

# PALLIATIVE CARE AND ITS RELATIONSHIP WITH MEDICAL AID IN DYING

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# Declarations

- No Conflicts of Interest to report
- Declare my associations with:
  - Alberta Health Services
  - Health Quality Council of Alberta
  - University of Calgary
  - University of Alberta
  - Canadian Medical Association
  - Vulnerable Persons Standard

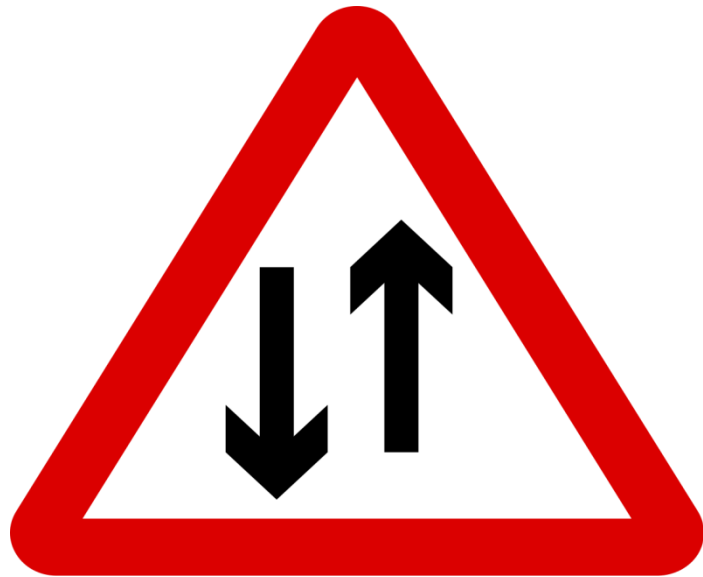
# Primary arguments against

- Will harm some patients who will fear being cared for by palliative care programs
- Will harm program integrity and weaken aims and opportunities for encompassing care for the majority of patients who will not pursue assisted death
- Will further conflate WD/WH of interventions with assisted death
- Effective move towards a “palliative approach to care” (versus “end of life care”) will be challenged

# Primary arguments against

- Will lead to moral harms to providers who cannot adhere to their moral commitments
- Potential downstream impact on human resources available for palliative care, reducing resources for all palliative patients
- While respect for autonomy is vitally important, autonomy does not exist in a vacuum of other considerations
  - End of life journey is continually transformative
  - Care is a human endeavor
  - Asking another person to deliberately help someone become dead must also consider the impact on that other person





# One analysis approach

- Is there a benefit by doing X
- What is the degree of benefit
- Can important benefits only be achieved by doing X
- Are there substantial harms (to individuals and to populations) and are those harms out of keeping with the putative benefits
- Can objectives be reasonably met in other ways
- Are benefits and harms fairly distributed
- Is inequity or vulnerability substantively increased by doing X

# Considerations frame

- Impact on patients
- Impact on providers
- System considerations
  
- Will consider from the perspective of duties rather than from virtue



## Many duties – both substance and process

- Duties to equity/justice
  - in application of policies, access, distribution of benefits and burdens
- Duties to respect for persons impacted
- Duties to optimize benefits and reduce harms
  - patients, providers, organizations
- Duties to include relevant voices in decisions
  - special attention to the voices of vulnerable persons
- Duties to study objectively and revise towards improvement

# Palliative care's beacons

- Care in order to optimize function, allowing best possible living as death approaches
- Ease death – neither hasten death nor prolong life
- Attend to physical, psychological, emotional and spiritual needs where desired
- Care in order to reduce suffering
- Promote dignity
- Support patient's circle
- Do not abandon





# Patients

- Need for care does not cease at a moment in time in which a patient asks about or declares intention for assisted death
- Recognize the response to suffering
  - Components of 'doing for' and 'doing to'
  - But also components of 'being with' and not having 'to fix'
- We require robust studies on the experiences of patients, families

# Patients

- Current
- Future
  
- Vulnerability
- Trust
  
- Values, hopes, fears cannot be assumed
  
- Families/patient's circle

# Providers

- Agency
- Moral commitments
- Obligations
  - To patients
  - To society
  - To self
  - To profession
- We need robust studies on the experiences of providers

# System considerations

- Health Quality Council of Alberta dimensions
  - Acceptability – how does the patient experience it
  - Accessibility – will either option influence positively or negatively
  - Quality – how is this optimized
  - Safety – risk of harm
  - Effectiveness – can fundamental needs be met
  - Efficiency – clinical and admin burden and funding

# System considerations

- programmatic authenticity
- obligations to society, including access and equity
- need for inter-sectoral, inter-agency collaboration



## Other considerations

- Do we confuse patients and providers with either approach, or with artificial delineations
- Relative benefits and burdens
  - Amplitude and direction
- Are there acceptable alternative approaches that minimize harm while optimizing opportunity
- Is it a dichotomy or a plurality of approaches

# What might be at the heart of the solitudes?

- Acceptance of human frailty and acquiescence to the vagaries of the human condition
- versus
- Desire to utilize science/technology to voluntarily control the manner and timing of our death

# Fundamental platform

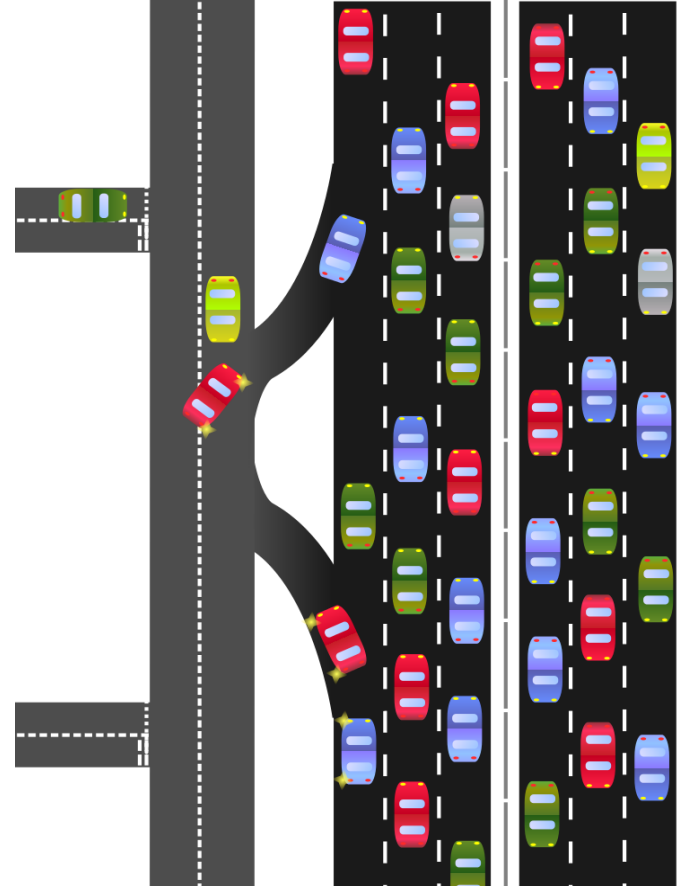
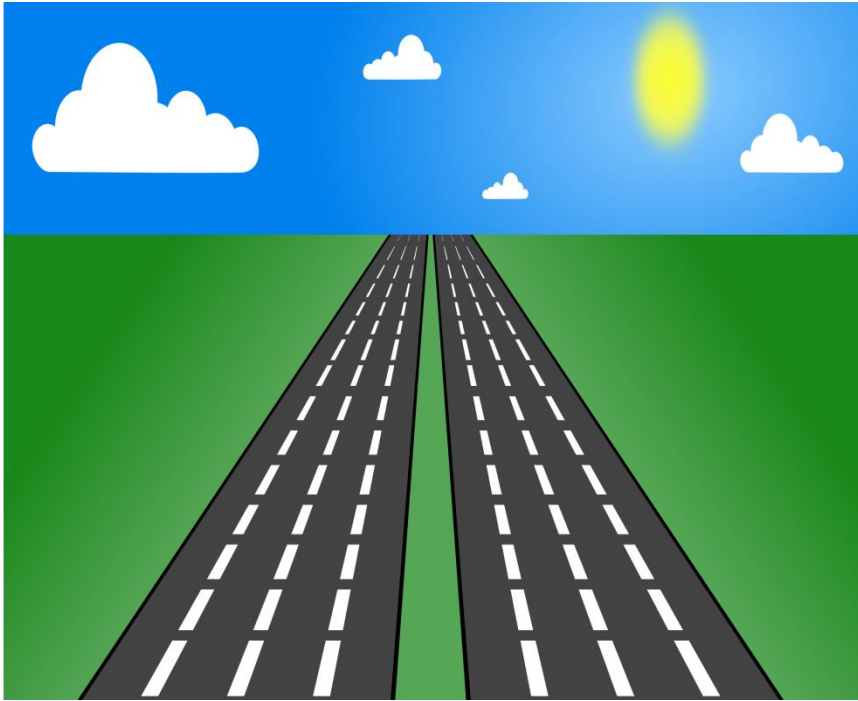
- Response to suffering
- Each approach does so with different tools and objectives even though the end result (being dead) may be the same
- Journey for some patients and some providers and some organizations cannot contemplate the opposing approach
- Risk of harm to the provision of excellent care of the patient, in the way each patient desires, is too great by conjoining the two services

## Is there a way forward?

- Considering the patient journey and what palliative care can offer, the two services ought to be available, and not exclusively so
- Best care invokes collaboration, potential sharing of care and provision of expertise where required, to maximize opportunity for each patient
- The two services ought to be separate organizationally and practically in order to minimize harms

# Patient-facing messages

- Cooperation
- Shared care when required
- Not exclusive, one does not preclude the other
- Non-abandonment
- Non-judgement



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# References

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# Thank you

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