



COLLÈGE DES MÉDECINS
DU QUÉBEC

Physicians, Appropriate Care and the Debate on Euthanasia

A Reflection

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Introduction

Physicians in Quebec are far from insensitive to the questions pertaining to intensity of care and euthanasia. In fact, these questions concern them deeply, but it is uncomfortable for them to respond, particularly publicly. These subjects raise moral and legal issues that cannot be disregarded, nor can their seriousness and complexity. Physician groups frequently flatly refuse any discussion about euthanasia, because of the perception that it runs contrary to medical ethics.

In light of how the debate on euthanasia is presently being conducted in Canada, it is indeed hard for doctors to take a stand. Neither the *status quo*, nor the draft legislation tabled in Parliament really take into account the diversity of clinical situations, the complexity of the decision making process pertaining to appropriate terminal care, or the active role that doctors must play. While the *status quo* threatens physicians with criminal sanctions, the draft legislation has the foreseeable consequence of confining doctors to the role of mere technicians.

The Collège in no way pretends to know the opinion of the majority of its members especially when it comes to matters as challenging as intensity of care and euthanasia. However, we believe that by examining these questions from a professional perspective rather than a strictly personal point of view, an institution like ours can contribute to advancing the debate.

Based on the reflections of the task force on clinical ethics, which focused on the subject for more than two years and whose report is accessible on its Web site, the Collège is putting forth certain ideas, in the present document, to allow for a more open discussion.

Essentially, we are suggesting that the debate on euthanasia be made to take a different direction, focusing on “appropriate end-of-life care”, as it is effectively at the heart of the question. Now that a number of terminal medical interventions have turned out to be more useful than first thought, it has become difficult to support the prohibition of some of these without taking other courses of action. The challenge is rather to assure that the treatment provided will be the most appropriate possible. In Quebec, we have now developed certain tools to meet this challenge that are as appropriate at the beginning, middle or end-of-life. Instead of legislating to prohibit or guarantee various treatments at the end-of-life, why not count on the decision making process itself, as we have learned to do for all other types of treatment?

1. Reorienting the Debate on Euthanasia Toward Appropriate End-of-Life Care

Despite all the progress made in the area of end-of-life care and decision making power, concerns clearly remain among both patients and physicians, as well as in the population in general. With the advances made in medicine, the moment of death, as natural as it was, is increasingly the subject of human decisions. How can we assure that people receive all the appropriate care (and only that care) at that final stage in their life? This is a time when they often can no longer make decisions for themselves,

participate in discussions, or even communicate. In the event of disagreements between loved ones and caregivers, who will decide on terminating vital treatment like resuscitation? For some, voluntary and planned euthanasia remains the surest way of avoiding aimless and futile treatment.

At the end-of-life, treatment options will always involve very difficult decisions. We believe, however, that preventive euthanasia is an excessive response that stems from the fear of disagreements, when these actually occur rarely and are quite resolvable. In fact, the difficulty that we are all coming up against is not related to possible disagreements. On the contrary, it arises mainly from the fact that legislation (which has nothing to do with treatment) can suddenly encroach on the decision making process. In effect, there are certain exceptional situations — uncontrollable pain or interminable suffering, for example — in which euthanasia could be considered to be a final step required to assure the provision of quality care. Subsequent to a careful and thorough decision making process involving all parties concerned, some treatments could be deemed appropriate even if they contravene certain legal stipulations. This could explain the fact that certain practices transpire despite being highly controversial.

A new sensitivity is clearly perceivable within the population and the medical profession advocating that we stop denying the existence of these difficult situations and that we openly discuss the various options facing us, which could range from abstaining from or ending treatment, to providing accompaniment, to adequately relieving pain, to terminal sedation and euthanasia. The Collège recognizes this and is of the opinion that physicians must acknowledge this new sensitivity, whether they share it or not. It concerns them — individually and collectively — and it is not inconsistent with the spirit of the Code of Ethics of Quebec Physicians, particularly with section 58 of the Code that stipulates:

“A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.”

It is not solely up to physicians to define which legislative or regulatory framework would best convey this social and moral openness on the question of euthanasia. However, doctors are necessarily involved in the current situation and will be more so in the event of legislative changes. The time is now or never for them to insist that we take the diversity of clinical situations into account, as well as the complexity of the decision making process related to appropriate treatment, and the active role they must play in that process. Like their patients, doctors want changes that aid the shared quest for the most appropriate end-of-life care possible.

The *status quo* clearly makes this quest difficult, if not impossible. For all kinds of reasons, our society (which includes doctors) maintains an attitude of veritable denial, not only with respect to euthanasia, but regarding death as well. The existing legislation in Canada certainly accounts for much of this reality. Within a context where any act aimed at shortening life is considered to be murder and punishable with criminal sanctions, it is indeed not easy to have a frank and open discussion on the various types of care that would be appropriate when a patient has reached the end of his life.

The legislative changes currently being proposed are at risk of failing to improve matters. The pressures being exerted to change the law are unfortunately not oriented towards decision making that would respect all parties concerned in a clinical situation. Rather, they are aimed at decriminalizing euthanasia as requested by patients and focused on certain conditions already provided for in the law pertaining to terminal illness or unrelieved suffering.

These conditions do not necessarily correspond to the various clinical situations in which the possibility of voluntarily shortening life is, in fact, envisaged as a final step in the provision of appropriate care — whether by the patient or their loved ones, by the physician and treating team, or jointly by all these parties. The conditions particularly fail to correspond to the most difficult clinical cases. While the specific request of an able adult patient is an absolutely necessary condition, there is no provision for patients who are not competent or for all those who may not have made a request while they were still able to do so. And yet, given the consent of a patient's loved ones, many doctors would probably feel justified in shortening the agony of certain incompetent patients in a terminal phase and suffering from uncomfortable pain. On the other hand, it is understandable for a doctor or anyone else to be reluctant to shorten the life of a patient who is depressed or to help a patient to die who refuses the appropriate care. The idea of having to accept a request for euthanasia due to the health system's inability to offer the appropriate care is absolutely unacceptable! The process of deciding on the appropriate care is far too complex and delicate to be reduced to certain specific conditions already prescribed in the law. Such legislative changes have a foreseeable consequence of confining doctors to the role of simply carrying out orders, which runs counter to the evolution of the decision making process.

Since the *status quo* currently limits the development of appropriate end-of-life care, legislative changes are probably required. Whether they are implemented in the Criminal Code or elsewhere, we believe these changes should be aimed at achieving one prime objective — reassuring patients, physicians and society as a whole that the end-of-life care provided will be the most appropriate possible. Patients must know that multiple alternative last resort treatments exist, to which they or their loved ones may choose to consent to or not. For their part, doctors must be aware that they will not be obliged to practice euthanasia. Nevertheless, those physicians who, in certain exceptional circumstances, would accept conducting activities that could be

interpreted as euthanasia must be reassured that they will not be exposing themselves to criminal sanctions if they respect the conditions of proper medical practice. Finally, society must be aware of how the State may intervene in the event of deviation.

For the Collège, an openness does indeed exist, but not without limits. If physicians feel concerned about certain requirements pertaining to terminal care logic, that is not the situation for other requests that may be justified but not really part of such logic — in the case of incurable but not terminal illness, for example. We also believe that we would be better advised for the time being to differentiate the question of euthanasia from that of assisted suicide.

2. Appropriate End-of-Life Care

What do we actually mean by “appropriate care”? Generally, we mean that the treatment must be proportioned, personalized and appropriate and not just technically feasible. In the final analysis, however, treatment is deemed to be appropriate when the decision making process has been properly and thoroughly conducted. Today, the way decisions are arrived at is indeed considered to be as important as the decisions themselves.

Palliative care is unquestionably the field in which efforts aimed at determining what is appropriate treatment have been the most purposeful and evident, and in which the importance of the decision making process and communication are clearly affirmed. Palliative care, where accompaniment is as essential a part of the treatment as technical interventions, has in a way become the example par excellence of appropriate care that is both personalized and proportioned. As such, we must aim to see that the spirit fuelling palliative care becomes more prevalent in Quebec.

In effect, the decision making process is of particular importance when people reach the end of their lives. This process generally enables patients, their loved ones, and physicians and other caregivers to arrive at a consensus. It also helps give rise to solutions that, if not arrived at by consensus, respect all parties involved in the clinical situation.

As we have learned to do in long-term care settings, determining the level of treatment desired in advance can avoid many disputes. If a consensus is impossible because the patient or their loved ones believe the proposed treatments are not appropriate, the discussion can nevertheless be pursued. Of course, these individuals can refuse treatment even if it is vital. However, patients or their loved ones sometimes ask for treatment that caregivers deem to be inappropriate, which is referred to as “futile”. This is often the case with resuscitation, and thus, the lines are less clear. Generally, we are satisfied with saying that nothing can oblige a physician to provide care that is not medically appropriate, and we consider that to be a matter

of good medical practice. Hence, the resumption today of the debates on withholding and withdrawing vital treatments within medical organizations.

By taking the reflection about the decision making process further, the discussions can continue in spite of possible disagreements, even if it means that certain parties withdraw from the situation or third parties are brought in.

3. Appropriate Care and the Decision Making Process

With such divergent viewpoints, just how do the various parties concerned arrive at considering the treatment provided or received to be appropriate? For some time, the debates on this subject have been very polarized. Based on the terms used alone, it would seem that one chooses one's camp and that the question to be answered is essentially: Who should be deciding — doctors or patients? Nevertheless, the debate on “prolonged artificial life support” has led to a major step forward — the right of patients to accept or refuse any treatment offered.

In several countries, this evolution has been quick and the emphasis within the healthcare field is now gravitating toward the decision making process. This is the case in Quebec, where the law gives patients and their loved ones a great deal of power. In fact, apart from exceptional cases, the Civil Code requires the patient's consent before any intervention. As such, patients, or their loved ones if the patient is inept, can refuse needed or life-saving medical treatment such as transfusions, respiratory aid or certain resuscitation operations. The legal system comes into play only in the event of obstruction, refusal without grounds or categorical rejection. For its part, the Code of Ethics of Quebec Physicians obliges doctors to adequately inform patients and to obtain their consent prior to any intervention.

Although patients and their loved ones are entitled to refuse care, this does not mean that they can demand treatment the physician deems to be inappropriate. The law is often silent in this regard, and the situation in Quebec is no exception.

The Collège believes that Quebec doctors now share the conviction that treatment is more appropriate when it stems from a process aimed at making the most consensual decision possible. Doctors no longer want to bear all the decision making power, but they are not ready to relinquish their share of the responsibility. For physicians, it is clear that the quality of the decision making process rests as much on the respect of each party's roles and responsibilities as on good communication, because it is not as much the decision as the responsibilities that must be shared. It is also clear to doctors that consensus is not always possible and that disagreements can persist. These must not, however, obstruct the process.

When we take these two new elements into account — responsibility of all parties and persistent disagreements — it becomes possible to gain a fuller and more dynamic understanding of how the decision making process can lead to appropriate treatment, which can be depicted as follows:

In a clinical setting, the doctor calls upon his knowledge and skills to offer the care that he objectively considers to be the most appropriate from a medical standpoint. Of course, the patient is the one to decide on the treatment as it is their life involved. For both subjective and objective reasons, the patient chooses to accept or refuse the care, or asks for some other type of treatment. Whatever the patient's choice, the doctor remains responsible for the actions taken. He/she can opt to agree to the patient's request, refuse it, or suggest some other course of action, in which case, the exchange resumes. Occasionally, the patient's request may initiate the process prior to the physician's recommendation.

The difference in perspective may seem subtle, but it has major implications, at least on the action that is expected of physicians. Whatever the clinical situation, we will encourage doctors to discuss the intensity of care with patients, their loved ones and other parties involved without delay and to continue these discussions as long as necessary. In the event of persistent disagreements, doctors will be asked to refrain from making any unilateral decision with respect to the treatment to be provided. However, we will assign them the right, under certain conditions, to conduct follow-up and to refuse to personally participate in the provision of any treatment they consider to be medically inappropriate, or which they object to on moral grounds.

In that sense, it is unthinkable for physicians to be simply taking orders and to be providing care on demand. The role of physicians must be to make clinical judgements, to offer information that is essential to the discussion and to the decision making process, and finally, to act in what will be determined to be in the best interests of the patient.

Conclusion

The Collège believes that perspectives have evolved a great deal regarding how to make healthcare-related decisions, and we must take advantage of this evolution to deal with the increasing number of difficult clinical decisions. There is nothing to be gained by a return to medical paternalism, nor by leaving patients on their own under the pretext of respecting their autonomy. On the contrary, we must emphasize solidarity and the sharing of responsibilities among patients and their loved ones, doctors and other caregivers, and society.

This evolution, which owes a lot to the end-of-life care field, should enable us to confront the challenges that remain to be overcome, most notably, the difficult question of euthanasia. A new sensitivity is clearly evident among both doctors and the public that there are exceptional situations where euthanasia could be considered by patients and their loved ones and by doctors and other caregivers as a final step necessary to assure quality care to the very end. This must be recognized in order to allow for more open discussion of all the options available at the end of a patient's life and to clearly identify the responsibilities of all parties concerned in that regard. Although certain distinctions must be drawn (i.e. between terminating treatment, relieving pain and euthanasia, between euthanasia and assisted suicide), the question of euthanasia must be integrated as a part of appropriate end-of-life care as soon as possible. If euthanasia is to be permitted, it should certainly be within a context of care and as a medical act.

It is not solely up to physicians to identify how this social and moral openness should be addressed from a legislative and administrative standpoint. However, it is important to reiterate the significance of the decision making process in the provision and management of care.

The more clinical situations call for difficult choices, the more we must concentrate on the decision making process, call upon open communication, and allow all parties concerned to assume responsibility. It is possible most of the time to arrive at a consensus on the treatment that is appropriate for a given individual in a specific situation, whether it be at the beginning, end or any time during the course of their life. A better understanding of the decision making process gives rise to solutions that are acceptable to all parties in the event of disagreements about vital treatment. Such understanding will also allow for the resumption of the debate on euthanasia in the best direction — focused on appropriate end-of-life care.

The Collège des médecins du Québec invites physicians, the general public, and the authorities concerned to pursue the debate with that perspective in mind.