



Hospice Care Ottawa

When it matters most

Physician Assisted Death (PAD) - Practical and Ethical Implications in the Hospice Setting and in the Home

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Ethics Symposium on PAD
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Conflict of Interest

- None to declare


Physician Assisted Dying-Defined

- Physician Assisted Suicide
- Euthanasia

Objectives

- Understand current practice and effectiveness of the management of intractable distress at residential hospice in Ottawa
 - Discuss whether or not PAD belongs in hospice
 - Discuss the ramifications of both allowing or not allowing PAD in hospice
 - Discuss the issue of PAD in home based patients.
 - Discuss the ethics of PAD from a physicians' perspective
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Hospice Care Ottawa

- 2 residential hospices – Maycourt and Central West
 - Total of 19 beds with more planned
 - RN, RPN and PSW +/- volunteer(s)
 - >700 volunteers
 - Family Support Programs
 - Day program and volunteer home visit program
 - Bereavement Services
 - Funding 65% MOHLTC, 35% Donations
 - PAD is NOT currently done at hospice.
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Intractable Distress - Causes

Agitated Delirium

Dyspnea (shortness of breath)

Seizure

Hemorrhage


Pain

Existential and/or Psychological suffering


Fear




Palliative Sedation Therapy

- Palliative Sedation Therapy (PST) is NOT the same as Physician Assisted Death (Euthanasia)
 - PST does NOT necessarily shorten life
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Palliative Sedation Therapy

- Therapy of last resort for intractable symptoms.
 - Change of intention from treatment of symptoms to sedation.
 - Often makes use of some of the same medications already being used.
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Palliative Sedation-Criteria

- A progressive, incurable illness - days to short weeks.
 - The presence of a refractory/intractable symptom(s)
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Palliative Sedation Criteria

- Interprofessional consultation with available team members
 - Discussion with patient or substitute decision maker surrounding goals of care - obtaining informed consent
 - Clear documentation – goals of care, DNR/AND, indications for the initiation of PST, and informed consent
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Palliative Sedation Criteria

- The intent is to control the symptom(s), not to intentionally shorten the patient's life, achieving comfort at the lightest level and lowest dose of sedative medication possible.
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Palliative Sedation Therapy

- All evidence suggests, if these 6 criteria are followed, PST does not necessarily shorten life
 - In cases where prognosis is longer i.e. weeks to months, once physical symptoms are controlled and patients are being treated with dignity, people want to live
 - Existential suffering is a more complex issue
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PST – The Importance of Intention

- PST begins with the change of intention
 - If intention to shorten life – euthanasia
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Use of PST Guidelines at HCO

- # of times PST guidelines have been used at HCO since they were instituted in 2012:


Use of PST Guidelines at HCO

- # of times PST guidelines have been used at HCO since they were instituted in 2012:

Zero



Does PAD Belong at Hospice?

- Hospice philosophy is aligned closely with the WHO definition of the scope of palliative care.
 - Seeks to improve/maintain QOL
 - Works to relieve suffering in all domains
 - Affirms life - regards dying as a normal process
 - Intends to neither hasten or postpone death
 - Offers a support system for patient and family
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Hospice Philosophy

- Help people live and die with dignity
- Alleviate suffering
- Be present and bear witness


Hospice Philosophy

- Provide whole person care
- Support the person in the context of family and community
- Honour the humanity of all involved – Patient, family, staff and volunteers


Does PAD belong at Hospice?

- Under the current definition of palliative care and with the prevailing hospice philosophy, the answer is No.
 - Is it time to rethink Hospice philosophy and include PAD in the services hospice provides?
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Questions To Consider if PAD is done at Hospice

- What will the impact of the fundamental change in hospice philosophy be on the people who make hospice what it is?
 - Will front line workers be obligated to provide PAD?
 - What will the impact be on donors?
 - Who will provide monitoring and oversight?
 - What about the volunteers?
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Questions To Consider if PAD IS done at Hospice

- How would hospice support staff and volunteers - both those who participate in PAD and those who do not?
 - What about the physicians?
 - Would it be better to have a mobile team?
 - Would patients with non-terminal illness come to hospice to access PAD?
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Questions To Consider if PAD IS done at Hospice

- Would everyone who worked in hospice need to be in favour of PAD?
 - Would hospice admit patients exclusively for PAD?
 - How would PAD be carried out?
 - What would the reporting structure be?
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Questions to Consider if PAD is NOT done at hospice.

- How would patients access PAD?
 - How would hospice ensure physicians adhered to the hospice policy on PAD?
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Questions to Consider if PAD is NOT done at hospice.

- Is it ethical to deny a person access to PAD when it has been deemed to be a constitutional right?
 - Is it ethical to transfer a person likely close to death, who is by definition suffering, to another facility or home for PAD?
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PAD in Home Based Patients

- Inter-professional support is more challenging
 - Has everything been tried to address the suffering?
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PAD in Home Based Patients

- How would monitoring and oversight operate?
 - How would reporting be structured?
 - Do we need mobile PAD teams?
 - Are clinics that specialize in PAD necessary?
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Education, Legislative and Regulatory Issues

- Will there be a “waiting period”?
 - How will oversight and monitoring work?
 - What about training and competency?
 - Who will provide the education in decision making and ethics?
 - Is the fear of future suffering a valid reason to request PAD
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Education, Legislative and Regulatory Issues

- How would intolerable suffering be determined?

PAD and Ethics for Physicians

- Death of a patient equals failure
- Difficult to apply the Principal of Double Effect when the positive outcome is death-always the worst outcome

Discussion

- Given what you know about hospice, what is your opinion on introducing PAD to residential hospice? Why?
 - Do you believe patient autonomy is the most important consideration?
 - If you do not believe PAD should be done at hospice, how would you ensure access?
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Thank you



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