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Ensuring access to euthanasia by encouraging physician participation: it's complicated

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In July, 2017, Canadian euthanasia/assisted suicide (EAS) practitioners and advocates alleged that patient access to euthanasia and assisted suicide was in danger because of "barriers" and "disincentives" to physician participation. Dr. Stefanie Green, president of their professional association, described the situation as "a crisis."[1] There was, in fact, no crisis — only a false perception of crisis fuelled by unrealistic expectations about levels of physician participation in euthanasia and assisted suicide.[2]

Nonetheless, it is reasonable for policy makers to respond to their concerns that physicians are discouraged from participating in euthanasia and assisted suicide. Indeed, objecting physicians are less likely to experience disadvantage and coercion if policy-makers seriously consider suggestions by EAS practitioners and advocates about how to encourage physician participation in euthanasia.

Removing barriers and disincentives to physician participation

Minimizing procedural and administrative requirements

Returning to the complaints and concerns of Canadian euthanasia practitioners (see *Canada's Summer of Discontent*[2]), reducing or streamlining procedural requirements and minimizing burdensome paperwork might encourage more physicians to participate. However, this raises a question that may prove difficult to answer. Is a procedural requirement a "barrier" — or a necessary safeguard? A "disincentive" — or an essential ethical prerequisite? The difficulty is illustrated by developments in Belgium.

In 2001, when Belgium was considering the legalization of euthanasia, the Flemish Palliative Care Federation urged that euthanasia requests should pass through a "palliative filter," an "indispensable precautionary requirement."[3] Among other things, the Federation argued that "an informed and therefore free and real choice for euthanasia is simply impossible" without full information about alternatives. It insisted that it was important to avoid "pseudo-choices" for euthanasia by patients who had inadequate knowledge and access to palliative care.[4] This position was reiterated in 2003[5] and again in 2013, in relation to the extension of euthanasia to minors, those with dementia, those "tired of living," etc.:

> Given the radical nature of euthanasia – where suffering is 'solved' by terminating the life of the sufferer – it can never be a first resort. To avoid the risk of euthanasia being administered for improper reasons, extending it to further populations groups should only be considered if basic palliative care is fully provided to these groups.[6]

Making adequate palliative care available to patients as a precondition for euthanasia was understood by the Federation to be both an ethical prerequisite for genuine consent and an important safeguard, not a barrier to access.

Dr. Wim Distelmans has a different perspective. Dr. Distelmans is, perhaps, Belgium's best-known euthanasia practitioner and advocate.[7] He was the president of the Flemish Palliative Care Federation from 1996 to 2002,[8] when he became chairman of Belgium's federal commission responsible for overseeing euthanasia.[7] He recently complained about delays even in Belgian facilities "that officially claim to allow euthanasia."

> All the delaying manoeuvres, such as waiting for the approval of the ethics committee of the hospital or the obligatory review of all palliative care options - the so-called 'palliative filter' - make it impossible to provide euthanasia in practice, or result in the patient dying 'spontaneously' or by suicide.[9]

Dr. Distelmans' sneering characterization of prioritizing palliative care as a delaying manoeuvre is at some distance from the position of the Federation. His views do not seem to reflect current attitudes in Canada, where exploring all palliative treatment options is considered preferred and even legally obligatory practice, not a delaying tactic.[10]

A similar conflict of perspectives arises with respect to the concerns of Canadian EAS practitioners and advocates. They identify a number of "barriers" or "disincentives"— that patients be near the end of life, that practitioners review medical histories, meet patients, refer them to specialists, ensure informed consent and voluntariness by means of witnesses, safeguard lethal medications, and report to the coroner or other authorities. However, some of these requirements reflect the norms of ethical medical practice. Others are intended to function as part of what the Supreme Court of Canada called "a carefully designed and monitored system of safeguards" designed to limit risks associated with allowing physicians to kill patients or help them commit suicide.[11]

It would seem that minimizing or eliminating some of these requirements would be inconsistent with ethical medical practice, while dispensing with others would eliminate or compromise the "system of safeguards" the Supreme Court believed necessary. This presents something of a conundrum for Canadian authorities, so a quick fix seems unlikely.

Reducing oversight

Granted that the Supreme Court of Canada expected careful monitoring of euthanasia/assisted suicide practice, one can appreciate Dr. James Downar's concern that EAS practitioners may resent and fear having their professional judgement second-guessed by oversight committees, especially committees consisting of people with no experience in the field.[12] Some modification of oversight arrangements might be possible, but a significant change would have to take into account entrenched practices and attitudes.

Prior to June, 2016, when someone was killed by a person claiming legal justification — by the police, for example — exceptional care was taken to investigate thoroughly in order to ensure that the killing could be justified by law. It was generally understood that killing people is an exceptionally serious business, that it must be avoided if at all possible, and that those authorized to kill must be held to an exceptionally high standard of accountability. Moreover, it was thought imprudent to allow those authorized to kill to act as judges of their own conduct. On the contrary: ultimate judgement was frequently left to a jury composed of independent but professionally inexperienced citizens.

This is still the case when the police kill someone. Like Dr. Downar, police representatives have sometimes expressed concern that a jury verdict against one of their number is demoralizing and will discourage them from doing their job.[13] Nonetheless, there is substantial support for existing mechanisms that hold police accountable when they kill someone.[14] The *ex post facto* review of EAS practitioners is not nearly as strict, so reducing it further may be difficult and controversial, at least for the time being.

On the other hand, EAS practitioners and other physicians are obviously anxious that they might be charged for murder if they make a mistake in assessing patient eligibility. Dr. Tanja Daws expressed this concern:

> She said there are serious consequences if doctors are forced to rush through assessments or medically assisted deaths because of poor pay.
>
> "The consequences of us doing shoddy work is we can go to jail," she said.[15]

This kind of anxiety is unnecessary and can be alleviated.

It is true that EAS practitioners who do "shoddy work" could face discipline by professional regulatory authorities, since it is the responsibility of medical regulators to ensure that physicians do not do "shoddy work," even if they are "forced" to do so by "poor pay." That expectation reflects the most basic principles of medical ethics and the ideal of patient-centred practice for all physicians. Exempting EAS practitioners from this kind of oversight would be difficult to justify.

However, regulators called upon to deal with good faith mistakes by physicians typically do not respond by imposing discipline, but by providing remedial advice, requiring further training or taking other steps to prevent mistakes from happening again.[16]

More important, physicians cannot go to jail for acting on "a reasonable but mistaken belief" when providing euthanasia or assisted suicide.[17] Assuming a *bona fide* intention to comply with legal requirements (as opposed to deliberate non-compliance), and assuming that "shoddy work" does not amount to criminal negligence (non-compliance showing "wanton and reckless disregard for the lives or safety of other persons"[18]), it is highly unlikely that EAS practitioners would be charged for murder or criminal negligence causing death merely for making a mistake or "doing shoddy work."

Providing incentives for physician participation

Increasing compensation: fair pay or more pay?

It is obvious from the complaints of EAS practitioners that increasing compensation would motivate

some physicians to participate in euthanasia and assisted suicide (see *Canada's Summer of Discontent* [2]). Here one can distinguish two issues, identified by Dr. Stefanie Green as "fair pay" and 'more pay.'[19]

Paying fully for all time actually spent doing what is necessary to provide the procedures and reimbursing their travel and out-of-pocket expenses are "fair pay" issues. Other things being equal, it would be unfair to compensate physicians generally for actual time and travel costs, but deny the same compensation to EAS practitioners.

However, compensation arrangements are determined independently by each province, so the issue is more complex than appears at first glance. If EAS practitioners and other physicians in British Columbia are all governed by the same compensation rules, are EAS practitioners in B.C. unfairly treated because a different province has more favourable physician compensation arrangements? If so, would that not imply that compensation should be increased for all B.C. physicians, not just for EAS practitioners?

Justifying "more pay" for EAS practitioners is more complicated still, since they complain mainly about compensation for services, responsibilities and burdens that are ordinary aspects of general medical practice.

- Especially when dealing with cancer or other serious illnesses or disorders, physicians routinely meet patients, review complex medical histories, and refer patients to specialists for assessment.
- Physicians dedicate time and energy to counselling patients and families about medical interventions, particularly in complex cases and in palliative care.
- Generations of physicians have been called out in the evenings and on weekends to attend to labouring mothers or patients needing urgent or specialist medical treatment, and this continues today.
- While house calls are no longer routine, some physicians and health care workers continue to visit patients at home when need be, even in squalid conditions; bed bugs and cat feces are not unfamiliar to them, or to first responders and social workers.
- Other physicians are also burdened by administrative paperwork, especially for injuries that are the subject of insurance and workers' compensation claims, and they, too, must provide documents and information required by coroners.

This probably explains the response of Dr. Trina Larsen Soles of Doctors of BC to complaints about inadequate euthanasia fees. Conceding that providing euthanasia/assisted suicide is "really stressful," she noted that counselling suicidal patients and bedside palliative care is also stressful. Moreover, she said, euthanasia/assisted suicide fees in British Columbia are determined in the same way as fees for other services, so "[if] we're going to argue about which part of our jobs are more stressful and whether all parts of our job are adequately compensated, that's a big discussion."[1]

One could argue that EAS practitioners should be paid more because killing patients is different from and more stressful or demanding than other services provided by physicians, so, in fairness, they deserve more pay for the work. Here the difficulty is that EAS advocates seem unwilling to make

this argument. They generally refuse to acknowledge that killing is involved,[20] insist that providing euthanasia/assisted suicide is no different from providing other physician services,[21] and, as will be seen presently, usually assert that it is personally rewarding.

Attracting physicians to an unattractive specialty

On the other hand, a claim for additional compensation (by special reimbursement of expenses and/or increased fees) could be based, not on fairness or the burdens of practice, but on a pragmatic need to attract physicians to what seems to be an unattractive specialty.

An article in *Mcleans* argued that doubling physician compensation for Caesarean sections had been shown to increase the rate of C-sections by 5.6%, so increasing compensation could encourage more physicians to participate in "assisted dying." The article suggested that higher fees, premiums or bursaries for euthanasia practitioners could be funded with money saved by providing euthanasia/assisted suicide instead of extended care and treatment.[22]

This would be effective in convincing some EAS practitioners to remain in practice and others to resume providing the service, but what about physicians generally?

An unknown number find euthanasia/assisted suicide so morally abhorrent or contrary to their philosophy of medicine that they are unwilling to facilitate the practices by consultation or even by referral. Increasing compensation would be completely ineffective in convincing them to change their minds.

Recruits are more likely to be found among physicians who support euthanasia/assisted suicide, especially those already providing consultations and assessments for the service. The number inclined to support the procedures appears to have increased since the *Carter* decision in 2015.[23] Nonetheless, the number of physicians willing to personally inject patients with lethal drugs or help them commit suicide remains much lower. Dr. Downar himself exemplifies the phenomenon. A member of Dying With Dignity Canada's Physicians' Advisory Council, he states, "I cannot foresee personally providing this for my patients."[24]

The extent to which increased compensation might convince more of these physicians to provide euthanasia/assisted suicide depends primarily upon the reasons for their reluctance. Here one cannot avoid the elephant in the room: reluctance arising from unease at the prospect of having to personally kill another human being.

The elephant in the room: reluctance to kill

This point is disputed by Dr. Downar. He admits that "a handful of physicians" might not be "comfortable" performing euthanasia, but he insists that factors like inadequate compensation, burdensome administrative and procedural requirements and legal uncertainties are by far the most common reasons for physician reluctance.[12] Further, a number of EAS practitioners have emphasized how much personal satisfaction they get from providing the service, describing it as "very rewarding"[25] and extolling death by lethal infusion as "dignified,"[26] "peaceful"[27] and "really, really beautiful."[28] Three prominent Belgian EAS practitioners referred to lethally infusing patients as "professional," one describing euthanasia as "deeply moving" with a "life intensifying and sacred dimension," another describing himself as"drained, but relieved and satisfied" afterward.[29] Finally,

several Canadian physicians have provided euthanasia or assisted suicide many times.[30]

This suggests that neither the prospect nor the experience of personally killing a patient need be distressing. However, the attitudes and inclinations of committed euthanasia practitioners are not necessarily or uniquely instructive with respect to those of physicians generally. One must also consider the very different reactions of physicians who did so, and later regretted it.

By February, 2017, eight months after legalization, 24 Ontario practitioners who had volunteered to provide euthanasia/assisted suicide had permanently withdrawn; 30 had suspended participation. The CMA's Dr. Jeff Blackmer acknowledged that this was occurring "at a systemic level." He said some were firmly convinced of the value of the work, but others "go through one experience and it's just overwhelming, it's too difficult, and those are the ones who say,'take my name off the list. I can't do any more.'"[12]

Dr. Blackmer noted that physicians who provide the procedure for someone they know well may find the experience "just too difficult and too traumatizing physiologically" to do it again.[31] Some believed they were prepared for the experience, but found it "just too difficult," he said. "They lost sleep and they didn't eat. They worried too much about it."[32]

Dr. Madeliene Li, an oncological psychiatrist who developed the euthanasia/assisted suicide protocol for Toronto's University Health Network, recognized the issue.

> Assisted death, the polite euphemism used to describe the act, is really a misnomer. Doctors don't "assist" in a death; they are the active agents. "We are doing euthanasia," says Li. "We are actively ending a life. And it's very new to us."[28]

She reported having seen physicians accustomed to dealing with death daily "break down after conducting a medically assisted death."[28]

In this context, it is relevant that a survey by the Royal Dutch Medical Association (KNMG) found that 85% of physicians who had arranged for euthanasia rated the emotional strain associated with doing so at five out of ten or higher, and 57% at eight out of ten or higher.[33] Eric van Wijlick, a KNMG policy advisor, said that physicians "find it very hard to carry out," he said. "On average they do it once or twice a year and it's very stressful."[34]

Euthanasia practitioners in the Netherlands are given a day off with pay after each lethal infusion so that they can "take care of themselves emotionally,"[19] a practice consistent with the findings of a 2007 study. Researchers found that performing euthanasia had "a major impact" on primary care physicians.[35] Moreover, as previously noted, it is reported that the Dutch rule of thumb is that a physician should not perform euthanasia more than four or five times a year.

> "It's unnatural, what you're doing," says Ruben van Coevorden, a doctor in Amsterdam who has been performing the procedure for 15 years. "You do it for a very good reason, but it's an exceptional part of medicine. It should not become routine."[28]

It seems, then, in some circumstances, some physicians are willing to kill another human being and can do so without suffering any apparent adverse effects, that a much larger number cannot do so without experiencing considerable stress, and that a certain number are unable to kill or continue

killing.

There is nothing new or remarkable about these conclusions. They are consistent with the observations of Belgian researchers published in 2012. They identified three groups among Belgian physicians who did *not* object to euthanasia: those "not reluctant to inject," those who dread doing so and typically impose restrictive conditions, and those who feel "incapable of injecting due to technical, intuitive or moral inhibitions" and use strategies like referral to avoid moral or emotional conflict.[36]

It is not unreasonable to think that most physicians — like most people — are reluctant to personally kill other people. Indeed, Dr. Li understates the case when she says that "actively ending a life" — that is, killing someone — is "very new" to *physicians*. It would, in fact, be a very new experience for all but a handful of Canadians, though physicians currently in practice might be disproportionately inclined against it.

Overcoming reluctance to kill

We need not debate to what extent the reluctance may be innate or acquired. The point here is that aversion to killing is likely a significant factor making EAS practice unattractive even to the group from which future EAS practitioners are to be drawn — physicians who don't object to the procedures in principle. If so, merely increasing compensation is likely to have only a marginal effect. Persuading them to join the ranks of EAS practitioners would have to involve education, policies and practices that are effective in overcoming their reluctance to kill.

This is by no means impossible, but implementing a public policy of overcoming reluctance to kill would be controversial and would entail risks: some readily foreseeable, others less so. The more prudent and practicable course might be the simplest and most realistic: learning to live with the fact that most people are reluctant to kill other people, and may well refuse to do so.

Learning to live with reluctance to kill and refusal to kill may impede efforts to increase the number of EAS practitioners. Here it is important to recall that euthanasia and assisted suicide are typically provided by a minority of physicians, and that the first year of legalization in Canada demonstrates that the demand for the procedures can be met by a relatively small number of willing providers.[2]

It's complicated

Concerns about patient access to euthanasia and assisted suicide can be addressed without suppressing fundamental freedoms. With this understood, and avoiding unrealistic expectations (See *Canada's Summer of Discontent*[2]), one can consider the claim by Canadian EAS practitioners. They assert that reducing or eliminating disincentives and increasing compensation will increase physician participation in euthanasia and assisted suicide. The claim is not unreasonable, but accepting and acting upon it would involve practical difficulties.

Some of the requirements identified as "barriers" or "disincentives" are essential elements in ethical medical practice, while others are intended to be safeguards deemed essential for the protection of patients. Reducing or dispensing with any of them would thus involve reconsideration of serious ethical and public policy issues.

With respect to compensation, what counts as "fair" is determined internally in each province in relation to compensation for all physicians in each jurisdiction. Other things being equal, it would not be fair to reimburse EAS practitioners for costs or pay them for services for which their provincial colleagues are not compensated. Similarly, fees for services provided by EAS practitioners must align with fees for the same services provided by other physicians in the same province. Since EAS advocates do not assert that the act of killing a patient or assisting in suicide differs significantly from other physician services — and even insist that there is no significant difference — working all of this out is a complex business.

Higher compensation could be justified, not by fairness, but by a pragmatic need to attract physicians to an unattractive specialty. However, this would be only marginally effective if — as seems likely — the primary reason for avoiding EAS practice is an aversion to killing another human being. In that case, increasing the number of EAS practitioners would entail significant efforts to overcome physician reluctance to killing — a contentious enterprise.

Should Canada increase physician compensation and reduce or eliminate "disincentives" and "barriers" alleged to discourage physicians from providing euthanasia/assisted suicide?

The best answer at the moment seems to be, "It's complicated."

That is not sufficient reason to suppress freedom of conscience among health care professionals.

Notes

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11. Carter v. Canada (Attorney General) 2015 SCC 5, [2015] 1 SCR 331, para. 117 (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) Accessed 2017-09-18.

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18. Criminal Code (R.S.C., 1985, c. C-46), Section 219(1): Criminal negligence. (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-51.html) Accessed 2017-10-13.

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20. Even eschewing the terms "euthanasia" and "suicide." Hence, "Medical Assistance in Dying" — MAID.

21. Consider this exchange between Mr. Justice Moldaver, one of the nine Supreme Court of Canada justices who ordered the legalization of euthanasia and assisted suicide, and Joseph Arvay, counsel for the plaintiffs.

Moldaver J: Here we are saying that a doctor can actually take an active part in, in, in injecting someone, for example, and killing them. Now, I see a difference - maybe you don't, maybe we're dancing on the head of a pin - I see a difference between that, and saying, "Okay, we're going to stop the life support, and let the patient die, the, the natural death." You don't seem to see a distinction between that, but, and based on what you're saying, it seems to me that the whole concept of unlawful homicide is really not at play here.
Arvay: Well, I think, after *Carter*, there is no distinction.

Supreme Court of Canada, Lee Carter, et al. v. Attorney General of Canada, et al, Webcast of Hearing on 2016-01-11, 169:09/205:01 - 169:36/205:09 (http://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1938%2f201601110500wv150en%2c001&urlfr=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1940%2f201601110500wv150en%2c001&date=

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