Physician-assisted death and the anesthesiologist

L'aide médicale à mourir et l'anesthésiologiste

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Received: 4 September 2015 / Revised: 15 October 2015 / Accepted: 16 December 2015 / Published online: 6 January 2016
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Abstract Although physician-assisted death (PAD) is established in certain countries, the legality and ethics of this issue have been debated for decades in Canada. The Supreme Court of Canada has now settled the issue of legality nationally, and as a result of the decision in *Carter v. Canada*, PAD (which includes both physician-assisted suicide and euthanasia) will become legal on February 6, 2016. It is difficult to predict the potential demand for PAD in Canada. This paper highlights other countries' experiences with PAD in order to shed light on this question and to forecast issues that Canadian physicians will face once the change to the law comes into effect. At present, there is no legislative scheme in place to regulate the conduct of PAD. Physicians and their provincial colleges may find themselves acting as the de facto regulators of PAD if a regulatory vacuum persists. With their specialized knowledge of pharmacology and interdisciplinary leadership, anesthesiologists may be

called upon to develop protocols for the administration of PAD as well as to administer euthanasia. Canadian anesthesiologists currently have a unique opportunity to consider the complex ethical issues they will face when PAD becomes legal and to contribute to the creation of a regulatory structure that will govern PAD in Canada.

Résumé Bien que l'aide médicale à mourir (AMM) soit une pratique établie dans certains pays, la légalité et l'éthique de cette question sont débattues depuis des dizaines d'années au Canada. La Cour suprême du Canada a désormais réglé la question de la légalité au niveau national et, en conséquence de la décision dans la cause *Carter c. Canada*, l'AMM (qui englobe le suicide assisté et l'euthanasie) deviendra légale le 6 février 2016. Il est difficile de prévoir la demande potentielle d'AMM au Canada. Cet article décrit les expériences d'autres pays en matière d'AMM afin de faire la lumière sur cette question et d'anticiper les problèmes auxquels seront confrontés les médecins canadiens une fois que les changements à la loi entreront en vigueur. À l'heure actuelle, il n'existe pas de cadre législatif pour réglementer la conduite de l'AMM. Si le vide juridique persiste, il pourrait incomber aux médecins et à leurs collèges provinciaux de devenir les organismes de régulation de facto de l'AMM. En raison de leurs connaissances spécialisées en pharmacologie et de leur leadership interdisciplinaire, les anesthésiologistes pourraient être appelés à mettre au point des protocoles d'administration de l'AMM et à administrer l'euthanasie. Les anesthésiologistes canadiens ont aujourd'hui une occasion unique de réfléchir aux questions éthiques complexes auxquelles ils seront confrontés lorsque l'AMM deviendra légale et de contribuer à la mise au point d'une structure réglementaire qui régira l'AMM au Canada.

This article is accompanied by three editorials. Please see Can J Anesth 2016; 63: this issue.

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Physician-assisted suicide (PAS) will become legal in Canada on February 6, 2016.^A This change in the law results from the decision of the Supreme Court of Canada in *Carter v. Canada* (hereafter referred to as *Carter*).¹ The *Carter* decision arose from a lawsuit brought by Gloria Taylor and the family of Kay Carter, both of whom wished to pursue PAS but could not because of Canadian laws that prohibit assisting a person to commit suicide. The direct result of the *Carter* decision is that PAS will become legal in Canada. An indirect result, in the absence of new legislation from the government, is that euthanasia administered by a physician will also become legal. Physician-assisted suicide and euthanasia are collectively referred to as physician-assisted death (PAD).

For physicians who primarily practice perioperative and critical care medicine, the *Carter* decision may not seem overtly relevant; however, the ruling carries potential implications for the practice of medicine as a whole and potentially for anesthesia specifically. Along with their interdisciplinary leadership, anesthesiologists are uniquely knowledgeable in the pharmacology of anesthetic drugs, and as a result, they may be called upon to develop protocols for PAD to ensure that it is carried out humanely and effectively.

In jurisdictions where some form of PAD is legal, PAS is uniformly allowed and euthanasia is variably available. In the United States, the states of Oregon, Washington, and Vermont have enacted laws specifically allowing for PAS but not euthanasia.² Swiss law prevents prosecution of a physician who participates in PAS, but euthanasia remains illegal. In Belgium, the Netherlands, and Luxembourg, both PAS and euthanasia are legal.² Similar to much of the European experience, the *Carter* decision will lead to legalization of both PAS and euthanasia in Canada.

Rates of PAD vary somewhat between countries where it is legal. In the Netherlands, for example, the rates of PAD have been well documented from comprehensive death certificate studies both before and after legalization of PAD in 2002. In the Netherlands in 2001, prior to legalization, euthanasia and PAS accounted for 2.6% and 0.2% of yearly deaths, respectively.³ The most recent of these studies from 2010 showed that euthanasia and PAS made up 2.8% and 0.1%, respectively, of total yearly deaths in that country.³ Over a one-year period from July 1, 2013 to June 30, 2014, there were 256,721 deaths in Canada.⁴ If the Canadian experience proves to be similar to that of the Netherlands, deaths from PAD could number more than 7,000 per year. In contrast, deaths by PAS in Oregon were only 0.36% of the total yearly deaths in 2013.^{5,6} This would translate into just over 900 deaths per

year if the rates in Canada end up being similar to those in Oregon.

It is difficult to know what accounts for the nearly tenfold difference in rates of PAD between the Netherlands and Oregon. The explanation may lie in longstanding societal acceptability and availability of both PAS and euthanasia (sanctioned or not) in the Netherlands. It should not be overlooked that PAD is available to a smaller group of patients in Oregon, where euthanasia is not legal, due to the exclusion of those who are incapable of ingesting a lethal substance independently. It is not clear whether either example will predict the rates of PAD in Canada.

The Canadian Supreme Court's decision lays out broad eligibility criteria for PAD. The individual must be capable of clearly consenting to PAD and must have a "*grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition*".¹ Unless legislation is enacted by parliament, this decision will grant patients a right to PAD even if they do not suffer from a life-limiting illness or terminal disease – i.e., a patient has the right to refuse effective treatment in favour of assisted suicide.

The laws in Belgium, the Netherlands and Luxembourg are similar in most ways. They require the individual to make consistent and well-considered requests for PAD in the context of unbearable physical or psychological suffering. Requests for euthanasia via advanced directives are permissible but are not often carried out.⁷ Those with non-life-threatening conditions are not necessarily excluded, and there are highly publicized cases of individuals receiving assistance in dying for non-terminal conditions. Belgium and the Netherlands, but not Luxembourg, allow PAD for minors as well.^{8,9}

We know from systematic review and survey data that, in Belgium and the Netherlands, general practitioners and those specialized in care of the elderly carry out 43–66% of PAD.³ Specialists are involved in 34–50% of the cases of assisted death; however, based on the literature, the types of specialists involved remain unclear.^{3,10} Nonetheless, the drugs that are used are often the province of anesthesiologists, and in a random sample of physician-assisted deaths in Belgium, opioids, benzodiazepines, barbiturates, and even non-depolarizing muscle relaxants were used, albeit less often.¹¹

While it is unclear whether anesthesiologists have been involved in PAD, anesthesiologists have been asked to administer drugs in order to ensure a painless and effective execution in the United States.¹² Ultimately, the anesthesiologists who were retained to perform the execution did not participate on moral grounds. Nevertheless, this prompted the American Board of Anesthesiology, citing the American Medical

^A This article appeared online before the February 6, 2016 legalization date.

Association's Code of Ethics, to promise to revoke the membership of those anesthesiologists who participate in capital punishment.¹³ Though participation in capital punishment is morally and ethically distinct from the provision of PAD, it is clear that anesthesiologists' skill in pharmacology could have applications that go beyond usual anesthetic practice and could be requested in the development of protocols for PAD or in the provision of euthanasia.

Beyond our specialist pharmacologic knowledge, anesthesiologists could be asked to be involved in PAD in other ways. For example, radiologists have speculated that they could be asked to insert a peripherally inserted central catheter (PICC) for a patient with poor venous access for use in euthanasia.¹⁴ Similarly, anesthesiologists could be asked to insert an intravenous cannula, PICC, or other central venous catheter for the same purpose. Anesthesiologists practicing critical care medicine are very likely to be faced with cases where PAD becomes an issue, and chronic pain physicians could be faced with requests for PAD from their patients suffering with chronic complex pain. How should an anesthesiologist respond when faced with a request to refer a patient for PAD, to perform PAD, or to be otherwise involved?

Opinions on physician involvement in assisted suicide and euthanasia are personal and are often partly informed by an individual physician's cultural and religious background. A survey of approximately 5,000 members of the Canadian Medical Association (CMA) in August 2014 revealed that 45% supported the legalization of PAD, 27% would likely perform PAS, and 21% would perform euthanasia.¹⁵ As a result of that survey, the CMA amended its position statement on medical assistance in dying to support physicians in choosing whether or not to be involved in PAD.¹⁶ This position is similarly supported by the Supreme Court ruling in the *Carter* case.¹

An arguably even more contentious question that will arise is whether physicians who conscientiously object to PAD are obligated to refer a patient for PAD. While the *Carter* decision is clear on the right of physician non-participation in PAD, it is silent on the issue of referral. Although mandatory referral for PAD is itself a point of controversy, as articulated by Dr. Chris Simpson,¹⁷ the CMA president, and other physician groups,¹⁸ in the absence of legal guidance, the policies of provincial regulatory bodies on physicians' obligation to refer seem to apply. Patient self-referral to a physician or organization that evaluates individuals for PAD has been proposed in order to avoid issues around conscientious objection. Nevertheless, at the moment, the obligations of physicians regarding referral for PAD remain unclear.

In Canada, the *Carter* ruling may place responsibilities on physicians beyond the task of providing PAD. The

Supreme Court of Canada wrote *Carter* expecting that the federal government would create a regulatory regime to manage the administration of PAD. Nevertheless, the government is not compelled to provide a regulatory regime, and it might not. In the absence of legislation, provincial colleges will be left to devise standards and protocols to guide the provision of PAD. The provincial nature of the colleges creates a risk that different PAD regimes will emerge across the country, with consequential unequal access by province.

Even if federal legislation is put into place to guide the practice of PAD in Canada, unknowns will likely remain. Should anesthesiologists be involved in PAD in any way at all? Then again, in light of anesthesiologists' expertise, do non-objecting anesthesiologists actually have an obligation to assist in the development of drug protocols to ensure a comfortable death for those patients who choose PAS or euthanasia?

It is likely that many Canadian anesthesiologists will face scenarios where the possibility of PAD is raised. While laws delineating the practice of PAD are being laid out, anesthesiologists have a unique opportunity to engage in discussions about the impact that legalization of PAD may have on our practice and potentially to shape how PAD is practiced in Canada.

Author contributions Miriam Mottiar and Mark J. McVey were involved in the conception of the article. Miriam Mottiar, Mark J. McVey, and Cameron Grant were involved in the design of the article, acquisition of references, analysis, interpretation, drafting the article, revision, and approval for publication.

Conflicts of interest None declared.

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