Canadian and Dutch doctors' roles in assistance in dying

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Abstract

According to the Canadian law legalizing physicians to provide medical assistance in dying (MAID) under certain circumstances, the patients alone determine if their suffering cannot be relieved under conditions “that they consider acceptable.” This contrasts with the laws on MAID in the Netherlands, which require that physicians only grant access to MAID if they concur with the patient that there are no other potential means of alleviating the suffering. In the Netherlands, when a doctor believes that other means to reduce the suffering exist, they must be tried before having access to MAID. This criterion is often applied and is considered an essential precaution to ensure that lives are not ended prematurely when other viable interventions exist. The Canadian emphasis on the patient’s right to decide whether to try potential alternatives a physician may suggest, such as palliative care, instead of dying by MAID, gives patients the liberty to make informed decisions, even when they may not seem to be in their best interest. This contrasts with the belief in the Netherlands that the state has an obligation to protect citizens from making decisions that are not in their best interest, such as choosing to die when the “intolerable suffering” can be diminished sufficiently for the person to abandon the desire to end the suffering by dying. The Canadian parliament, when they consider expanding access to MAID, should incorporate the Dutch due care safeguards to ensure that death is not the solution when other ways of reducing suffering exist.

Résumé

Selon la loi qui légalise l’aide médicale à mourir (AMAM) au Canada dans certaines circonstances précises, les patients déterminent seuls si leurs souffrances ne peuvent être soulagées dans des conditions qu’ils « considèrent comme acceptables ». Cette situation diffère de celle des Pays-Bas où les lois concernant l’AMAM exigent que le médecin donne accès à l’AMAM à son patient seulement s’ils accordent ensemble sur le fait qu’il n’existe pas d’autre moyen potentiel pour abréger la souffrance. Aux Pays-Bas, quand un médecin croit qu’il existe d’autres moyens pour diminuer la souffrance, ces moyens doivent être essayés avant d’avoir accès à l’AMAM. Cette exigence est souvent utilisée en pratique et elle est considérée comme une précaution essentielle qui assure que les personnes ne meurent pas prématurément quand d’autres interventions existent. Au Canada, l’importance accordée au droit des patients de décider d’essayer ou non les alternatives suggérées par leur médecin, comme les soins palliatifs, au lieu de mourir par AMAM, confère aux patients la liberté de prendre des décisions après avoir été informés, et ce, même quand ces décisions ne semblent pas être dans leur meilleur intérêt. Cette approche va à l’encontre de la croyance néerlandaise qui veut que l’État ait l’obligation de protéger ses citoyens face au fait de prendre des décisions qui ne sont pas dans leur intérêt, par exemple en choisissant de mourir quand la « souffrance insupportable » peut être suffisamment diminuée pour qu’un patient abandonne son désir de mettre fin à sa souffrance par la mort. Dans ses futures délibérations sur l’élargissement des critères d’accès à l’AMAM, l’Assemblée nationale canadienne doit incorporer les précautions de bons soins qui existent aux Pays-Bas afin de s’assurer que la mort ne soit pas la solution quand d’autres moyens pour diminuer la souffrance existent.

Keywords Medical assistance in dying · MAID, euthanasia · Assisted suicide · Ethics · Legislation · Palliative care, physicians

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This analysis compares the role of physicians in applying the laws on medical assistance in dying in Canada and in the Netherlands, and their ethical and practical implications. On June 17, 2016, the Parliament of Canada passed a law (Bill C-14: An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), 2016) legalizing the practice of medical doctors offering assistance in dying under certain circumstances, providing that specific criteria are met. “Medical assistance in dying” (MAID) is defined in the law as “the administration by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, so that they may self-administer the substance and in doing so cause their own death.” This definition describes the two practices that are called “euthanasia” and “assisted suicide” in the Netherlands (Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002), or taken together called the “termination of life on request.” Euthanasia is defined as when a physician intentionally ends the life of a patient for compassionate reasons by direct actions, such as injecting a lethal medication. Assisted suicide is defined as when the physician provides assistance by prescribing lethal medications that the patient may procure and take by himself. This is called “assisted suicide” since the patient rather than the physician initiates the actions to end life. In both Canada and the Netherlands, the form of medical assistance in dying most often practiced is euthanasia, although the term “euthanasia” has almost never been used in Canada since the law legalizing MAID was adopted.

In the Netherlands, the law’s “due care criteria” stipulate that both the physician and the patient must concur that there are no viable alternative ways available to alleviate the patient’s physical, psychological, and moral suffering other than by ending the patient’s life. The physician must ensure that all potentially effective methods to alleviate suffering have been tried before having recourse to death as a solution. In 45% of all requests (Onwuteaka-Philipsen et al. 2017), the request did not lead to euthanasia, either because the patient died before the request could be effectuated (57% of the non-implemented cases), because the physician concluded that the due care criteria were not being met (30%), or the requests were withdrawn after discussion with the doctor (20%). After trying other ways to alleviate suffering in instances when the due care criteria obliged physicians to refuse MAID, some patients may ask again to end their lives and have the request granted. However, patients usually do not again request to die, since the physical, psychological, or moral suffering was sufficiently reduced.

In Canada, the physician does not have a duty to ensure that all viable alternative treatments have been tried before having access to death as the solution. The Canadian law (Bill C-14: An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying) 2016) stipulates that only the patients must feel that their suffering “is intolerable to them and [...] cannot be relieved under conditions that they consider acceptable.” This stipulation follows the criteria in the Quebec provincial law on end-of-life care (Bill 52: An Act Respecting End-of-Life Care 2014). In Canada, only the patient decides if he or she thinks an available treatment is “acceptable.” The physician cannot refuse a request for MAID if the other criteria are met because the physician believes that another treatment, such as better pain relief, medical assistance at home, treatment of depression, counseling or psychotherapy, and family support, could sufficiently alleviate the suffering that motivates the request for MAID. The only criterion the physician must consider is whether or not death is reasonably foreseeable, whether the request is repeated and a second physician must concur that the patient meets those criteria.

In the Netherlands, the person need not be near death. However, the vast majority of cases of euthanasia and assisted suicide occur when death is imminent (Onwuteaka-Philipsen et al. 2017). In Canada, when the legislation was passed, the government agreed to consider in the future whether or not to expand the practice of MAID in other circumstances. In 2017, the government, in preparation for considering expanding the availability of MAID, mandated the Council of Canadian Academies to undertake independent reviews related to three types of requests for medical assistance in dying not currently permitted: requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition. The Council’s report is scheduled to be completed by the end of 2018.

The premise underlying the law in the Netherlands is that there is a responsibility to alleviate suffering by allowing people to choose to die when life is unbearable, but there is also an obligation of the state to protect vulnerable individuals who may choose to die when there are viable treatments and interventions available to alleviate the suffering. The concern in the Netherlands is that the choice of MAID may sometimes reflect a non-competent decision process on the part of the patient, perhaps because of depression or other mental disorders, or simply a lack of understanding about potential alternatives to reduce suffering. In the Netherlands, this obligation to treat is the main reason for refusing requests and it is the criterion that is the most difficult for physicians to apply (Onwuteaka-Philipsen et al. 2017). The fact that most people

in the Netherlands who are refused on these grounds do not repeat their request for MAID after trying the recommended treatments has been used to justify the importance of this criterion. In the Netherlands, this criterion avoids the expedited death of many people who requested euthanasia or assisted suicide. After the physician insists on trying treatment options before accepting the request, patients may continue to lead meaningful lives despite their terminal or chronic illness. Of course, the patient has a right to refuse every means to alleviate their suffering; the doctor cannot apply palliative care without the patient's consent. But if the patient refuses and the doctor is convinced that viable alternatives to MAID that could be tried exist, the doctor can refuse access to MAID on these grounds. "It must be clear that there is no realistic alternative way of alleviating the patient's suffering, and that termination of life on request or assisted suicide is the only way left to end that suffering. The focus is on treating and caring for the patient and on limiting and where possible eliminating the suffering, even if curative therapy is no longer possible or the patient no longer wants it. The emphasis in medical decisions at the end of life must be on providing satisfactory palliative care. However, this does not mean that the patient has to undergo every possible form of palliative care or other treatment" (Regional Euthanasia Review Committees 2012).

The premise underlying the laws in Canada and in Quebec is that the patient is the sole person who can decide whether additional treatments could be useful or viable alternatives to try. Although the physician can suggest treatments that may alleviate the suffering leading to the request for MAID, there is no obligation in Canada for the patient to try the suggested interventions if, for any reason, the patient thinks this is not "acceptable." This emphasis on the absolute right of patients to decide to die rather than trying alternative means of reducing suffering may reflect an individualistic ethic in which people are considered to be free to make decisions about their well-being, even when a knowledgeable professional believes that the decisions are not in their best interest. However, the application of this extreme individualistic perspective contrasts with other Canadian laws in which the government obliges people to act in their best interest, regardless of what they desire. For example, laws oblige everyone to wear a seatbelt while driving or to use a helmet on a motorcycle, and access to many drugs is restricted to protect people from harming themselves.

In the Netherlands, to obtain MAID, the patient has to convince the physician that he or she suffers unbearably without any prospect of alleviation. The doctor may have doubts about this and may insist on trying other ways of finding relief. As long as the doctor sees other viable options for the patient, there will be no MAID. This process is assumed to prevent premature or unnecessary cases of termination of life on request. In Canada, the doctor will have to convince the patient that other viable alternatives exist. If that does not work, the physician must be

obedient to the wish of the patient and has to approve MAID, even if the doctor knows that other viable options to relieve the suffering are available. Canadian physicians may therefore be obliged to go along a path they do not believe is necessary.

In the Netherlands, the practice of ending a patient's life brings emotional burden to the physician. Physicians often report they experience distress when they lose a patient this way. One would expect that the emotional burden to physicians in Canada will be even greater, particularly in cases when they have to comply with the process of helping a patient to die when they themselves see better options.

In the Netherlands, all reports of abuses and their investigations are publicly available, and the applications of the due care criteria are carefully documented and available for public scrutiny. In Canada, committees are mandated to study the practice of MAID and make recommendations, but the practice of MAID is not openly accessible to the public. In Canada, required reports by physicians do not include information on the potential alternatives to MAID, such as providing better palliative care. In the Canadian context, where physicians do not have a determining role in requiring that viable alternative interventions be tried, we fear that some Canadians requesting MAID will die prematurely, rather than continuing to live longer with the symptoms motivating their request for MAID adequately controlled. We believe that the CMA and other organizations should recommend that when the Canadian parliament considers modifications to expand the availability of MAID to other populations, they should modify the existing law to incorporate the safeguards used in the Netherlands that require trying viable alternative treatments to diminish suffering before accepting death as the solution.

Compliance with ethical standards

Competing interest The authors declare that they have no competing interest.

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