



# Physician-assisted death is not palliative care

*L. Herx MD PhD\**

On February 6, 2015, the Supreme Court of Canada made a unanimous decision that it is unconstitutional to prohibit physician-assisted death. Physician-assisted death includes both physician-assisted suicide and voluntary euthanasia. In the past weeks, much has been said about end-of-life care and physician-assisted death being a “therapeutic service” for some Canadians, but critical elements have been lacking or clouding this discussion. In particular, little has been said about what palliative care is, and while much has been said about death, little has been said about the life stage of dying. Lastly, a myriad of confusing language has been used in this debate. Physician-assisted death is not “medically-aided dying,” nor should it be confused with palliative care.

The World Health Organization’s definition of palliative care states that “palliative care is an approach that improves the quality of life of patients and their families facing the problem 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.” Palliative care also “affirms life and regards dying as a normal process” and “intends neither to hasten or postpone death.” By definition, palliative care does not hasten death, but supports dying as a natural life process.

When faced with a life-threatening illness, all aspects of personhood are affected, and distress is often experienced across multiple interconnected domains—physical, psychosocial, existential, and spiritual. Palliative care seeks to identify and alleviate suffering across the trajectory of a life-threatening illness, including care at the end of life, and supports living well while dying. To those ends, palliative care must address all aspects of personhood and provide holistic person-centred care through an integrated interprofessional team approach.

Dying is hard work for everyone involved—the patient, the family, and care providers. It is innately an existential matter and asks us what life is all about.

Dying is a normal process and a final growth stage of life. Like birth, it is an important developmental stage in the lives of humans, but unlike birth, it is one that we seldom talk about as a society. Those of us privileged to work with and to journey alongside the dying and their families will tell you that dying can be transformative: relationships can be healed and past hurts reconciled. Dying is often a time of spiritual growth and creation of a legacy for loved ones.

Requests for hastened death are predominately related to existential suffering and do not correlate with physical symptoms such as pain. Those existential concerns are typically the result of a loss of control, loss of hope, and loss of meaning in life, or a sense of burden to others. Thanks to the great work of Canadian palliative care physicians such as Balfour Mount and Harvey Chochinov, holistic dignity-conserving palliative care interventions that aim to restore purpose, meaning, and hope in the face of the loss that accompanies a life-threatening illness have been developed. Such therapies help a person to focus on living while dying.

The foundations of our work in palliative care are trust and relationship. Trust between patient and physician, between family and care providers, and between the members of the health care team. Is trust really engendered when we reach out with one hand inviting patients to engage in the hard and intense work of addressing their suffering, while in the other hand we hold the needle to end life?

Suffering is limited not only to the individual. Individuals are inevitably part of a community—family, friends, and caregivers, to name a few. Individual choices affect that entire community. Although it has been said that very few will choose physician-assisted suicide or euthanasia, the effects of that individual choice will spill over onto the many. There will be members of the community, as well as other patients and families receiving care from the same health care team, who will find the individual’s act to be morally unconscionable and would be caused harm as a result. Many patients and families are already

reluctant to involve palliative care in their treatment out of the mistaken fear of what that means: giving up hope and imminent dying. If physician-assisted suicide or euthanasia, or both, were to become part of the provision of palliative care, many more people would likely decide to forgo palliative care.

Lastly, we need to be clear on the language being used. Many different terminologies have been used interchangeably in the media since the Supreme Court decision. We are not talking about “medically-aided dying” or “physician-aided dying”—that is the work done every day in palliative care by providing the best possible symptom management for those who are dying. And let us not confuse that work with a decision to discontinue life-prolonging therapy such as dialysis, chemotherapy, or assisted ventilation, whereby death occurs because of the underlying illness. What we mean when we say “physician-assisted suicide” or “physician-assisted euthanasia” is an act with the direct intention of causing death through a lethal dose of medication. Some might call it killing, and by all reasonable definitions, it does not belong in the realm of palliative care.

I am proud to be a palliative care physician. I am privileged to journey alongside those facing a life-threatening illness. My work is to provide care with the intention of alleviating suffering and restoring dignity, and to focus on living while dying. As a palliative care physician, I do not intentionally hasten death, but approach dying as a normal process and important stage of life. Physician-assisted suicide and euthanasia go against the very core of the palliative care approach and have no place within palliative care.

#### CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology*'s policy on disclosing conflicts of interest, and I declare that I have none.

**Correspondence to:** Leonie Herx, 710–3031 Hospital Drive, South Tower, Calgary, Alberta T2N 2T8.

**E-mail:** leonie.herx@albertahealthservices.ca

\* Department of Oncology, University of Calgary, Calgary, AB.