

Physician Assisted Death

Response to the Provincial/Territorial Expert Advisory Group

Q + A

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In Fall 2015, Covenant Health presented to the Canadian Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying.

The following represents our contribution to that consultation:

How does Covenant Health view the Supreme Court of Canada's decision?

The Supreme Court ruling, while regrettable and morally problematic, is nevertheless a reality which Covenant Health and other Catholic health care organizations, which have consistently opposed assisted death and euthanasia, must now legally recognize. To this end, we have engaged in a series of consultations with our clinicians about how we would respond to such requests in our facilities, that neither risks abandoning the person in our care, nor abandoning clinician or organizational integrity (conscience rights; faith/morals) in the process.

What is the appropriate role of health care institutions like Covenant Health?

While Covenant Health will care for patients who request physician-assisted death, we will not compromise our institutional integrity and actually provide physician-assisted death or euthanasia. We believe that staying engaged with the patient in a non-discriminatory, non-coercive way, and helping to explore the nature of a person's request for physician-assisted death is completely consistent with our moral and ethical tradition, even if we do not provide the service or directly refer for same. It is our assumption that, while a minority of patients will ever request physician-assisted death, an even smaller number of people will intend and follow through this request. While we will never condone or participate in an activity that is deemed unacceptable from a Catholic moral perspective, we wish to propose defensible strategies seeking to minimize harm, and to engage the regulatory bodies and others to ensure adequate safeguards are in place, without compromising our Catholic, institutional identity.

Who should govern physician-assisted death?

Ideally, having a consistent legislative approach nationally will reduce the risk of public confusion, as well as potential misunderstanding among providers and institutions if different terminology, practices, and safeguards are enacted across the country. At minimum, physician-assisted death should be regulated by the appropriate professional colleges if a national legislative framework cannot be achieved, to ensure at least consistent practice and protections provincially. This should include the right to exercise conscientious objection. The regulatory bodies should develop policy and educational materials to support their members, underscoring both what obligations they have to people who request physician-assisted death, and what conscience protection rights they have so neither parties are abandoned. We do not recommend it should be left for individual physicians and patients to govern.

What eligibility criteria should be considered?

As a way of minimizing potential harm given the gravity of such a contemplated decision, we believe a cautionary approach should be taken, and that a competent adult be defined as a person who is, by law, capable of giving consent. The competency requirement (to consent or to rescind consent) should apply throughout the process. We believe it will be a challenge to consistently define "grievous and irremediable medical condition" given the subjective nature and unique variables shaping a person's experience. This underscores that a response is required to explore, in a non-discriminatory

way, the nature of the person's request, and to seek to understand underlying needs/concerns that may be inherent but potentially remaining unaddressed. Engaging these conversations with patients will require discernment and a reflective stance that will benefit from a cooling off period and at minimum, a second physician consultation.

What safeguards should be in place?

It is our assumption that the verbalization of a request may not necessarily connote an actual intent to pursue physician-assisted death, and thus it needs to be explored in a respectful and compassionate way. Physicians and health professionals best suited should work with the patient to explore the nature of the person's request, disclosing all factually relevant information—including access palliative and hospice care—so that a person can make a free and informed choice. At all times, these conversations should be conducted in a supportive way, without discrimination or coercion. From a Covenant Health, and Catholic health care perspective, while there will remain moral boundaries in what we cannot provide the patient, it is our experience that respectful, open-ended conversations will often reveal much more that we can and must do to support patients.

Should there be a mandatory waiting period?

Yes, there should be a cooling off period of some reasonable time interval. We recognize that consent is a process; for some this may require multiple conversations and exploration over a longer period of time. If either the attending or consulting physician believe the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, they must refer the patient for counseling. During this time of exploration, it is important the person is not abandoned and that every effort is made to seek to understand the nature of the person's request and be sensitive to other possible reasons motivating the request, and therefore, other appropriate options to offer the person if indicated.

Should physicians have the right to refuse physician-assisted death for reasons of conscience?

Yes. In keeping with our code of conduct and our ethics framework, we support the exercise of conscience, insofar that "the exercise of conscientious objection must not put the person receiving care at risk of harm or abandonment" (Health Ethics Guide, #165). We have a positive moral obligation to stay engaged with the patient, and to provide factually relevant information to support the process of informed consent. This may require informing the person of other options for care (HEG #165).

What resources should be provided for physicians and health professionals?

Along with resources to support conscience and legal protection, physicians and other health care providers should be provided with training to facilitate end-of-life conversations, as well as dispute resolution/mediation support. It is important providers are confident in having such value-laden discussions in which their own biases and moral boundaries will likely surface.

What resources should be provided to patients?

There already is a lack of basic public education regarding end-of-life care in general, and now with the introduction physician-assisted death there is the added risk of confusion and misunderstanding around terminology. The current focus on developing the legislative and regulatory frameworks will definitely assist providers and institutions, but public messaging is also required to support patient and families. From an informed consent perspective, the public needs to understand the difference between palliative and hospice care with that proposed by physician-assisted death. Covenant Health does and will not include physician-assisted death in its definition and model of palliative, hospice, and end-of-life care.