

The Value of Palliative Care

IACB Guidelines for Health Care Facilities and Individual Providers Facing Permissive Laws on Physician Assistance in Suicide and Euthanasia

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In an increasing number of countries and other jurisdictions, the law permits physician assistance in suicide¹ and/or euthanasia² under certain conditions. What should health care providers and facilities that affirm the inviolability and intrinsic dignity of human life do under these circumstances? This statement is intended as a starting point for discussions and as a guide for care practices.

General Guidelines

1. A change in the law to permit assistance in suicide and/or euthanasia does not change the accumulated moral wisdom of a community. Communities that

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1. Euthanasia is the act of intentionally and deliberately ending the life of a patient. (Based on the WMA Resolution on Euthanasia. Online at: <http://www.wma.net/en/30publications/10policies/e13b/>)

2. Assistance in suicide is the intentional and deliberate act of enabling another person to end his or her own life. (Based on the WMA Resolution on Euthanasia. Online at: <http://www.wma.net/en/30publications/10policies/e13b/>)

affirm the inviolability of human life should continue to seek protection and care for every human being; uphold intrinsic human dignity, which is not diminished by any particular human condition, such as illness, disability, or nearness to death; and address the challenges of every phase of human life by promoting opportunities for individual flourishing and communal growth.

2. Education and conversations should be supported among providers, recipients of health care, and the general public regarding palliative care,³ optimal relief of pain and other distressing symptoms, the promises and the limits of biomedical interventions, and the ethics of forgoing and withdrawing life-sustaining interventions.

3. All involved in health care should recognize and act to remedy current attitudes and practices that contribute to the fears, suffering, and perceived loss of dignity among people with illnesses or disabilities and those who are dying. They should strive for an ethos and culture that sustains patients' sense of their own worth.

4. When there are no legal prohibitions against assistance in suicide and euthanasia, patients are even more vulnerable. They should be assured of and have access to a supportive care environment from which assistance in suicide and euthanasia are excluded,⁴ and where excellent health care is championed instead.

5. Current best health care practices demand that providers of curative and life-sustaining treatments always attend to palliative concerns. If palliative care runs concurrently with other forms of health care, collaboration and coordination among care providers will foster patients' trust and the continuity and integration of their care.

6. Health care providers and facilities should persist in seeking the necessary statutory, professional and policy protections and means that enable them to provide care with moral integrity and without having to assist in a patient's suicide or provide euthanasia.

7. Where there are laws permitting physician assistance in suicide and/or euthanasia, it is morally permissible and may be prudent, in order to protect vulnerable people, for providers and facilities to work with legislators, regulators and educators to limit the scope of these practices and ensure transparency and oversight.

8. Those who share a commitment to the principles and goals outlined above should seek to collaborate across differences in cultural, political and faith

3. Palliative care is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO: Definition of Palliative Care. Online at: http://www.who.int/cancer/palliative/definition/en/#.VZLSJi_f65o.email. Note that WHO, subsequent to this definition, specifies that palliative care "intends neither to hasten or postpone death" and lists eight additional aspects of palliative care.)

4. As already expressed in its 2004 consensus statement, the IACB "affirms the Church's traditional position that assisted suicide and euthanasia are morally illicit." (IACB: Globalization and the culture of life: Consensus statement. *National Catholic Bioethics Quarterly*, Spring 2004: 154–158).

backgrounds. They should clearly articulate their commitments, make these known to those they serve and to the public at large, and avoid misleading language that confuse ethical and unethical practices.

Recommendations for Health Care Facilities

9. All health care facilities should have clearly written ethics policies regarding end-of-life care and educate the members of their staff and the people they serve about them. These policies should:

- Explain the kinds of palliative care offered, including effective management of pain and other sources of distress, and clearly stipulate whether the facility offers physician assistance in suicide and euthanasia.⁵
- Affirm the freedom of individual patients, protect them against undue pressures, and guard them against inadequacies in their care generated by conflicts of interests in health care providers and administrators.
- Address decision making, advance care planning, and substitute decision making in a manner consistent with the principle of respect for the dignity of the patient, which encompasses respect for their moral agency, and with the principles of solidarity, subsidiarity, and the importance of community.
- Ensure that people who request assistance in suicide or euthanasia are assessed by an inter-disciplinary team, including mental health care and palliative care specialists, for the presence of an unaddressed mental illness or disorder and/or existential suffering that can be managed by life-affirming and suffering-reducing care.⁶
- Include instructions about counseling and support of patients who exhibit suicidal behavior, such as by voicing requests for assistance in suicide or euthanasia.
- Include provisions regarding the continuity of care of patients whose request for assistance in suicide or euthanasia and rejection of alternatives become persistent as well as provisions regarding their ultimate discharge and transfer of care in a way that respects the ethical integrity of the members of the health care team.

5. Again, the IACB holds that assisted suicide and euthanasia are morally illicit. See footnote 4.

6. Gopal AA. Physician-assisted suicide: Considering the evidence, existential distress, and an emerging role for psychiatry. *Journal of the American Academy of Psychiatry Law* 2015 Jun; 43(2):183-90; Macleod S. Assisted dying in liberalised jurisdictions and the role of psychiatry: A clinician's view. *Australia and New Zealand Journal of Psychiatry* 2012 Oct; 46(10):936-45. An example of an intervention that helps persons who are facing death to find meaning and value in their lives is dignity therapy. See Chochinov, HM. *Dignity Therapy*. Oxford: Oxford University Press, 2011.

10. Facilities should commit adequate personnel and financial resources to palliative care teams and thereby minimize the likelihood that patients experience the desire to request assistance in suicide or euthanasia. Families who face the death of beloved members, as well as others who care for these patients, should also receive compassionate and effective support, including access to respite care, mental health care, and spiritual care.

11. Health care facilities, including medical and health sciences schools, should create opportunities for health care providers and the public at large to learn about and reflect on human finitude; possibilities for personal flourishing and communal growth at the end of life; the goals, promises, and limits of health care interventions; and their own spiritual identity.

Recommendations for Individual Health Care Providers

12. Health care providers should routinely include a holistic assessment of mental health as well as existential and spiritual challenges in the care of their patients. Discussions about patients' feelings, anxieties, hopes, preferences and values regarding health care interventions during the final phase of life should, as much as possible, be initiated with patients and their family members before the onset of life-threatening health crises. At the same time, health care providers should make known to those they serve the wide range of palliative care options they can offer them, but also clearly stipulate whether they offer or facilitate assistance in suicide and euthanasia.⁷

13. Health care providers, in planning care with their patients, should always evaluate the goals, benefits, risks and burdens of various interventions to meet those goals. They should also continue to assess, together with their patients, the actual outcomes of initiated interventions and be ready to discontinue those that have failed to deliver the hoped-for benefits or have become disproportionately burdensome for particular patients.

14. In planning and assessing health care interventions, providers should involve persons in need of care, whatever their level of decision-making capacity, and the substitute decision makers, other family members and loved ones of patients as needed. Providers should respect patients' moral agency and support the legally appropriate roles and responsibilities of substitute decision makers to make decisions on behalf of patients who have become legally incapable of making particular health care decisions. Patients, substitute decision makers and the family should not bear full responsibility for making difficult end-of-life care decisions when they prefer a shared decision-making approach or the guidance or direction of trusted health care providers.

15. Health care providers have a responsibility to remain knowledgeable and competent regarding current palliative care practices and expand their understanding of ethical decision making concerning such care.

7. Again, the IACB holds that assisted suicide and euthanasia are morally illicit. See footnote 4.

16. Health care providers should develop competence in engaging persons in need of care in ethical discussions and assessing what values, hopes, and fears lie behind a request for assistance in suicide or euthanasia. These might not always be the same as the patient's stated reasons. Providers should offer appropriate care for persons requesting assistance in suicide or euthanasia who are experiencing unmanaged pain, psychosocial or spiritual distress.⁸

Recommendations for Health Care Associations

17. Associations of health care providers should cooperate to affirm publically the value of palliative care in general and at the end of life in particular, and affirm that only by refraining from all engagement in assistance in suicide and euthanasia can they adhere to the goals of medicine and of therapeutic interventions in health care.⁹

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8. In a recent study of persons with psychiatric disorders in the Netherlands whose request for assistance in suicide or euthanasia was granted, most had complex histories including attempted suicides and were socially isolated or lonely. Kim SY, De Vries RG, Peteet JR. Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry*. 2016 Apr. 73(4): 362–8.

9. The American Medical Association, Australian Medical Association, New Zealand Medical Association and World Medical Association all consider that doctors' involvement in euthanasia is inappropriate and unethical.

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