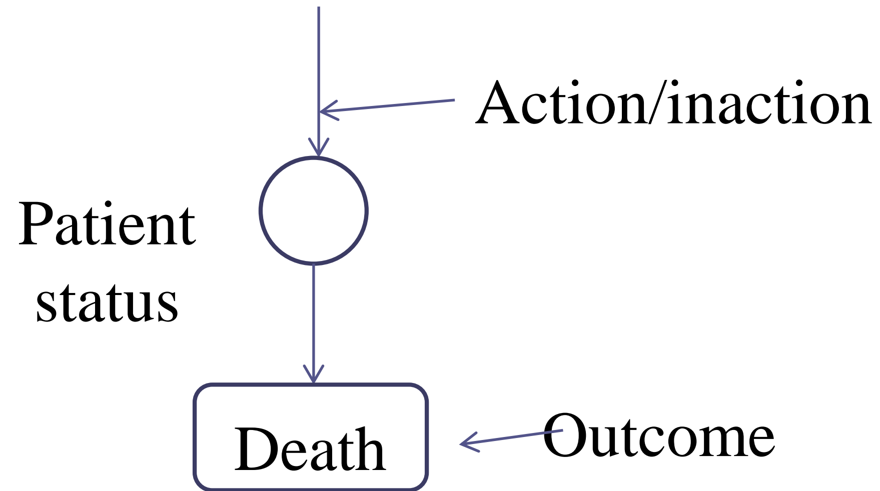
Withdrawal of treatment and palliation

- *Rasouli v. Sunnybrook Health Sciences Centre* et al. 2013 SCC 53
  - "… if the legislature intended that consent was required to the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate, we would have expected clearer language to that effect"
  - "we are prepared to accept that the *Act* does not require doctors to obtain consent from a patient or substitute decision-maker to withhold or withdraw "treatment" that they view as medically ineffective or inappropriate."
- Does not mean that may withdraw treatment ***and initiate palliative care***
  - Palliative care is distinct treatment and hence requires consent

Active vs. Passive Euthanasia

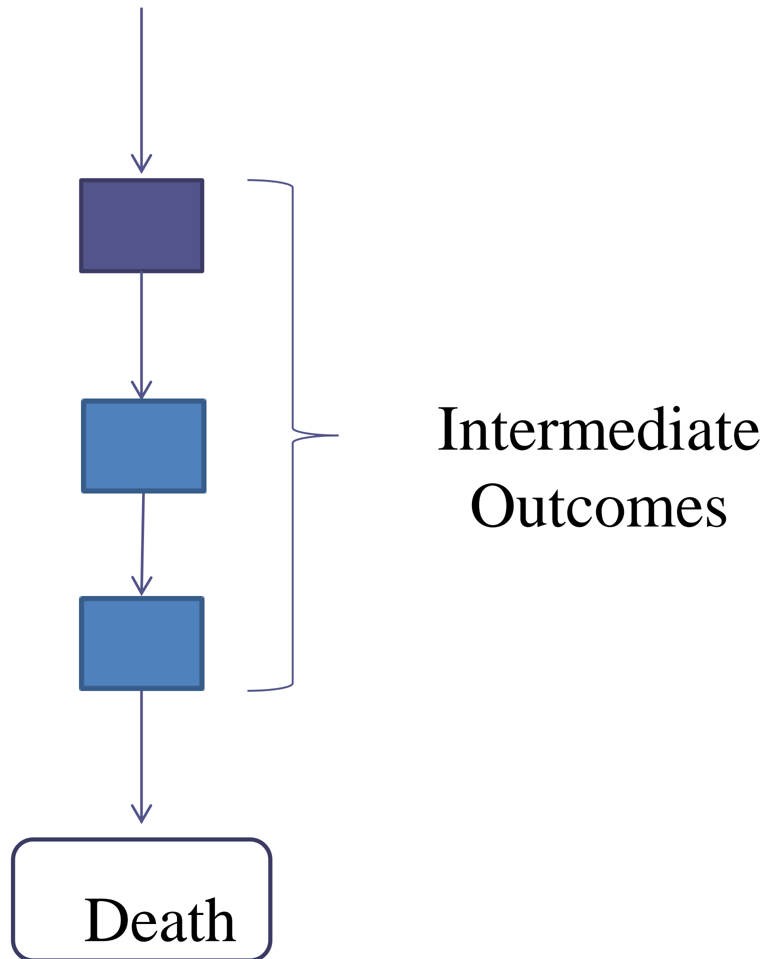
- Ethically there is no difference between active and passive euthanasia
- The question is not whether an action has occurred but whether there was a duty to keep the patient alive
  - Concept of culpable negligence


Established course of events
Decision-point x
B
Outcome if physical action is performed
A
Outcome if physical action is not performed

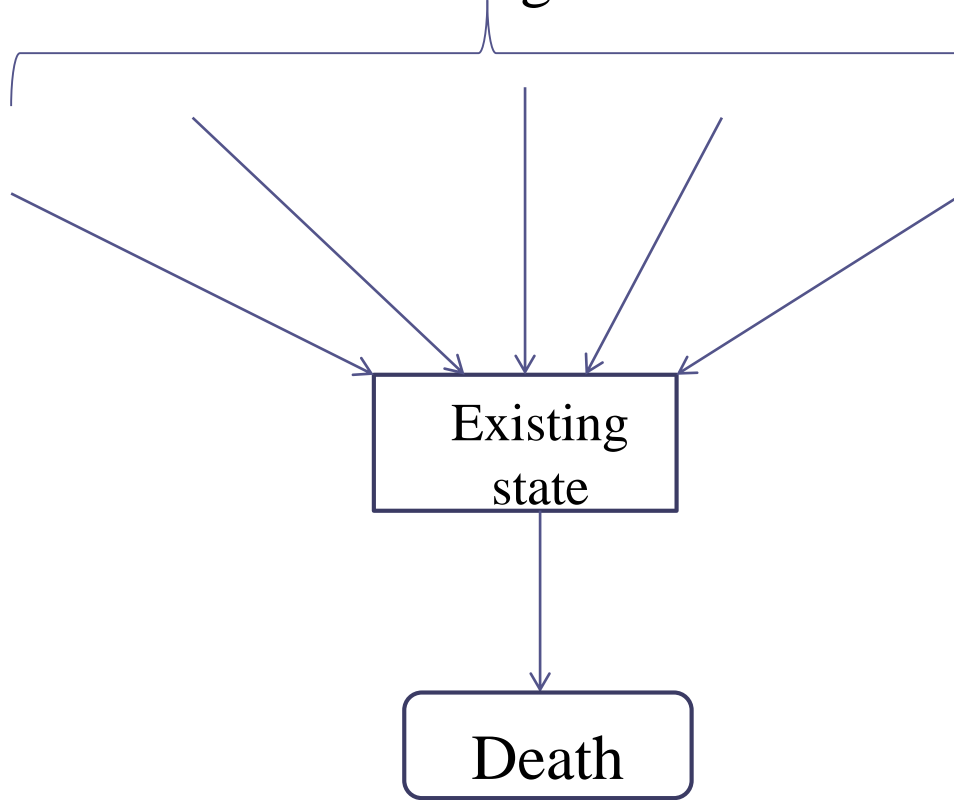


Direct Euthanasia

Initial Action



Indirect Euthanasia



Indirect Euthanasia

MAiD and Codes of Ethics

- Hippocratic
- WMA
- CMA

Hippocratic Oath

- "I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, *according to my ability and judgement*, I will keep this Oath and this contract …."
- Therefore MAiD not contrary to Hippocratic Oath

WMA Rejects MAiD as contrary to International Code of Medical Ethics

- Euthanasia
  - *"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."*
    - https://www.wma.net/policies-post/wma-resolution-on-euthanasia/

Cont.

- Assisted Suicide
  - “Physicians-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.”

Canadian Medical Association Policy Statement

- No obligation on individual physician
- Should refer if will not personally provide MAiD
  - "There should be no undue delay in the provision of end of life care, including medical aid in dying."
    - https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf

College of Physicians and Surgeons of BC

- “Physicians who object to MAiD on the basis of their values and beliefs are required to provide an effective transfer of care for their patients *by advising patients that other physicians may be available to see them, suggesting the patient visit an alternate physician or service*, and if authorized by the patient, transferring the medical records as required.”

- But
  - “A physician is not required to make a formal referral on behalf of the patient”

Pope Pius XII

- “Natural reason and Christian morals say that man (and whoever is entrusted with the task of taking care of his fellow man) has the right and duty in the case of serious illness to take the necessary treatment for the preservation of life and health … But morally, one is held to use only ordinary means—according to the circumstances of persons, places, times and cultures—that is to say, means that do not involve any grave burdens for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of a higher, more important good too difficult.”
    - “Prolongation of Life: Allocution to an International Congress of Anesthesiologists,” Nov. 24, 1957; Pope Pius XII, *Osservatore Romano 4 (1957)*

Arguments in favour of MAiD

Doctrine of Double Effect
Force majeure argument

Doctrine of Double Effect (DDE)

- Engaging in an act with both a negative and a positive outcome is ethically acceptable if and only if the following four conditions are met:
  - Act has both a negative and a positive outcome
  - Act in itself is ethically acceptable
  - Negative outcome is not temporally prior to and necessary for the positive outcome
  - Intent is only to achieve positive outcome

Logical problem with DDE

- Awareness of negative outcome is integral to awareness of the consequences of the act
- Therefore cannot isolate negative outcome from intent
- Therefore intent is intent to achieve positive outcome *despite* negative outcome
- Therefore, logically, the intent condition of DDE cannot be met

Force majeure argument

- Ethically, physicians have two fundamental obligations
  - Act in the best interest of the patient
  - Preserve life
- When these conflict, duty to act in best interest of patient takes priority

Best interest

- Is value-dependant
- Values
  - Material vs. non-material
- Whose values should be determinative?
    - Physician?
    - Patient?

Law and ethics

- Ethics holds that values of patient are determinative
  - Principle of Autonomy
- Law stipulates that values of the medical profession are not determinative
  - *Reibl v. Hughes [1980] 2 S.C.R. 880*

Ethically relevant conditions for MAiD

- Appropriate care
- No duty for **individual physician /nurse practitioner** to provide MAiD
  - Duty to refer
- Duty on **profession** to make MAiD available
  - Ethically derivative of licensing
    - Service provider monopoly

Ethically questionable aspects of current legislation

- Exclusion of advance directives
- Exclusion of substitute decision-making
- Exclusion of under-18 years old
  - Groningen Protocol
- Requirements
  - Irreversible decline
  - Reasonably foreseeable death
- Exclusion of purely psychological/psychiatric condition

Likelihood of constitutional challenge

Thank you for your kind attention

Comments?

Questions?

Advance directive

- Loss of competence does not entail loss of rights
- Duty of MRP to explore with patient if there are reasonable grounds to suppose that the patient may face loss of competence
- Particularly relevant in end-of-life or similar situations
- Binding unless
  - Made when incompetent
  - Requires interpretation
  - Reasonable grounds to suppose that has been withdrawn
    - Legally binding
      - *Malette v. Shulman* DLR (4th) 321)

Exclusion of under-18 years old

- Assumption that cannot suffer to the same degree as someone over 18 years of age
  - Groningen protocol (under 1)
    - The presence of hopeless and unbearable suffering
    - The consent of the parents to termination of life
    - Medical consultation having taken place
    - Careful execution of the termination
- Assumption that not competent to request MAiD
  - Contradicts
    - *A.C. v. Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 S.C.R. 181.
    - *B.C. Infants Act*

Requirements

- Irreversible decline
  - Ambiguous
  - Ignores suffering as “steady state”
- Reasonably foreseeable death
  - Legitimates insistence on extended period of suffering

Exclusion of substitute decision making

- Forces continued suffering on incompetent persons who would be eligible for MAiD if they had been competent
  - Contradicts ethics of substitute decision making
  - Violates Principle of Equality and Justice
  - Violates s. 15 of *Charter*

Exclusion of purely psychological/psychiatric condition

- Assumes that mental health should not be treated like physical health
- Assumes that all suffering is physical
  - Contradicts common understanding of term
    - See argument in *Rodriguez* and *Carter*
- Contradicts logic and ethics of *Starson v. Swayze*
    - *Starson v. Swayze, [2003] 1 S.C.R. 722, 2003 SCC 32*

Thank you for your kind attention

Principle of Autonomy

- Everyone has the right to self-determination subject only to the equal and competing rights of others
  - Underlies right to informed consent
    - In particular, the right to accept or reject any health care intervention

Principle of Equality and Justice

- All persons are equal insofar as they are persons and should be treated the same. Exceptions to this must always be based on ethically relevant differences in the nature or status of the person in question.