REFLECTIONS ON THE SCC DECISION ON PHYSICIAN ASSISTED DEATH

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Alberta Disabilities Forum

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Route

- Philosophy of palliative care
- Dying today
- Health care and human-ness
- New challenges with the SCC Carter *v.* Canada decision

Transparency

- My own declaration so that you can put what I say in context

Beechey Island

EAW 2012

Genesis

- *Pall* – ‘to cloak’
- Modern Hospice movement – Dame Cicely Saunders
- Palliation, late life care, end of life care and terminal care

Palliative care's beacons

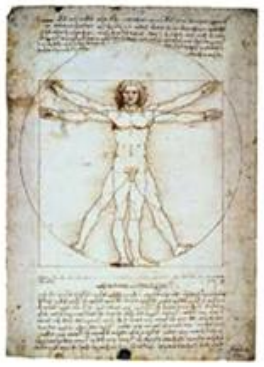
- Care in order to optimize function, allowing best possible living and preparation as death approaches
- Ease death – neither hasten death nor prolong life
- Attend to physical, psychological, emotional and spiritual needs where desired
- Care in order to reduce suffering
- Promote dignity
- Support patient's circle
- Do not abandon

Genesis and overall goals

- Locations
  - Home
  - Hospice – varying definitions
  - Long Term Care
  - Hospital

How we die

- The moral battleground is really between our western fascination with autonomy and control over our lives and deaths; and a deeper psycho-sociologic and perhaps spiritual narrative about experiencing and acquiescing to the full range of life`s offerings.



Medicine`s place

- With credit to Dr. Beverley Smith, this quote from Timmermans: ``While questioning the inevitability of death, modernity added anguish to it: security of small victories over some acute, devastating disease enhanced insecurity in light of the ultimate demise.``
- Is our sense of (need for) human control over death merely an illusion – perhaps a conceited one?
- And I am speaking here about patients, but also about clinicians.

How Canada got to the *Carter* decision

- *Rodriguez*
- 5 parliamentary attempts
- National Palliative Care reports (Senate - Carstairs)
- Relentless advocacy by the right to die movement
- Strategic use of challenging disease and fearsome symptoms
- Public opinion polls – about what
- Canadian pluralism and respect for diversity of views

How Canada got to the *Carter* decision

- Charter of Rights and Freedoms
  - Strong focus on individual rights
- Examples of other countries
- Sociologic changes
  - Decline of religiosity
  - Notion of autonomy and of the self v. community
  - Notion of control over existent

How a patient can die by intention (1)

- Excluding patients dying by error and catastrophic medical misadventure
- Excluding non-patients
  - Trauma, outside of care
  - Natural death, outside of care
  - Suicide, outside of care

How a patient can die by intention (2)

- Allow expected death by withholding potentially life-saving medical intervention (Do Not Resuscitate)
- Cause immediate death by withdrawal of particular medical intervention (withdraw ventilator)
- Allow eventual death from underlying illness by withdrawal of particular medical interventions (stop chronic oral cancer chemotherapy)

How a patient can die by intention (3)

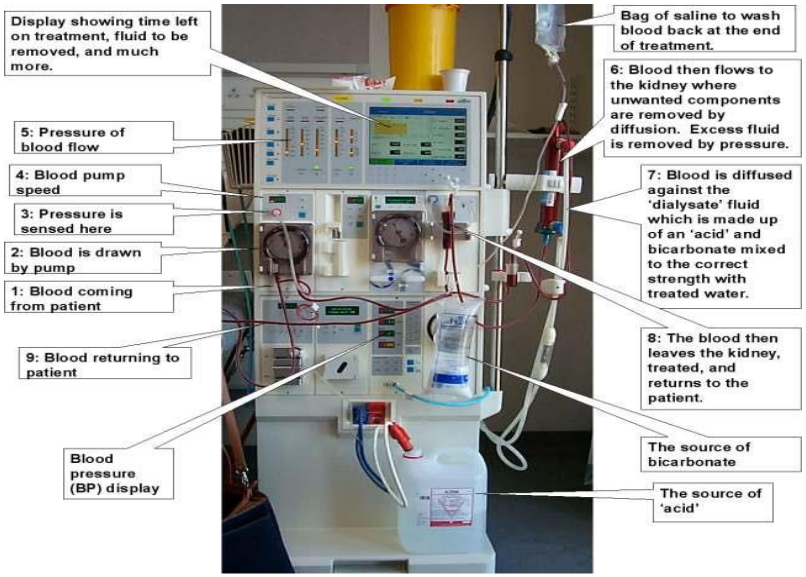
- Allow eventual death caused by VSED
- Cause immediate death by the administration of a lethal dose of medicine:
  - Administered by patient
  - Administered by clinician

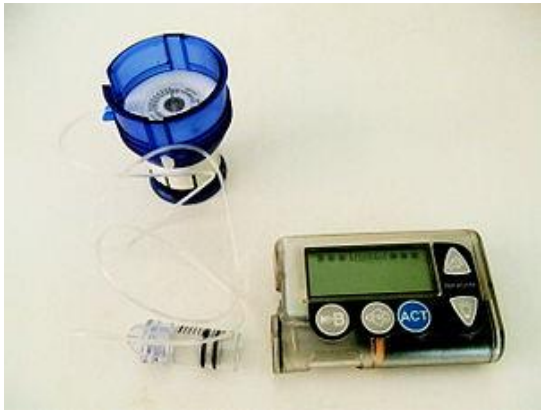
How we die is also changing

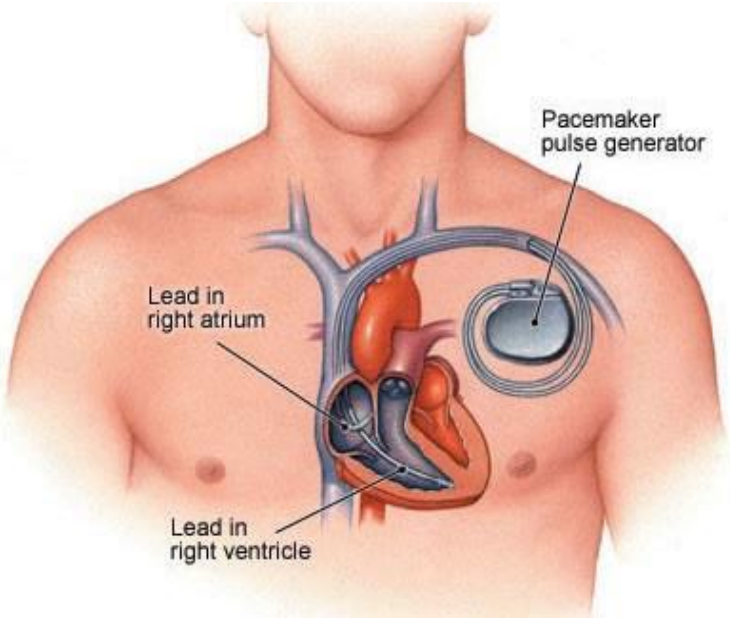
- Used to be from trauma and infection diseases
- Then increasingly from cancer
- Now will be from older age, but with chronic illnesses
- Withdrawal of therapies

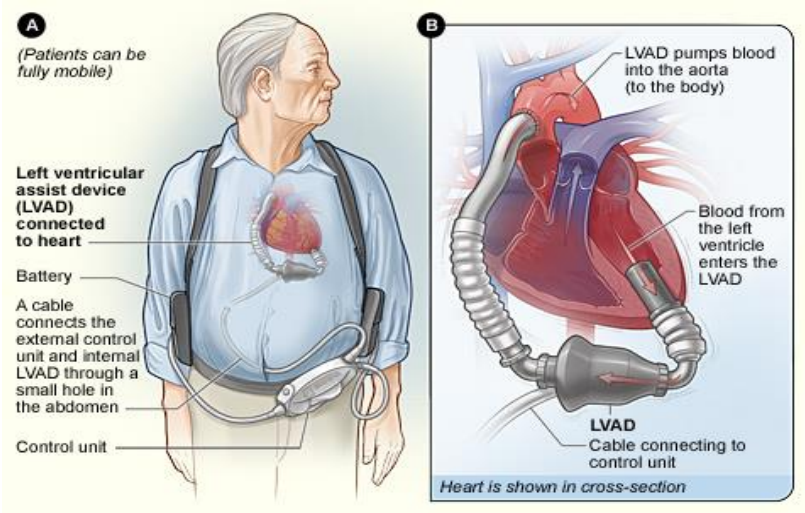
The majority of patients and clinicians will face…

- Decisions about the withdrawal of life prolonging interventions for chronic disease:






Pacemaker
pulse generator
Lead in
right atrium
Lead in
right ventricle


A
(Patients can be
fully mobile)
Left ventricular
assist device
(LVAD)
connected
to heart
Battery
A cable
connects the
external control
unit and internal
LVAD through a
small hole in
the abdomen
Control unit
B
LVAD pumps blood
into the aorta
(to the body)
Blood from
the left
ventricle
enters the
LVAD
LVAD
Cable connecting to
control unit
Heart is shown in cross-section

Extrinsic or intrinsic to self?

- To what degree is a medical device or therapeutic part of a person's being (pacemaker example)?
- Can that degree have any moral relevance to withdrawing it?

Kidney disease example

- High mortality
- Shortened lifespan
- Higher mortality than colorectal, ovarian, NH lymphoma, breast and prostate cancers
- 50% of patients starting dialysis are older than 65.
- Fastest growth in 70-75 age range
- On the day a person decides to stop this therapy, what is different than the previous day?

Palliative care

- Our hope that we will never hear uttered from the lips of a physician – ‘there is nothing more that I can do for you’.
- A time of living during death’s approach
- Care beyond cure
- Treating and healing
  - This approaches ‘personhood’ not ‘disease-hood’
  - Curing ≠ healing. Healing ≠ curing.

Palliative sedation

- Not Euthanasia
- Criteria to use it must be adhered to
  - Terrible distress, refractory to reasonable treatment steps
  - Close to death
  - Clear goals for medication
  - Supervision by experienced providers
  - Document well
  - Do Not Resuscitate Order (non R1 GCD) is in place

Carter *v.* Canada

- Struck down criminality of assisting or counselling for suicide
- One year declaration suspension to provide time for legislation to be developed and enacted
- Not exclusive for dying patients
- Physicians need to be involved
- Balance conscience rights and patient rights

Reasoning

- The Court decided that experience in other places demonstrates that appropriate safeguards can be created in order to protect vulnerable persons.
- The current prohibition may force people to end their lives sooner than otherwise necessary.
- No evidence for a slippery slope.

Carter *v.* Canada

- Some concerns, from a long list:
  - Will Palliative Care be viewed with more fear?
  - Potential impact on other patients
  - Potential impact on trust commitment
  - Difficulty in assessing decisional competence
  - Distinction between injecting and prescribing
  - Organ and tissue donation
  - Protections for vulnerable people

Range of legislative actions

- Invoke Notwithstanding clause
- Ask SCC for extension of declaration suspension
- Ignore
- Consult, all party committee, public, etc.
- Legislate
  - Very restrictive
  - Permissive
  - Federal (criminality) and Provincial (health system delivery)

Key decisions

- How broad or narrow should access be?
- How available should it be geographically?
- Who can perform this act?
- How do we reconcile access rights with conscientious objection?
- Should it be euthanasia and assisted suicide?
- How do we protect care providers from moral harm and legal risk?
- Ought there be a monitoring and reporting function after, or a review and approval mechanism prior?
- Is it part of medicine? Health Care?

How is Alberta preparing?

- Description of preparedness planning and challenges
  - AHS
  - Partner organizations
  - Public
  - Advocacy groups

Legislative schemes to protect persons

- David will discuss
  - the details of the legal decision
  - some of the approaches of other jurisdictions
  - what can be incorporated in legislation and regulation in order to protect people and especially vulnerable persons.

Key context

- The provision of expert, dignified, human, compassionate and loving care is accomplished by everyone who surrounds a person experiencing an end of life journey.

- Caring for anyone’s health needs, and certainly for end of life care needs is a profoundly human endeavor.

Humility

-recognize our place as mere intervenors in the person`s life journey

Discussion

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