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A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia

PREPARED BY THE CFPC TASK FORCE ON END-OF-LIFE CARE

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Introduction

Physician-assisted suicide and euthanasia involve complex issues for the family physician that deserve careful reflection. Here are some key questions: When a patient asks for assistance in dying, what should the family physician do? What are the family physician's values personally and professionally? How might he or she discuss and respond to the patient's values respectfully? What words could he or she use?

Family physicians bring a variety of perspectives and approaches to the practice of their profession, but all agree that the ethical deliberations involved in their practice should always be undertaken with due diligence and care. The Task Force on End-of-Life Care of the College of Family Physicians of Canada (CFPC) prepared this guide to highlight for our colleagues some key considerations relevant to ethical deliberations in this important area, which arise as a result of recent changes in Canadian law affecting physician-assisted suicide and voluntary euthanasia.

The CFPC offers this reflective guide to help family physicians address difficult questions. We are aware that our members will also look for continuing professional development and further training and information on assisted suicide and voluntary euthanasia. The CFPC is now considering the implications the Supreme Court of Canada ruling will have on the standards of family medicine education, curriculum, and continuing professional development. It is planning to consider developing or encouraging the development of further material to assist family physicians in dealing with their patients in the last phase of their lives.

Changes in the law

In June 2014, Quebec became the first province in Canada to pass legislation (*An act respecting end-of-life care*¹) to allow "medical aid in dying" under certain circumstances. The Act defines "medical aid in dying" as "administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death." This law will come into effect in December 2015.

In February 2015, the Supreme Court of Canada (SCC) rendered a decision on the case *Carter v. Canada (A.G.)*.² The Court ruled that sections 241(b) and 14 of the *Criminal Code of Canada*, which prohibit any individual from assisting in another's suicide³ or inflicting death on another even if consent is given,⁴ will no longer apply to situations in which physicians "assist" dying or death at the request of patients under certain circumstances (namely, they must be adults capable of consenting who experience "intolerable" and "enduring" suffering due to a "grievous and irremediable" illness, disease, or disability). The appellants in the case defined *physician-assisted dying* or *physician-assisted death* as a situation in which "a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient." The Court's ruling has been suspended for one year to enable legislatures and medical colleges in Canada, if they wish, to enact laws or develop policies that regulate these newly permitted interventions by physicians.

What do these legal changes mean for physicians?

Both Quebec's legislation and the SCC's ruling on *Carter v. Canada (A.G.)* are based on the premise that, under certain conditions, *aid in dying* or *assisted death* should fall within the scope of care provided by the medical profession in Canada. Both documents, however, state that individual physicians are not legally bound to provide such interventions. Some latitude is given to physicians to decide, as individuals and, collectively, as a profession, whether to provide any, some, or all of these new interventions and, if so, under what circumstances. The onus remains, therefore, with physicians to engage in ethical deliberation on these questions and their implications.

What does adequate ethical deliberation mean?

If a patient approaches a physician regarding assisted suicide or euthanasia, the physician must take into account all relevant questions, considerations, and alternatives.^{5*} This deliberation includes ample consultation and discussion with the patient and his or her family members and loved ones, other health care professionals involved in the patient's care, and any person whose expertise and perspective will contribute to an informed decision.

Ethical deliberations between physician and patient should be specific and take into account the unique circumstances of each case. The same standards of due diligence and care in ethical reasoning that pertain to the care of *any* patient should be maintained when physicians deliberate about the care of patients who have serious illnesses, diseases, or disabilities, and/or who are dying. The physician should be aware of the possible impact of his or her own attitude and beliefs regarding disability, suffering, and death on discussions with the patient and the patient's loved ones.

Sometimes the values and other ethical principles of the physician, the patient, and the others involved come into conflict. Through further reflection and discussion, however, they can often find a way of prioritizing their values that is acceptable to all, or of identifying a previously overlooked option for action that reconciles the conflict. If reflection and discussion do not reconcile the conflicts between the physician's and patient's values, the physician should discuss transferring the patient's care to another physician in a way that neither compromises the physician's moral integrity nor affects the patient's quality of care.

*For examples of ethical considerations and their application to concrete decisions, see Ogle K et al. *Ethics in family medicine*. CFPC; 2012.

What are some ethical issues for the medical profession?

Issues bearing on the profession's identity

Recent legal changes raise profound questions for the medical profession. For example, what are the goals and limits of medicine? What is the nature of the physician-patient relationship? Different views held by individual physicians in their ethical deliberations in particular cases should be acknowledged and respected. However, medical professional bodies should also initiate and encourage in-depth education and reflection within their professions on fundamental ethical questions that involve the identity, goals, and philosophy of care of the profession as a whole, and should also promote discussion on the basis of differences on these ethical issues.

Ethical issues relating to health care systems

Canadians should have access to quality palliative care in their communities. This access is an issue of social justice.⁶ Permitting physician-assisted suicide and voluntary euthanasia should not undermine efforts to improve comprehensive medical, mental health, and palliative care. Rather, these efforts should be intensified. Individual physicians and the medical profession should recognize and act to support patients who have serious illnesses or disabilities and those who are dying. Actions could include:

- Recognizing the limits of medicine in addressing human finitude and mortality
- Considering the patient's assessment of the overall proportion of benefits and burdens of life-sustaining interventions for himself or herself
- Improving training and addressing other barriers to initiating and engaging in end-of-life conversations with patients, and to managing pain and other distressing symptoms effectively
- Challenging attitudes and behaviours that regard some patients as “non-productive” and costly members of society, for instance, by referring to the demographic of aging Canadians as the “silver tsunami.” These attitudes and behaviours among care providers can reinforce patients' sense of being a burden to others and their perception that they have a “duty to die.”
- Acknowledging the limits of biomedical interventions to address human existential concerns, which invariably arise during serious illness and the prospect of imminent death
- Maintaining continuity of primary care when referring patients to appropriate specialized care, to provide coordination among different parts of the health care system and to ensure that patients are cared for by physicians whom they trust and who know them well

What is the meaning of a physician's right to freedom of conscience?

Normally in law and ethics, the right of freedom of conscience protects and fosters an individual's responsibility to maintain moral integrity by refusing to participate in an action that a policy or law mandates but that the individual objects to on ethical grounds.^{7,8*} In its updated policy on euthanasia and assisted death (December 2014), the Canadian Medical Association interprets the physician's right to freedom of conscience to cover both the freedom of physicians to decide not to provide assisted suicide and voluntary euthanasia as well as the freedom of physicians to decide to do so.⁹ The freedom of the latter would *de facto* be protected by legislation under certain conditions.

Further, the right to freedom of conscience in law and ethics normally extends to an individual's right to limit cooperation with others in a practice that he or she objects to on ethical grounds. This is pertinent to the degree of involvement that a physician judges to be ethically acceptable in responding to a patient's request for assisted suicide or euthanasia. Such involvement might range from providing information to the patient on how to end his or her life, to prescribing medication or administering medication, to referring or transferring the care of the patient to another physician or third party. In general, the more essential and direct the cooperation is in bringing about an outcome to which that physician objects on the grounds of conscience, the more complicit the physician would be in it. However, physicians must be cognizant of the scope of their responsibility in providing care to a patient. The CFPC opposes in principle any action that would abandon a patient, without any options or direction.

All physicians, and all those responsible for health care facilities, should deliberate on the values or ethos guiding their practices relating to physician-assisted suicide and euthanasia, and should communicate their policy to concerned patients.

What does the Supreme Court of Canada ruling say about patient autonomy?

The Supreme Court of Canada ruling affirmed that the *Canadian Charter of Rights and Freedoms'* protection of the "liberty" of competent adults⁸ includes upholding their freedom from undue state interference in personal choices.

Some have interpreted the Court's ruling in a manner that makes respect for patient autonomy the absolute or paramount ethical consideration in decisions regarding physician-assisted suicide and voluntary euthanasia. Others note that the Court's ruling addresses the legal issue of balancing individual and state interests.

Although the ruling discusses the right of a particular group of patients to make personal choices regarding "physician-assisted dying" without undue interference from the state, it does not address the physician-patient relationship as such, which ought to be characterized by shared decision making.

Legal reasoning cannot automatically be applied to ethics and does not fully determine the ethical responsibilities of physicians and patients.

*The United Nations' *Universal Declaration of Human Rights* recognizes the right of all humans to freedom of conscience (art. 18). This was influenced by the Nuremberg Charter after World War II, which held that acting on orders from a government or superior is not sufficient by itself to excuse individuals' responsibility for their decisions. The right to freedom of conscience is also guaranteed in article 2(a) of the *Canadian Charter of Rights and Freedoms*.

What does respecting patient autonomy entail for the physician?

Some hold the view that autonomy simply means self-determination in choosing. The ethical notion of autonomy, however, pertains both to the freedom of the individual and to the exercise of moral agency. In this case, a patient's moral agency includes having the capacity for ethical reasoning—making responsible ethical judgments that reflect one's personal values, goals, and other ethical concerns and commitments. Determinations of such capacity involve discussions with patients that are attentive and nuanced. These discussions require sensitivity from the physician—who in turn requires training and resources to support the development of these interpersonal skills—as well as an appreciation of the patient's own ethical decision-making framework to make decisions about his or her own care. The ethical notion of *autonomy* should also be distinguished from the legal criteria for *capacity to give consent*—a comparatively less exacting concept—which typically focus on the ability to understand and appreciate the consequences of one's decisions, while leaving out other aspects of moral agency.

The following are some practical considerations regarding patient autonomy:

- When a patient requests assistance in suicide or euthanasia, the physician needs to take time—having and applying the appropriate skills and resources—to discern whether depression or suicidal ideation, which compromise patient autonomy, is present and can be addressed therapeutically.
- Physicians accept that they should not take over the decision making of competent patients. They also know that they need to be self-aware to avoid projecting and imposing their own values on their patients and to avoid allowing their own perceptions to pre-judge the quality of their patient's life.
- Equally, however, a physician should not mechanically convey medical information to a patient. The physician should offer to the patient opportunities for adequate discussion of the patient's concerns and related ethical issues in view of the patient's medical condition. This process includes discerning with the patient who requests assisted suicide or euthanasia, and the patient's loved ones, what values, hopes, and fears lie behind the request, which might not always be the same as the patient's stated reasons. For this discernment, the physician needs to know his or her patient well and to engage in attentive, non-judgmental listening.
- The physician should be attentive to signs not only of biological and psychological distress, but also to those of existential and, for many, spiritual suffering, which often arise when individuals face declining health, diminished function, and the reality of death.
- Because patients might not always be aware of or able to articulate their thoughts regarding these struggles, physicians have to be adept at discussing feelings and interpreting behaviours, and be able to draw on the expertise of others to do so. The physician's attentive and empathetic listening, availability to discuss issues of concern, offer of appropriate supports, and expression of commitment to continuing care throughout the patient's illness are themselves important therapeutic responses for patients and their loved ones.

What terminology should physicians use regarding these new permitted interventions?

The legal terms *medical aid in dying* and *physician-assisted dying* are too general as stand-alone terms for use in clinical practice and ethics. While applied to specific clinical practices and scenarios, they can give rise to uncertainty and misunderstanding among physicians and patients.^{10*} They also conflate various practices and scenarios that entail distinct ethical considerations. For example,

- The term *physician-assisted dying* used in the SCC's ruling does not differentiate between voluntary euthanasia and physician-assisted suicide. There are, however, significant psychological and ethical differences between these two practices for many physicians and ethicists. Euthanasia engages physicians as agents who intentionally end the life of their patients, whereas in assisted suicide, it is the patient who ends his or her own life.
- The SCC's ruling does not differentiate ethically between *physician-assisted dying* and currently accepted practices of physicians withholding or withdrawing life-sustaining interventions at a patient's request and of palliative sedation that is administered for symptom control. Many physicians and ethicists maintain, however, that there is a significant difference in terms of the physician's intention. When a physician provides palliative sedation, the intention is to alleviate unbearable suffering. Similarly, when a physician acts on a patient's request to withhold or withdraw life-sustaining interventions, the intent is to support shared decision making and avoid unwanted medical interventions.

When physicians use the terms *medical aid in dying* and *physician-assisted dying*, they should understand the legal definitions of these terms. They should not use these terms to describe withholding or withdrawing life-sustaining interventions at a patient's request or palliative sedation. The terms *physician-assisted suicide* and *voluntary euthanasia* are more specific than the new legal terms. Physicians should use these more specific terms together with descriptions of the practices and scenarios involved (eg, counseling, prescribing, or administering lethal medication to induce a patient's death).

*A recent survey of physicians and nurses in Quebec found that about 60% of them believed wrongly that *medical aid in dying* under Quebec's legislation excludes administering lethal medication to end a patient's life at the patient's request, while about 35% thought mistakenly that the law permitting *medical aid in dying* allows a physician to induce an incompetent patient's death at a family member's request. See Marcoux I et al. *Can Fam Physician* 2015;61:e196.

What does addressing patients' concerns about "losing dignity" involve?

In requesting assistance in suicide or euthanasia, patients often express a concern about "losing dignity" in their present condition or at some future stage in their progressive illness or disability. The term *dignity* can have different meanings and is open to interpretation. It is important for physicians and patients to be aware of and to discuss various meanings in order to identify the patient's concerns and address them appropriately.

There is general agreement that dignity is intrinsic in all human beings because all have equal worth and belong to the human community.* Dignity in this sense cannot be diminished or lost by such changes as disfigurement, illness, or decline in capacities.

There is another sense of dignity that is related to the flourishing or well-being that patients experience in their lives. Dignity as associated with flourishing and well-being can be subject to variation with illness and disability for some individuals, particularly for those who are concerned with their loss of control or independence. These concerns in many patients can be mitigated or addressed by effective care, so that their dignity in this sense can be preserved or even enhanced. In other patients, their adjustment to and acceptance of the limitations imposed by illness, disability, and death can result in overall well-being in the patient and can provide a sense of meaning and inspire their loved ones and others in the midst of suffering.^{11†}

A third sense of dignity, *attributed dignity*, is connected with how patients perceive themselves or how they perceive others' regard for them. Negative self-perception and concerns about being a burden to others can often lead patients to consider physician-assisted suicide and euthanasia. Physicians have a variety of options at their disposal to explore and address these concerns:

- Listen nonjudgmentally to the concerns of patients regarding "losing dignity" and discern with them what underlies these concerns.
- Reassure patients of their intrinsic worth and of their belonging within their communities.
- Discuss with patients and their loved ones available options for enhancing "dignity" in the second sense by seeking appropriate environments and supports.
- Explore and address with patients and their loved ones the basis for the patient's negative self-perceptions or perceptions of the regard of others.
- Point patients to resources, such as counseling and other psychosocial supports and, for those patients who want them, spiritual supports, to help them adapt to and find meaning in their changed circumstances.

It is possible, however, that competent patients who meet legal criteria for physician-assisted suicide or euthanasia might persist in requesting these interventions after these avenues have been explored. The physician then must deliberate on what his or her informed conscience will allow. For some physicians, the considerations regarding conscientious objection and the transfer of care of patients, as outlined above, might apply.

*For example, the United Nations' *Universal Declaration of Human Rights*, which almost all nations have ratified, begins its *Preamble* by stating that "recognition of the inherent dignity and ... the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."⁷

For a contrary view rejecting any firm basis for "species-related human dignity" (or intrinsic dignity), see Royal Society of Canada Expert Panel. *End-of-Life Decision Making*. Ottawa, ON: RSC; 2011:51-59.

†This is the sense of "dignity" referred to in the palliative care interventions that Dr Harvey Chochinov and others have developed. See Chochinov HM. *Dignity Therapy*. Oxford University Press; 2011.

Conclusion

The recent legal changes in Canada relating to physician-assisted suicide and voluntary euthanasia raise many ethical issues upon which the medical colleges and individual physicians will need to deliberate. Physicians should, above all, remain committed to their relationships with patients and their patients' loved ones during this last chapter of life. Recognizing that those who have serious illness or disabilities and those who are dying are among their most vulnerable patients, family physicians can be health advocates on behalf of such patients. Collectively and publicly, we can affirm to them and their loved ones that:

- We are ready to care for you and try to make each of life's chapters the best it can be.
- We will never doubt you when you say you are in pain or distress; instead, we will look for effective ways to relieve your suffering.
- If you do not want a particular medical intervention, or no longer want it, we will never force it upon you but will look for other ways of providing good care.
- Consistent with our professional obligations and bound by individual conscience, we will advocate for you to receive available interventions that are appropriate in your circumstances.
- We will always listen to you. We will ask you to tell us what your hopes and preferences are; in turn, we will actively listen and do our best to develop a care plan with you that meets your wishes.
- We will always honestly inform you about your health and prognosis. We will always share what we find out with you. We will not make false promises or raise false hopes about the possible effects or outcomes of certain medical interventions.
- We will try to come to you. We will try to provide care for you and visit you where you want it, whether that is at your own home, a hospital, a hospice, or some other facility.
- We will care for your whole family. We will keep an eye on your family members and other loved ones who are caring for you, and we will be there for them after your death.*
- And, if your wish is for physician-assisted suicide or euthanasia, we will listen without judgment, abide by our conscience, and ensure that you will be cared for with respect and dignity until the very end, within the accepted legal framework.

*Adapted from a list presented at the Task Force's colloquium on June 24, 2014.

Further reading

This paper's considerations regarding adequate ethical deliberation are elaborated on in detail in the CFPC's Committee on Ethics' online publication, *Ethics in Family Medicine: Faculty Handbook*.⁵ The interested reader is directed there.

About the Task Force

The Task Force on End-of-Life Care of the CFPC was established in 2013 to examine for the CFPC's leadership and members ethical issues for which family physicians might require education and guidance concerning end-of-life care, assisted suicide, and euthanasia. Members are Isabelle Arsenault, Romyne Gallagher, Eric Mang (CFPC staff member), Patricia Marturano (CFPC staff member), Larry Reynolds, Susan MacDonald, Artem Safarov (CFPC staff member), Dori Seccareccia, William F. Sullivan (Chair, primary author of the Guide, and co-author of the Task Force's Report), and Michael Yeo (Editorial Subcommittee member). Keith Ogle is the primary author of the Task Force's Report and member of the Editorial Subcommittee. David Gass, Chair of the Canadian Medical Association's Ethics Committee, provided input. In 2014, Task Force members participated in a colloquium together with representatives from the CFPC's Executive Committee, the Canadian Medical Association, and other Canadian physicians' organizations. The Executive Committee of the CFPC reviewed the May 26, 2015, version of this Guide and suggested some changes, which have been incorporated. As part of its mandate, the Task Force will produce a report. In addition to this Guide, the Task Force plans to develop other resources on ethics for family physicians.

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