

Physician-Assisted Death: The first 6 months...

- **James Downar**, MDCM, MHSc, FRCPC, Critical Care and Palliative Care Physician, University Health Network and Sinai Health Systems, Toronto, Ontario

The Supreme Court of Canada's landmark Carter ruling decriminalized Physician-Assisted Death (PAD) in Canada and set off a series of events aimed at establishing a legal and policy framework for PAD. Ultimately, the Carter ruling came into effect before this framework was in place, and there are still many aspects of policy, practice and oversight that have yet to be finished. We will review some of the key elements of the framework that have been created, and those that are still not finalized. We will also review some of the challenges faced by different stakeholders in an environment where PAD is legal.

Get Resuscitation-of-Life Right...then let's focus on death

- **Peter Brindley**, MD, FRCPC, FRCP (Lond), FRCP (Edin), Critical Care Physician, University of Alberta Hospital and Professor, Critical Care Medicine, Anaesthesiology, Medical Ethics, and Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

This talk argues that Medical Assistance in Dying (MAID) is likely to suffer many of the same issues as have bedevilled our understanding of cardiopulmonary resuscitation (CPR) and do not resuscitation orders (DNR). In other words, if we can't get resuscitation right then we should not be surprised that palliation is so imperfect. Therefore, this talk covers CPR and DNR in terms of its societal expectations, the likelihood of survival, but also the likelihood of disability and the cost to patients, healthcare workers, and to an already stretched healthcare system. Even the term "resuscitation" means many different things to different people...and that's before we even wade into such terms as "autonomy", "paternalism" and "patient-focused care". Doctors, nurses, patients and families can no longer shy away from discussing hard topics like resuscitation. It's time to talk about life before we focus on death.

I Was Not Trained for This!

- **Daniel Garros**, MD, FRCPC, PICU, Attending/Staff Physician, Stollery Children's Hospital and Clinical Professor, Department of Pediatrics and John Dossetor Health Ethics Centre, University of Alberta

The new paradigm in medicine is in front of us. While we were trained to save lives, give comfort when we can't save, do not harm and even remove excessive technology when we agree with families and patients that it is not in their best interest to prolong life, we were not trained to kill. In our western society, autonomy is the main ethical principle driving people's actions in health care. This principle trumps every other one, and physicians seem to be on the receiving end of the deal. Physicians' own autonomy to act the way we think is correct is at stake. It is impossible to be working closely with a person asking to be killed and not having some aspect of our own personal values and boundaries touched. Such moments make us rethink of our choice of being a physician, a nurse, or other health care professionals. We care for patients, we want (and have the means) to alleviate suffering, ... but don't ask or legislate us to kill people. There are other professions that are trained to do exactly that.

Protecting the Rule of Law and the Vulnerable: Examining the Canadian Legal Landscape Surrounding Physician-Assisted Dying

- **Anna Zadunayski**, BA, LLB, MSc, Lawyer, Ethicist, Researcher, Writer, and Lecturer, Calgary, Alberta

Since 2015, a number of decisions have been issued in response to applications for physician-assisted death in Canada. The Canadian judiciary has been called upon to balance competing values of great importance: the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition on the one hand, and sanctity of life and the need to protect the vulnerable on the other. The role of the courts has been to determine whether a particular applicant meets the criteria set out in *Carter v. Canada (Attorney General)*, 2015 SCC 5, based upon the particular person, his or her particular condition, and the actual record before the Court. The inquiry is individual and fact specific, with the courts being mindful of the legal framework and overall constitutional context of the inquiry. Following *Carter*, many governments and organizations worked diligently to respond. The Supreme Court granted an extension to June 2016 for Canada to draft an appropriate legislative response. Canada responded with Bill C-14, which became law on June 17, 2016. Some have argued however, that the new law is too restrictive, and new legal challenges have been brought forward. For patients, families and health professionals, many questions remain. This presentation will explore the *Carter* criteria, along with subsequent Canadian jurisprudence and legislation, with a view to clarifying questions that have been answered through the legal landscape, and questions remaining.

Should Able Patients be Expected to Actively Participate in MAID?

- **Brendan Leier**, PhD, Clinical Ethicist, Alberta Health Services; and Clinical Assistant Professor, John Dossetor Health Ethics Centre, University of Alberta

The original Supreme Court appeals of Ms. Rodriguez and Ms. Carter argued that a disabled patient does not have the capacity to end his or her life and therefore legislation should be changed to allow the facilitation of this goal. In Alberta, the current policy guiding MAID allows for physicians to provide both assisted dying (the provision of a fatal drug cocktail consumed by the patient) and euthanasia (the lethal injection of a patient by a physician). The decision to choose one intervention over another is based on patient preference. There is no recognition in policy or legislation that there is a moral or clinical difference between assisted dying and euthanasia. However, intuitively, and arguably empirically, a moral/clinical distinction is easily discernible in attitudes and opinions of physicians and other clinicians who would agree to participate in one practice, but not the other. I will argue that the failure to clearly address this question is to gloss over a significant ethical element of the actual provision of MAID and creates the potential for both error and the limitation of clinical discretion for vetting potential MAID candidates. I will further argue that the underlying ethical assumption made by the proponents of equivalency, "saying is equal to doing" is philosophically and clinically inaccurate. I will conclude by examining how the concept of weakness of the will (akrasia) is as relevant and problematic for the defenders of radical autonomy in both healthcare and ethics.

Medical Assistance in Dying for Persons with Mental Disorders

- **Carla Ventura**, BA, LLB, LLM, PhD, Associate Professor, College of Nursing, University of São Paulo at Ribeirão Preto, Brazil and Postdoctoral Fellow, Faculty of Nursing and John Dossetor Health Ethics Centre, University of Alberta

Over the last two decades acts of legalization of physician-assisted death have occurred in several Western European countries. This has been influenced by societal changes emphasizing individual liberties, increased general public acceptance, and polarization of the idea of “good death”, set against a background of medical advances with respect to artificial life extension, higher life expectancy rates and increasing risks of functional impairment, especially in old age. In Canada, although the February, 2016 Report of the Special Joint Committee on Physician-Assisted Dying, *Medical-Assistance in Dying: A Patient-Centered Approach*, recommended allowing non-terminal suffering as eligible for MAID, that an individual with a psychiatric condition who is competent be eligible for MAID and that a second stage of the legislation should occur addressing MAID for mature minors, these do not appear in the legislation. Many believe that, due to such omissions, the legislation does not go far enough and is open to constitutional challenges. The moral acceptability of MAID in the context of psychiatry has relatively seldom been discussed in the literature. The suffering experienced by psychiatric patients who lack autonomy can be as difficult as the distress that autonomous patients undergo when asking for MAID. Although the debate over psychiatry euthanasia or assisted suicide typically focuses on persons with treatment resistant depression, little is known about individuals receiving MAID for psychiatric conditions. In this context, this presentation aims at highlighting ethical and legal concerns related to Medical Assistance in Dying focusing on psychiatric patients.

MAID: An autonomous decision?

- **Diane Kunyk**, RN, PhD, Associate Professor, Faculty of Nursing and Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

Patient autonomy has been the cornerstone of our approach to decisions regarding Medical Assistance in Dying (MAID). However we die, as we live, in a web of complex relationships. Decisions taken about end-of-life are often multi-layered taking into consideration the needs of loved ones, opinions of those in positions of power, availability of desired healthcare options, and financial issues. The focus on this presentation will be to consider patient autonomy from a relational perspective, one that takes into account the importance of relationships and context in MAID decision-making.