



Statement concerning euthanasia and physician-assisted suicide

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for the Ethics Committee of the College of Family Physicians of Canada

The Ethics Committee of the College of Family Physicians of Canada (CFPC) introduces a new statement endorsed by the National Board of the CFPC on December 8, 1999, regarding assisted suicide and active euthanasia (see sidebar¹⁻⁵). This statement is a complete reworking of a 1990 statement entitled "The Dying Patient: Ethical Considerations for Canadian Family Physicians." This new statement has gone through numerous revisions and received suggestions from a variety of committees and individuals inside and outside

the CFPC. We believe it fairly represents the current ethical consensus regarding assisted suicide and active euthanasia. It cannot be the last word on these subjects because the debate concerning these practices continues to evolve. The CFPC issues this statement both to guide Canadian physicians and to promote dialogue and debate about ethically sensitive matters.

This new statement simply says that, at this time, certain medical practices for dying patients are relatively uncontroversial ethically and others

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The College of Family Physicians of Canada (CFPC) distinguishes palliative care and appropriate decisions to forgo life-sustaining treatment from acts of assisted suicide and active euthanasia. Specifically:

- The CFPC *does not* support assisted suicide and active euthanasia, as they are illegal and controversial acts.
- The CFPC *does* support and recommend guidelines on appropriate end-of-life care and ongoing societal discussion of these issues by members of the CFPC, physicians generally, other health care professionals, patients, their families, and, indeed, all citizens in our society.^{1,2}

1. The goals of medicine are not only to cure disease and decrease suffering but also to provide the best possible end-of-life care, when cure is no longer possible.

2. Patients and families are due effective, comprehensive, and competent palliative care.* Such care strives to meet physical, psychological, social, and spiritual expectations and needs of those living with illness.³

3. Patients have the right to participate in decisions about their care. This includes the right to appropriate medical care¹ as well as the right to forgo life-sustaining measures.

4. A decision to withhold or withdraw certain treatments might result in the earlier death of a patient, but this consequence is ethically acceptable and legally permissible if carefully and thoughtfully made.[†] Where a patient's wishes to have specific treatment withheld or care withdrawn run counter to the physician's own values and an impasse is reached, the physician must seek to transfer the patient to

another physician who might accommodate the patient.

5. Substitute decision makers for an incapable[§] patient should make decisions for the patient in accordance with the patient's prior expressed wishes or, if such wishes are unknown or not applicable, shall act in the incapable person's best interests (taking into consideration the patient's prior wishes, beliefs, and values, and the treatment's effect upon the patient's well-being and its balance of benefits and harms).

6. Physicians ought to seek clarification of a patient's views about care at the end of life by providing counseling and assistance in the area of advance care planning (living wills, mandates for health care, powers of attorney for personal care, proxy decision making). The goal of advance care planning is to encourage physicians,

are more morally contentious. Palliative care and decisions to forgo life-sustaining care are, with appropriate provisions and safeguards, ethically and legally acceptable. The more morally contentious practices are, of course, assisted suicide and active euthanasia, and physicians in Canada ought to avoid these practices at this time.

The committee believed it important to distinguish between these end-of-life practices to help guide and support front-line physicians caring for the dying and the critically ill. It reminds physicians not to abandon patients who are dying but to provide comfort to them, even if such measures might hasten death. Palliative care physicians know all too well, however, that the purported danger of “overdosing” a dying patient with drugs such as morphine is exaggerated and causes some physicians to undermedicate patients. Family physicians face very few professional hazards in this area, as long as the palliative treatment is proportionate to the patient’s suffering; is not intended to directly cause death; and uses appropriate, symptom-directed, escalating doses of drugs.

Faced with implicit or explicit requests for assisted suicide and active euthanasia, physicians are encouraged to explore such requests with patients and their families and care providers. Often requests to accelerate death—and this can equally apply to requests to withdraw or not to provide life-sustaining care—are born out of patient suffering, loneliness, and despair. Not all of these patients are easy to treat, but sometimes they can tolerate the seemingly intolerable if they know someone *cares* for them. This means taking time to explore with patients the meaning of requests for death and what, if anything, can be done to help manage the whole spectrum of a patient’s suffering.

Too readily acquiescing to requests for assistance to die (as such requests might arise out of temporary despair and reversible depression) can send a subtle message to patients: “You can’t be helped because I cannot help you. Unfortunately, it is your time to die.” Therapeutic nihilism regarding end-of-life care ought to be strenuously resisted, as a great deal can be done to improve care at the end of life.^{6,7} Clinicians

patients, and their significant others to discuss issues concerning death and dying; such discussions can better prepare patients for serious illness and encourage realistic end-of-life care.

7. It is sometimes claimed that treatment aimed at alleviating suffering might occasionally hasten a patient’s death.⁴ This concern, especially pertaining to opioids, has been overstated. The reality is that the suffering of many dying patients is undertreated.
8. All care aimed at alleviating symptoms due to advanced, terminal disease is ethically acceptable and

legally permissible if administered to relieve the patient’s suffering, if it is commensurate with that suffering, and if it is not a deliberate infliction of death.⁵

9. Acts intentionally causing a patient’s death either by a physician (active euthanasia) or with a physician’s help (assisted suicide) are to be distinguished from the appropriate practice of withholding or withdrawing life-sustaining care. Even if done out of best possible compassionate motives, the former practices are ethically controversial and illegal under the Criminal Code of Canada.

10. A patient’s request for the deliberate infliction of death by a physician or with a physician’s help ought not to be agreed to and calls for urgent attention by the physician. Such requests are often prompted by depression, poor palliation, isolation, and fear of abandonment. Input and consultation might be required from other health care professionals (such as a palliative care specialist, a social worker, an ethicist, a psychiatrist) for help in clarifying the patient’s needs and exploring alternative ways of helping the patient.

* The College of Family Physicians of Canada’s Palliative Care Committee is currently developing clinical guidelines for care at the end of life.

† Appropriate care means the care that a reasonable practitioner would provide. Patients or families might, at times, ask for treatment that, in the eyes of health care providers, is futile or inappropriate. Such differences in perspective ought to be subject to negotiation and discussion among patients, families, and health care professionals.

‡ Such treatment decisions must be made by a capable patient and accord with the principles of informed choice, that is, the consent must relate to the treatment being declined, be informed, be voluntary, and not be obtained through misrepresentation.

§ “Incapacity” means that the person, as regards treatment, is unable to understand the relevant information, appreciate the consequences of a decision or lack thereof, or express his or her wishes. All people are presumed competent unless there are reasonable grounds to the contrary. Incapable patients must have treatment decisions made for them by appropriate substitute decision makers.

need to recognize that requests to accelerate death are often cries for more help, not genuine requests to end life. Physicians who fail to provide appropriate medical treatment to critically ill patients might face professional or legal sanctions. (A physician in Toronto, Ont, was recently jailed for providing a lethal dose of drugs to a suicidal nonterminally ill patient.⁸)

The committee recognizes that death is not the worst fate for some patients; there are conditions of unrelieved suffering and imminent death that call for reducing treatment. Hippocrates recommended that physicians ought to cease treatment for patients "overmastered by their disease." Just when this point is reached is a matter of clinical judgment that is made more difficult because of the new technology of medicine. Results of the SUPPORT study have shown how challenging it is to change end-of-life care.⁹ Because we can do so much more in medicine these days, it is difficult to recognize when "enough is enough." Clinicians, patients, and families can, unfortunately, sometimes collude in overtreatment.

Decision making at the end of life is difficult and unlikely to get easier.¹⁰ But maybe that is how it should be. If decisions to limit care or to allow patients to die were ever to become easy or routine, we should all worry about medicine. This statement does not, and cannot, resolve the ethical debate over whether assisted suicide and active euthanasia could ever be a morally appropriate response to suffering. Oregon has legalized physician-assisted suicide and some empirical data are available on that experience.¹¹ That article joins an already rich literature on medical practices and attitudes in various countries regarding physician-assisted suicide.¹²⁻¹⁴ Physicians are encouraged to contribute to the ongoing debate on how best to manage end-of-life care.

The Ethics Committee and the CFPC hope you find this new statement regarding assisted suicide and active euthanasia helpful. We welcome your comments on it. ♣

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