Prospective judicial approval of assisted dying

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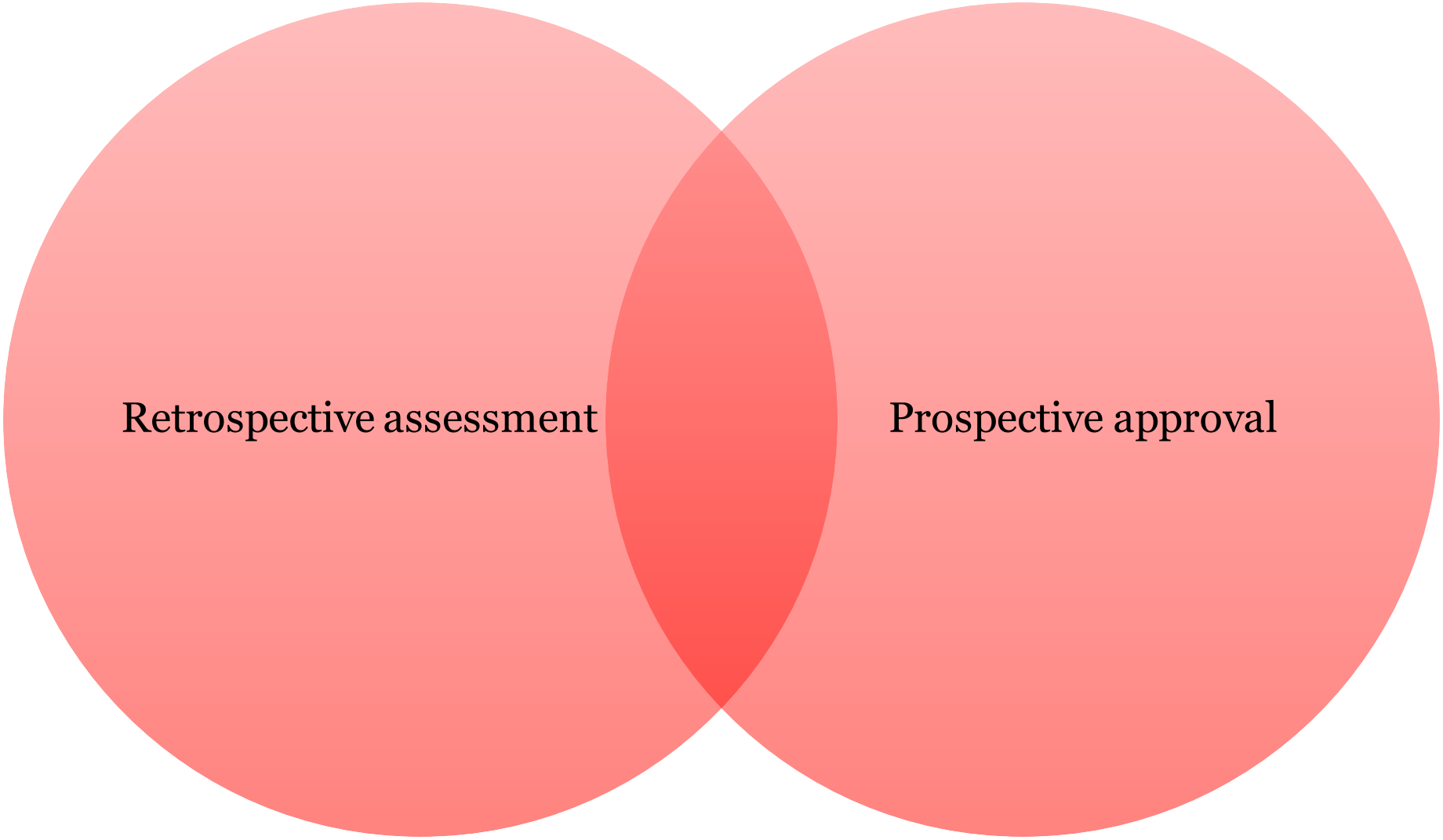
Conflicts of interest

No conflicts to disclose

Disclosures

- I was a law clerk to Iacobucci J. when the Supreme Court of Canada heard and decided *Rodriguez*
- I was an expert witness for the plaintiffs in *Carter* on the legal regulation of assisted dying in permissive jurisdictions and its effectiveness
- I am an expert witness for the claimants in the (separate) current English cases of *Conway* and *Omid T*

Review and scrutiny



The intersection

- widespread agreement that reporting obligation with retrospective assessment necessary for legitimate regulatory regime
  - retrospective assessment will decide whether criteria met, and (if needed) whether terms of any prospective approval were satisfied
- less agreement on extent of prospective approval needed

Prospective consultation

- proponents of legalisation tend to prefer prospective consultation (independent peer review) + some form of retrospective scrutiny
  - examples:
    - Dutch model as adapted for Belgian & Luxembourg contexts
    - US jurisdictions of Oregon, Washington, Vermont, California, Colorado and DC

(Quasi-)judicial involvement or approval: limited

Columbia

- requires approval of special three-person multi-disciplinary hospital-based committee
- regulation creating this regime dates from 2015 and no official information on decisions taken by such committees
  - as very few cases have proceeded to euthanasia, functioning of the committees will be difficult to evaluate

Canada

- judicially-crafted constitutional exemptions requiring judicial approval did exist in Canada for a four month period in 2016, but this was not a fully-fledged regulatory regime
  - small number of reported cases involved makes generalisation from this experience difficult

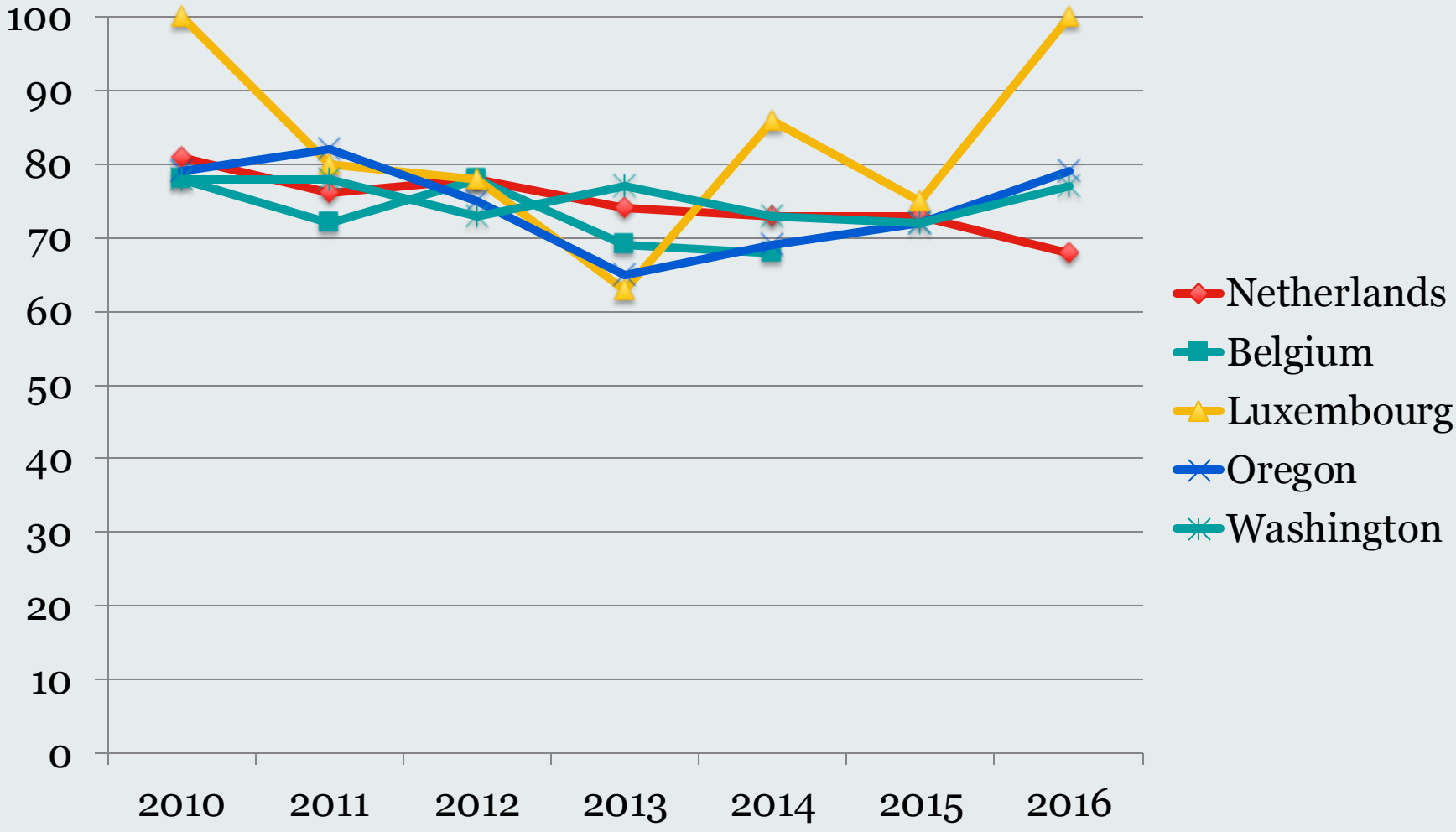
Typical request for assistance in dying

Typical patient

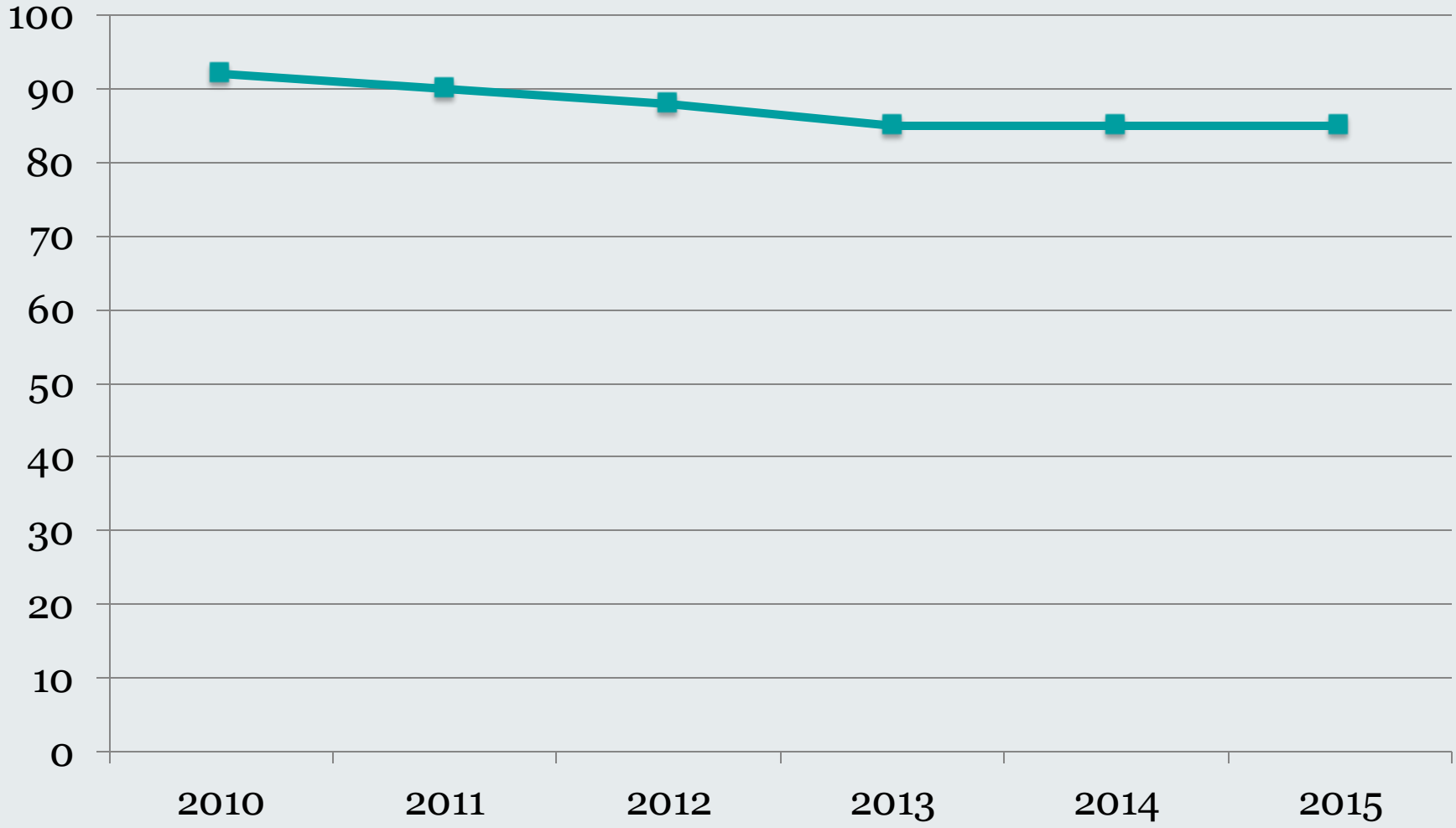
- **legal requirements relating to the requesting person's condition and/or experience of suffering vary widely across permissive jurisdictions**
- **however, in both regimes which impose a 'terminal illness' requirement and those that use a 'suffering' based requirement not limited to terminal illness:**

  over 70% of all reported cases of euthanasia or physician assisted suicide (PAS) involve cancer Ps

Rate of cancer in reported euthanasia/PAS cases



Percentage of reported Belgian euthanasia cases where patient expected to die in the near future



Typical patient …

…is dying of cancer and likely to die soon

- bearing this typical patient in mind, how would a prospective judicial approval requirement contribute to achieving the regulatory goals of:
  - respecting autonomy
  - protecting the vulnerable, and
  - responding compassionately to unbearable suffering?

Respecting autonomy

imposition of extra substantive or procedural requirements could interfere with an individual's autonomy if the requirements prevent her from obtaining assistance in dying or make it significantly more difficult to do so

- … provided individual's request for assistance is made autonomously
- particular characteristics of those who seek assistance in dying may correlate positively with an autonomously-made request when compared with other (much more common) serious and difficult medical decisions made by sick persons

Adherence to the Request Criterion in Jurisdictions Where Assisted Dying Is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland

Penney Lewis and Isra Black

1. Introduction

Some form of assisted dying (voluntary euthanasia and/or assisted suicide) is lawful in the Netherlands, Belgium, Oregon, and Switzerland. In order for individual instances of assisted dying to be lawful in these jurisdictions, a valid request must precede the provision of assistance to die. Non-adherence to the criteria for valid requests for assisted dying may be a trigger for civil and/or criminal liability, as well as regulatory sanctions where the assistor is a medical professional.

In this article, we review the criteria and evidence in respect of requests for assisted dying in the Netherlands, Belgium, Oregon, and Switzerland.[1] Our aim is to establish whether individuals who receive assisted dying do so on the basis of valid requests.

First, we present the legal and regulatory criteria for requesting lawful assistance to die in each jurisdiction. Second, we use the available evidence to assess adherence to these criteria. At the outset, it is worth noting that prosecutions for non-adherence to the request criteria are extremely rare. However, the absence of criminal or indeed other proceedings may not necessarily indicate that the request criteria are met in all cases. Therefore, we draw on a substantial range and number of sources, including the official reports of the relevant oversight bodies, quantitative and qualitative research studies on aspects of end-of-life decision-making in the four jurisdictions, and articles reviewing the empirical data in order to ascertain whether the law is respected. We group the evidence under the following headings: presence of request, timing of request, capacity, voluntariness, information provision, written request, and age. These headings reflect the basic legal requirements for valid consent to medical treatment generally, as well as additional procedural and substantive factors that may be relevant to the validity of the request for assisted dying.[2] Finally, we comment on our findings, and draw some conclusions; in particular, we note that the evidence suggests that individuals who receive assisted dying in the four jurisdictions examined make valid requests, and that third parties who assist individuals to die do not act unlawfully.[3]

Before proceeding, we should stipulate that our review relates only to adherence to the request criteria under the legal regimes for assisted dying in these four jurisdictions. In addition, we do not consider evidence that relates to termination of life without request.

2. Legal and Regulatory Criteria for Requesting Assistance to Die

In the Netherlands, in order to avoid liability for the offense of termination of life on request or assisted suicide,[4] the attending physician must meet the requirements of due care set out in article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.[5] The physician must be satisfied that "the request by the patient was voluntary and well-considered."[6] The patient must have capacity to make the request, and the attending physician must consult a psychiatrist if he or she suspects the patient lacks capacity.[7] The physician must also provide sufficient information to the patient to make his or her request well informed.[8] The Act does not require that the request be made in writing, but it is established

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- evidence suggests that the legal criteria governing requests are well-respected, and that individuals who receive assistance in dying do so on the basis of valid requests
  - both capacity and voluntariness criteria are used by doctors to weed out invalid requests
  - retrospective review bodies have not found substantive problems with the validity of requests in reported cases

prospective judicial approval requirement not routinely needed to ensure that requests are granted only when made voluntarily by individuals with capacity

- would be more useful to focus such approvals on cases in which the treating or consulting doctors or the patient's loved ones have concerns about P's capacity or voluntariness by permitting referral for judicial determination in such cases
- applying judicial approval requirement more selectively would contribute to the regulatory goal of respecting autonomy

Protecting the vulnerable

aside from capacity and voluntariness issues, are some or all patients in this group presumptively "vulnerable", so that imposing a judicial approval requirement might protect them?

- presumptive vulnerability premise is undermined by the Battin et al's conclusion that "the available data … shows that people who died with a physician's assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges."

  MP Battin et al, 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups' (2007) 33 JME 591

Depression

- for typical patients who are dying of cancer, relationship between depression and requests for assistance in dying is unclear
- it is possible that a small number of individuals requesting assistance in dying will be suffering from treatable depression which is not identified by their treating physician or the reviewing consulting physician
  - additional evaluation by a mental health professional more likely to identify these individuals than a requirement for judicial approval
  - blanket (eg Scotland) approach may infringe P's autonomy & cause additional suffering without achieving aim of protecting vulnerable
  - focused (eg Oregon) approach of questionable effectiveness
    - those providing EoLC should be trained to assess Ps for possible symptoms of depression
- this would better achieve the regulatory aim of protecting the vulnerable than a requirement for judicial approval

Compassionate response to unbearable suffering

Burden

depends on details of regime but could include:

- additional examination(s) by
  - physician(s)
  - psychiatrist
  - coroner/medical examiner
- periodic re-certification of
  - capacity
  - request
  - voluntariness
- time limit
- court/tribunal application
- involvement of lawyers
- hearing

Judicial process is cumbersome & bureaucratic

particularly acute in group of patients dying of cancer:

1. likely to be frail and physically weak, finding rigours of the judicial process, however sympathetically handled too much for them
   - if willing and able to, may seek judicial approval earlier than would wish while still strong enough to go through the process, just as patients in prohibitive jurisdictions commit suicide or assisted suicide earlier than would wish while still mentally and physically strong enough to do so
   - if approval is granted, may activate assistance earlier than would wish to avoid real or perceived expiration of approval
2. lack time
   - may make it difficult to find a doctor who is both willing to assist and willing to go to court

To avoid prospective judicial approval …

- evidence from prohibitive jurisdictions shows that patients will instead, possibly earlier than would have wished:
  - commit suicide without assistance
  - seek assistance underground
    - assister likely to have no experience, little access to relevant information, and little access to appropriate medications
    - attempts to provide assistance likely to be more difficult, less successful & more stressful for patient and their loved ones
  - seek assistance offshore in permissive jurisdiction
  - give up their request

imposing a prospective judicial approval requirement on the terminally ill is not a compassionate response to unbearable suffering

Conclusions

- **highly formal prospective approval too burdensome for majority of cases where P close to end of life**
- fails to meet the regulatory aims of respecting autonomy, protecting the vulnerable and responding compassionately to unbearable suffering in typical case where the person seeking assistance is close to the end of life
- claims for improved decision-making fail to take into account lived experience of the relevant patient group
- quality of decision-making is not improved by incentivising off-shore and underground practice

Proposal

- **highly formal prospective approval mechanisms should not form part of regimes restricted to the terminally ill**

- **more assessment of different models of decision-making needed, to determine impact on quality of decision-making**
  - prospective approval could be studied as part of such an assessment

Proposal

if trialed, prospective judicial approval should be reserved for two categories of more complex cases

1. particularly difficult cases in which the person requesting assistance is terminally ill or expected to die in the near future, eg those involving:
   i. conflict between the medical team and P's family
   ii. conflict within the family
   iii. a less certain diagnosis, or
   iv. disagreement between treating & consulting physicians on criteria
   v. doubts about the validity of the request
2. cases where P not terminally ill or expected to die in the near future, to focus attention on more complex cases, eg:
   - dementia
   - psychiatric illness
   - existential suffering ('tired of life')

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