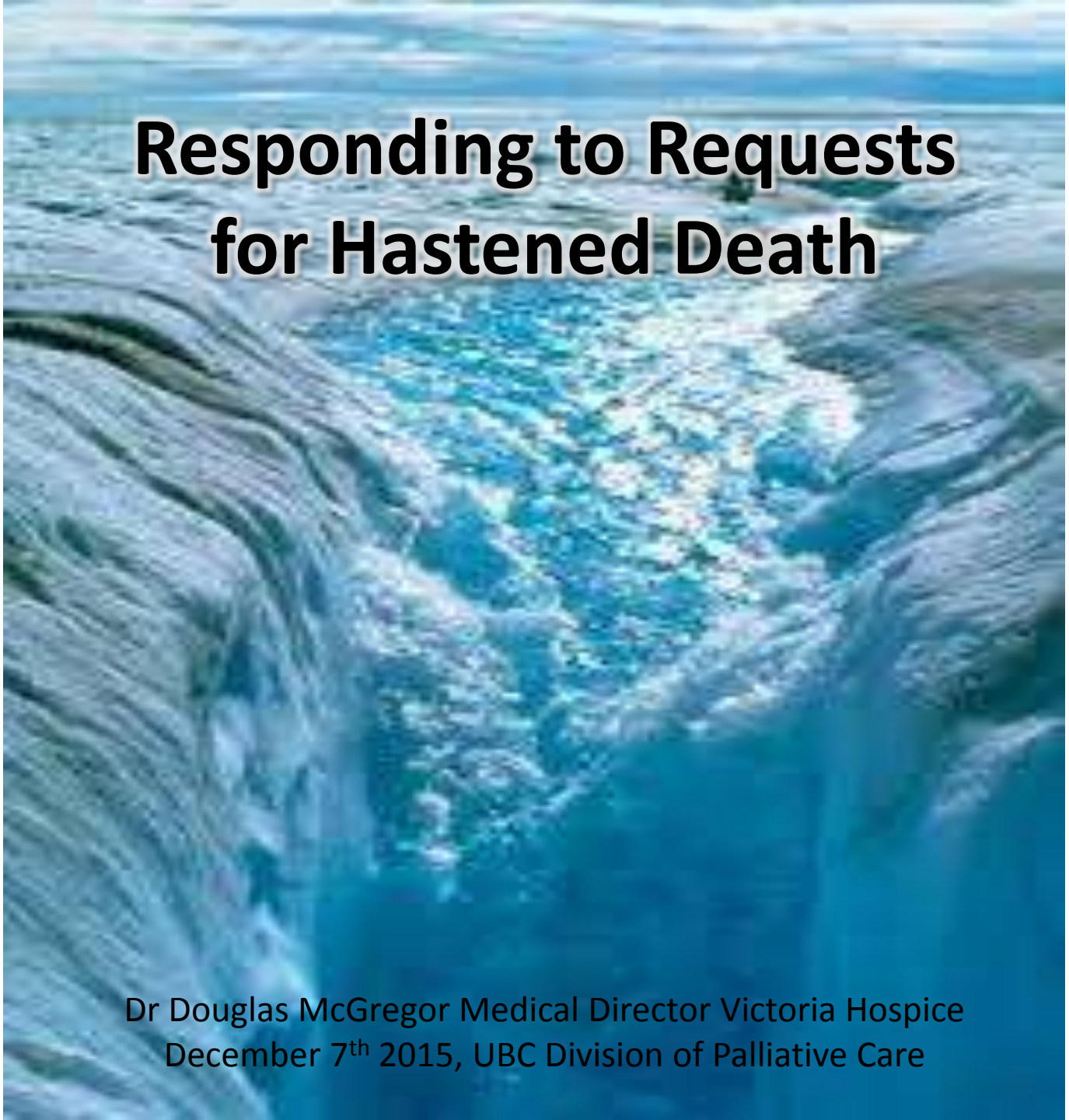


Responding to Requests for Hastened Death

Dr Douglas McGregor Medical Director Victoria Hospice
December 7th 2015, UBC Division of Palliative Care

a place of mind
UBC

June 2014

NATIONAL ASSEMBLY

FIRST SESSION FORTIETH LEGISLATURE

Bill 52

An Act respecting end-of-life care

Introduction

Introduced by
Madam Véronique Hivon
Minister for Social Services and Youth Protection

Québec Official Publisher
2013

February 2015

SUPREME COURT OF CANADA

CITATION: Carter v. Canada (Attorney General), 2015 SCC 5 DATE: 20150206
DOCKET: 35591

BETWEEN

Lee Carter, Hollis Johnson, William Shoichet, British Columbia Civil Liberties Association and Gloria Taylor

Appellants

and

Attorney General of Canada

Respondent

AND BETWEEN

Lee Carter, Hollis Johnson, William Shoichet, British Columbia Civil Liberties Association and Gloria Taylor

Appellants

and

Attorney General of Canada and Attorney General of British Columbia

Respondents

- and -

Attorney General of Ontario, Attorney General of Quebec, Council of Canadians with Disabilities, Canadian Association for Community Living, Christian Legal Fellowship, Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario, Association for Reformed Political Action Canada, Physicians' Alliance against Euthanasia, Evangelical Fellowship of Canada, Christian Medical and Dental Society of Canada, Canadian Federation of Catholic Physicians' Societies, Dying With Dignity, Canadian Medical Association, Catholic Health Alliance of Canada, Criminal Lawyers' Association (Ontario), Farewell Foundation for the Right to Die, Association québécoise pour le droit de mourir dans la dignité, Canadian Civil Liberties Association, Catholic Civil Rights League, Faith and Freedom Alliance, Protection of Conscience Project, Alliance of People With Disabilities Who are Supportive of Legal Assisted Dying Society, Canadian Unitarian Council, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition — British Columbia

Interveners


BUT…
Tuesday 1st December
Quebec Superior Court: “provincial law legalizing euthanasia …is in “flagrant” conflict with the Criminal Code.”
Thursday 3rd December
New Liberal Government petitions the Supreme Court of Canada for a 6 month extension

How did we get here?

- **Societal change**
  - Dying older of different, lingering diseases, alone
  - Change in values
  - Access to care & choices for all – not just the rich
  - Sense that people have a right to decide about "their own bodies" autonomy trumps everything
- **Physicians called to "get real / honest"**
- **Desperate things people do otherwise**

In Canada

■ DOCTORS Michael Downing and Debra Braithwaite fuel the debate over assisted suicides.
Ray Smith/Times-Colonist

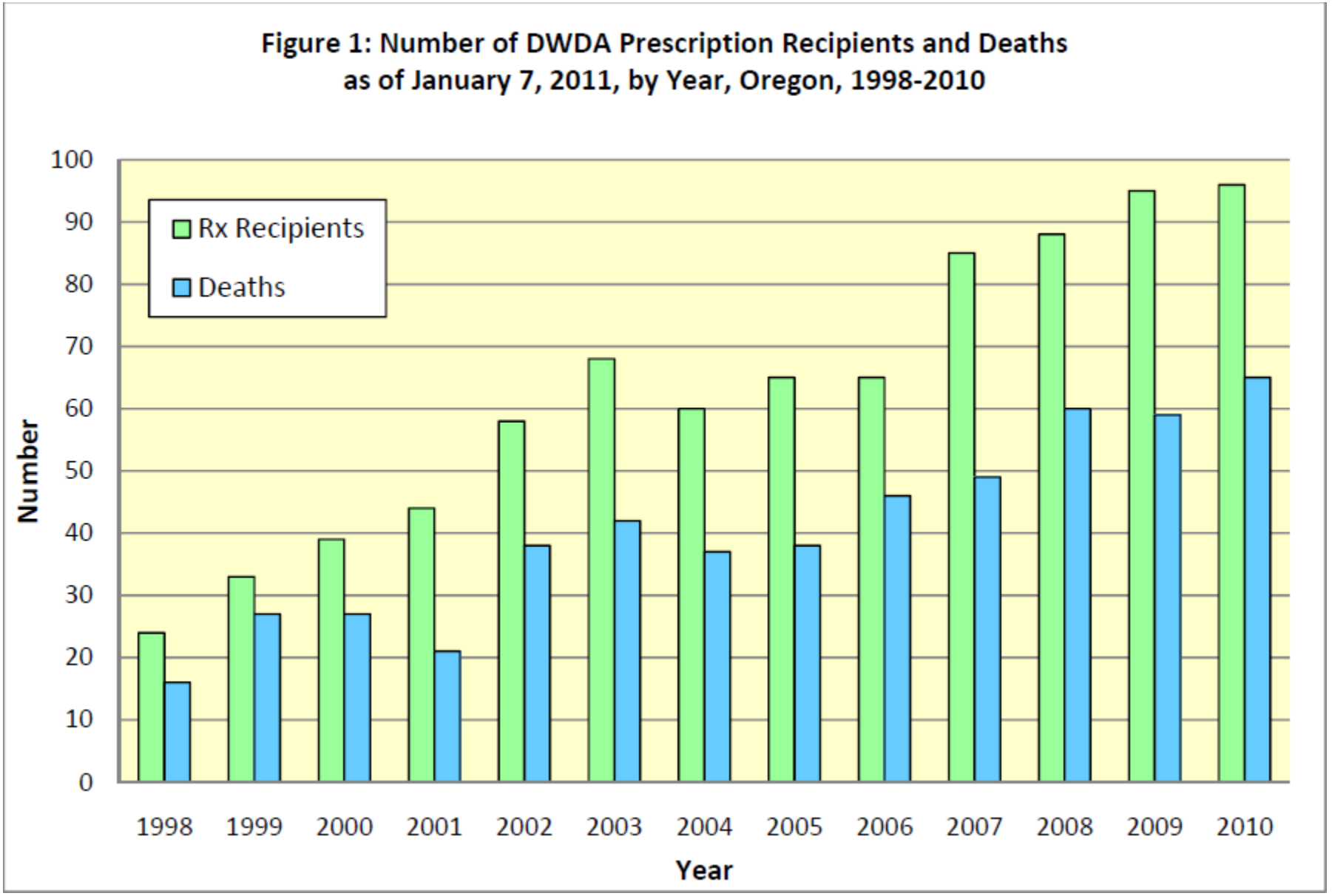
Sue Rodriguez
died Feb. 12, 1994

In the USA

- Oregon (oldest) 1997
  - Since 1998; 1327 lethal prescriptions & 859 deaths
- Washington 2009
- Montana (may not prosecute physicians) 2009
- Vermont 2013
- New Mexico reversed on Appeal
- California 5 Oct 2015

23 new bills in different states so far in 2015

Oregon 13 Years of DWDA



Europe

Belgium: 2002 voluntary euthanasia legalised.

All who are mentally competent and have an incurable illness (including mental illness)

2014 children of any age with parental consent

Flanders: 4.6% of deaths, including “tired of living”

BMJ 2015;351:h4481, **JAMA Internal Medicine** 10 August 2015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HOW ?

Clinical Criteria for Physician Aid in Dying

To be sure, clinical criteria are included in the AID statutes in California, Oregon, Vermont, and Washington. But those criteria are incomplete….

Our clinical criteria discuss the ways in which physicians should respond to a request for AID, including (1) discussion of the patient's reasons for requesting AID, (2) evaluation of the patient's decisional capacity, and (3) assessment of the patient's understanding of palliative measures that might be used instead of or concurrent with AID / broad discussion of other issues that may arise.

Physicians should also document that the patient understands (1) the near certainty that ingesting the prescribed life-ending medication will cause death; (2) the possibility that ingesting the medication could cause nausea or vomiting or, rarely, could fail to cause death; (3) that the patient always retains the right to decide against AID; and (4) that the physician is willing to continue caring for the patient and to address subsequent palliative needs, whether or not the patient chooses to take the medication.

Clinical Criteria for Physician Aid in Dying. David Orentlicher et al, JOURNAL OF PALLIATIVE MEDICINE; Volume 18, Number X , 2015

End-of-Life Medication Procedure

The medication protocol is a two-step procedure.

First, the patient takes an antiemetic (e.g., metoclopramide or ondansetron).

Forty-five to sixty minutes later, the patient ingests 9 g of a short-acting barbiturate (e.g., secobarbital or pentobarbital). The powdered barbiturate is mixed with a half cup of water into a slurry and consumed.

The barbiturate must be consumed quickly, within 30 to 120 seconds. Otherwise, the patient may fall asleep before ingesting an effective dose. The patient may then drink juice or other liquid as desired.

Clinical Criteria for Physician Aid in Dying. David Orentlicher et al, JOURNAL OF PALLIATIVE MEDICINE; Volume 18, Number X , 2015

The Oregon Death with Dignity Act:

A Guidebook for Health Care Professionals

Developed by
The Task Force to Improve the Care of Terminally-Ill Oregonians

Convened by
The Center for Ethics in Health Care, Oregon Health & Science University

Patrick Dunn, M.D., Task Force Chair and Co-Editor
Bonnie Reagan, M.D., R.N., Co-Editor
Susan W. Tolle, M.D., Reviewer and Major Contributor
Sarah Foreman, Manuscript Preparation

Initial writing of the Guidebook was supported in part by
The Greenwall Foundation

First Edition (print): March 1998

Current Edition (2008): Published on this website
Updated as information becomes available

The Oregon Death with Dignity Act: A Guidebook for Health care Professionals

4. Hospice, Palliative Care, and Comfort Care

" …This observation leads the Task Force to reaffirm its recommendation of referrals to hospice who are interested in a prescription under the Oregon Death with Dignity Act, or any other end-of-life option, if they are not already receiving hospice or palliative care services.

Oregon hospices respect the right of dying Oregonians to choose legal end-of-life options.

The high quality of hospice and palliative care in Oregon is offered as one explanation for the low number of deaths under the Oregon Act."

MEDICAL AID IN DYING

11/2015
PRACTICE
GUIDELINES

Ordre des pharmaciens du Québec

Ordre des infirmières et infirmiers du Québec

a place of mind
UBC

SECTION 29

"Before administering medical aid in dying, the physician must:

1° be of the opinion that the patient meets all the criteria of section 26, after, among other things:

a) making sure that the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure;

b) making sure that the request is an informed one, in particular by informing the patient of the prognosis for the illness and of other therapeutic possibilities and their consequences;

c) verifying the persistence of suffering and that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals given the progress of the patient's condition;

d) discussing the patient's request with any members of the care team who are in regular contact with the patient; and

e) discussing the patient's request with the patient's close relations, if the patient so wishes;

2° make sure that the patient has had the opportunity to discuss the request with the persons they wished to contact; and

3° obtain the opinion of a second physician confirming that the criteria set out in section 26 have been met.

The physician consulted must be independent of both the patient requesting medical aid in dying and the physician seeking the second medical opinion. The physician consulted must consult the patient's record, examine the patient and provide the opinion in writing."

A second kit containing a duplicate set of the products and injection material must be systematically prepared and sealed. It may be useful in the event of damage or improper handling.

Example of a sealed kit:

Table 13
Medications for IV administration – Phenobarbital

MEDICATION	DOSAGE	ROUTE AND DURATION OF ADMINISTRATION
Midazolam 1 mg/mL	2.5 to 10 mg to be titrated based on patient response (10 mL)	Slow direct IV injection, over 2 minutes
Parenteral lidocaine 2% without epinephrine 20 mg/mL	40 mg (2 mL)	Direct IV injection, over 30 seconds
Phenobarbital 120 mg/mL	3000 mg (25 mL) (complete *ad* 50 mL with NaCl 0.9%)	Slow direct IV injection, over 5 minutes
NaCl 0.9%	4 x 10 mL	Direct IV injection, to flush the syringe and/or tubing
Rocuronium bromide 10 mg/mL	200 mg (20 mL)	Rapid direct IV injection, over 30 seconds

"The Devil is in the Details"

p.16 "In the most difficult cases, in addition to consulting with the interdisciplinary team, a consultation with a specialist in the patient's condition or a palliative care team may be indicated to review the approaches used thus far to relieve the patient's suffering and propose other options, where appropriate."

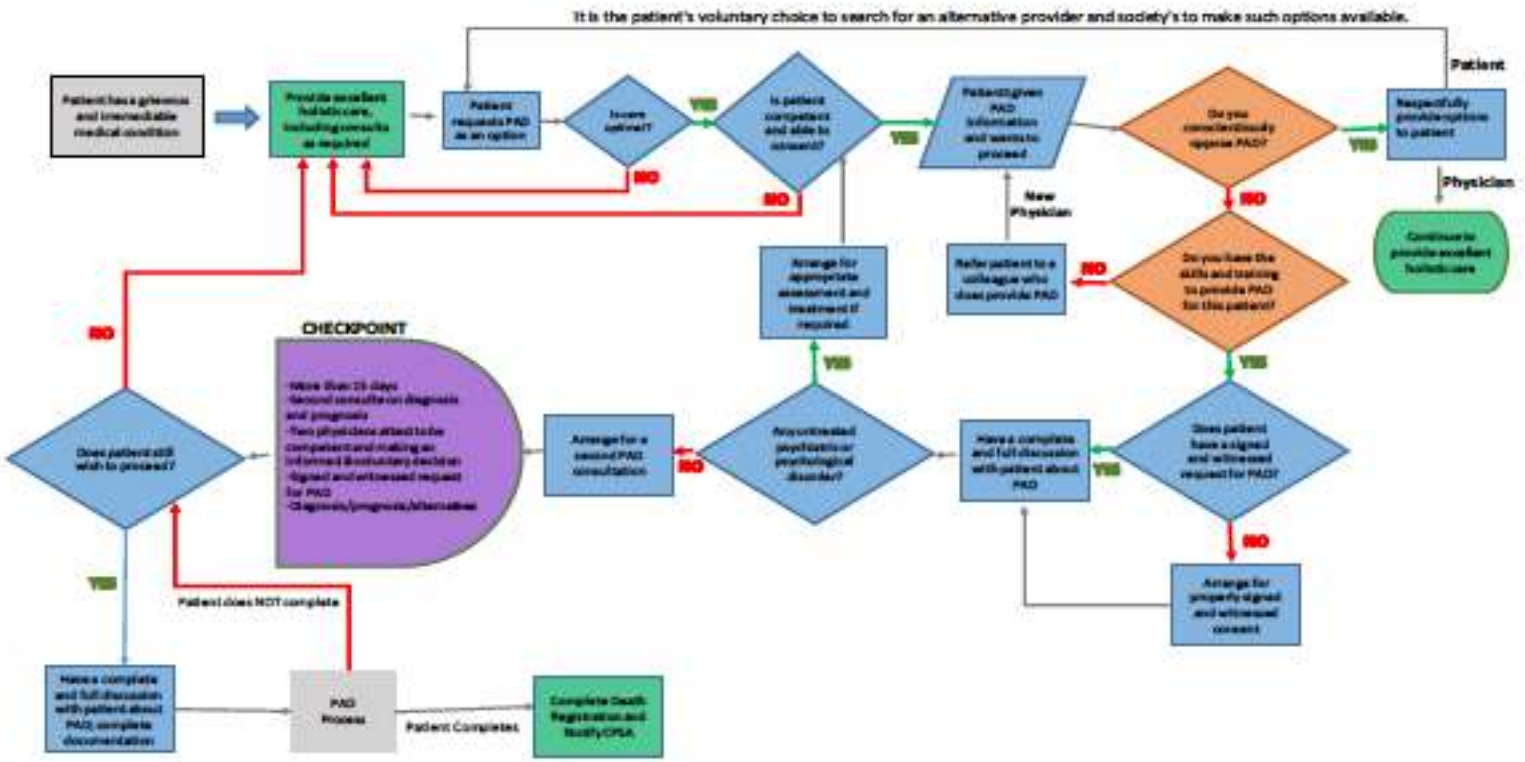
p.57 Decision Tree

3 links to "possible consultation with other professional" for

- assess suffering
- assess the prognosis of survival
- establish a diagnosis

College of Physicians & Surgeons of Alberta

DECISION FLOW CHART FOR PHYSICIAN-ASSISTED DEATH



Note: In this flow, holistic care means treatment of the entire person extending beyond their disease process to the social, spiritual and cultural determinants of health.

Questions that Remain

What will the impact be on Hospices?

What will the impact be on physicians and nurses?

Who will teach this?

Why are the numbers in Oregon so different from Flanders?