

Respecting a new right: What are physicians' responsibilities?

On 6 February 2015 the Supreme Court of Canada ruled that Section 241 of the Criminal Code, prohibiting assistance with the death of a person, was void for a “competent adult person... who clearly consents to the termination of life” and who “has 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 The ruling went on to note that “‘irremediable,’ it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.” The Supreme Court immediately suspended the ruling for 12 months to give the federal government time to amend its laws in response to the decision.

The ruling does not require the person to be suffering a life-limiting or terminal illness, only “enduring suffering that is intolerable.” Could this include a major mood disorder or an older person who is “tired of living,” as is supported by a minority of physicians in the Netherlands?² Many physicians want clear regulations as well as guidance on how to assess patients who make a request for physician-assisted death.

Statistics from Oregon, where physician-assisted dying has been permitted since 1998, reveal that less than 0.5% of all deaths are from legal fatal prescriptions. The vast majority of people still choose to die naturally. The concern is that in BC equitable access to quality palliative care is not a reality, meaning poorly controlled symptoms and lack of patient- or

family-centred care may result in stories of poor-quality dying. Multiple factors drive a request for hastened death, including poorly controlled psychological, spiritual, and physical symptoms; perceived loss of control; perceived loss of dignity and meaning; and not being aware of other ways to relieve suffering.³ All patients should automatically receive quality palliative care that controls symptoms and addresses suffering.

A pan-Canadian strategy to improve access to high-quality palliative care is essential, as is education about palliative care and what it can do to improve the quality and quantity of life for those with a life-limiting illness. Integrating palliative care into life-limiting disease will require implementing accreditation standards for palliative care into chronic disease management. This is an opportunity for physicians to review what palliative care can do for those with advanced illness and how they can provide or access it for their patients.

Canada has the opportunity to develop physician-assisted dying regulations that improve upon those in other jurisdictions and ensure safeguards are in place. Concerns about safeguards pertain to the lack of processes to assess capability, the impact of medical and mental illness on capacity, coercion as a factor in decision making, and dealing with conflict among assessing physicians.

Currently there is no widely accepted process for evaluating a person's capacity to consent to termination of life or other serious medical decisions. We do know that capacity is compromised by age, cognitive impairment, medical illness, health literacy, and language barriers. Incapacity rates of 31% and 26.7% have been found on acute medical wards,

60.6% in the emergency room, and 78% in the ICU.⁴ There are four key principles of capacity: understanding the medical situation, appreciating all the options for management, reasoning why one option is better than others, and expression of choice.⁵ Regulations should specify that a capacity assessment be documented using these principles.

Assessing for factors that may compromise capacity is essential. Severe depression is one such factor that can compromise capacity, and a systematic review shows a prevalence for depression of 19% to 34% in the palliative population.⁶ In a research questionnaire answered by 290 US forensic psychiatrists, 61% recommended psychiatric assessment on all requests for hastened death and 58% recommended an automatic incapacity finding if a mood disorder was diagnosed.⁷ Yet a review of physician-assisted dying programs in Belgium, the Netherlands, Luxembourg, Oregon, and Washington showed psychiatrist referral rates ranging from only 4.2% to 6.7%.⁸

Referral to psychiatry for a formal capacity assessment should be applied to all patients who request a hastened death, as is frequently done for patients who refuse or withdraw from treatment. Physicians should also be encouraged to talk to an applicant's family and friends for collateral information rather than allowing the applicant to forbid this, as some programs do.

Physician education about patient assessment for physician-assisted dying should be formalized and should include capacity evaluation, psychiatric assessment, and whole-person assessment as is done in palliative care. Assessors should have ready access to palliative care and

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psychiatric consultation. The fee for providing this service should be high enough to ensure proper assessment and documentation.

All physician-assisted dying programs should track and follow the patients who have applied to the program, rather than relying on voluntary reporting of physician-assisted deaths. Physicians need processes in place that will hold them accountable to the law. Reliance on physicians to report a physician-assisted death after it has happened has led to elaborate retrospective studies in the Netherlands that have serious limitations that compromise the ability to rule out abuse.⁹

In the US, barbiturates are the only medications used for physician-

assisted dying and they can be tracked. Tracking is necessary because many patients who request hastened death may receive a prescription after their assessment and then not use it. An oversight committee of physicians, lawyers, and other appropriate public and professionals should review all requests and completed cases, similar to what is required in other jurisdictions. This committee could also examine cases of conflicting assessments of a patient's appropriateness for physician-assisted dying. In existing programs the agreement of two physicians is needed for a person to qualify for physician-assisted dying, but there is no provision for what to do if conflicting assessments arise and no limit on the number of physicians

a patient may request an assessment from.

The new regulations should also allow physicians and other health care providers to exempt themselves from participating in an assessment or managing a request for physician-assisted dying due to conscientious objection. We are a nation of diverse values and beliefs, which must be respected. The integrity of our society is discernible in how we treat vulnerable people.

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References

Available at www.bcmj.org.

college library

Better decision making with library search services

As high-quality medical information becomes more readily available online, straightforward clinical questions can often be addressed quickly. Point-of-care tools offer simple interfaces to current, evidence-based guidance for clinical decision making. The College Library offers two tools, BMJ Best Practice and First Consult, while another tool, UpToDate, is available from most BC health authority libraries and the provincial Divisions of Family Practice office. The utility of these tools, however, can be exhausted by clinical questions arising from care of patients with complex comorbidities and contexts. Whether an ensuing search for evidence to support a chal-

lenging question is conducted is often determined by whether clinicians have enough time and whether they feel efficient in selecting an information source.¹

Literature search services by librarians at either the College Library or BC health authority libraries offer timeliness and expertise in locating high-quality evidence. Librarians have the knowledge to efficiently select resources and can devote the time needed for comprehensive information searches. Librarians use careful question analysis and controlled vocabularies to develop logical search strategies. Studies demonstrate that librarian-supported literature searching changes physicians' approaches to patient care and results in better-informed clinical decisions and fewer adverse events.²

Literature search services for physicians are offered by librarians in six

of the BC health authorities and for the entire province by the College Library. No annual limits are placed on the number of search requests made to the College Library, and every effort is made to respond within the requestor's deadline. Contact the College Library at 604 733-6671 or medlib@cpsbc.ca, or your local health authority library.

—**Karen MacDonell, PhD**
Director, Library Services

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