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Canada's Summer of Discontent
Euthanasia practitioners warn of nationwide "crisis"
Shortage of euthanasia practitioners "a real problem"

Sean Murphy, Administrator
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There were 803 euthanasia/assisted suicide (EAS) deaths in Canada during the first six months after the procedures were legalized. In the second half of the first year (ending in June, 2017) there were 1,179[1] — a 46.8% increase. EAS deaths amounted to about 0.9% of all deaths in the first year. Health Canada correctly states that this falls within the range found in other jurisdictions where euthanasia/assisted suicide are legal,[2] but the Canadian EAS death rate in the first year was not reached by Belgium for seven to eight years.[3] The dramatic increase of EAS deaths in the last half of the first year would have had a direct impact on EAS practitioners, and this may be why, in July, they sounded the alarm about access to the service.

Physicians refusing euthanasia: a nationwide "crisis"

"Recent changes to the MSP Physician Fee Schedule have made MAID economically untenable and I unfortunately can no longer justify including it in my practice."[4]

Dr. Jesse Pewarchuk of Victoria, British Columbia, had provided euthanasia or assisted suicide for more than 20 patients.[5] However, in July, 2017, having concluded there was "no conceivable way" that providing euthanasia or assisted suicide ("MAID") made "economic sense" for any physician, he made public a letter announcing that he would no longer provide the services. He explained that the fee cap set by the province for the procedures ($200.00) worked out to about $25.00 per hour after overhead, and practitioners were not paid for time and travel involved in service delivery. Dr. Pewarchuk complained that fees approved for some physician specialties provided "7 figure annual incomes," but funding for euthanasia/assisted suicide was "grossly inadequate."[4]

Billing issues and euthanasia/assisted suicide advocacy had been among the topics discussed at a conference held the previous month in Victoria by the Canadian Association of MAID Assessors and Providers (CAMAP). Dr. Pewarchuk and other conference participants — Shanaaz Gokool, Dr. Stefanie Green, and Dr. Chantal Perrot[6] — featured in several Canadian media articles that appeared in early July. Their common theme was that patient access to euthanasia and assisted suicide was in danger because inadequate compensation and burdensome bureaucracy were discouraging physicians from providing the services.

"It's a real problem, the shortage in the number of physicians," said, Shanaaz Gokool, CEO of Dying With Dignity Canada (DWD).[7] Dr. James Downar, a

member of DWD's Physician Advisory Council,[8] had complained four months earlier that the "scarcity of doctors" providing euthanasia/assisted suicide was "putting serious pressure" on the few who were.[9] According to Dr. Green, president of CAMAP, by July the situation had become "a crisis."[5]

Attempts to compel unwilling practitioners and institutions to provide or facilitate euthanasia and assisted suicide are frequently based on the claim that compulsion is necessary to ensure patient access to the procedures, even at the expense of fundamental freedoms. Allegations of a nationwide "crisis" caused by a shortage of EAS practitioners thus warrant close attention.

Providing euthanasia/assisted suicide can be "financial suicide"

Dr. Green, an EAS practitioner in British Columbia, agreed that the province's fee schedule was unsatisfactory, even, perhaps, a "planned disincentive" to discourage practitioners from providing the service. Noting that fees in some other provinces were based on time actually spent in consultation and delivery, she insisted EAS practitioners were looking only for "reasonable compensation" based upon "what the work actually entails."[10] She had restricted her travelling to deliver the service.[11]

Rates for euthanasia/assisted suicide in British Columbia had risen to $40.00 per 15 minutes consultation to a maximum of 90 minutes, plus $200.00 for administering the drugs: an overall maximum of $440.00. However, EAS practitioners still considered this to be "woefully inadequate." Dr. Tanja Daws a self-described "hard core" euthanasia/assisted suicide advocate, reported that she had refused three requests because continuing to provide the service was "financial suicide."[11]

Euthanasia/assisted suicide fees in Canada were said to compare unfavourably with those offered in the Netherlands, which are about five times higher: 1,500.00 euros per case ($2,200.00 Canadian dollars).[11] Compensation arrangements for Canadian physicians vary from province to province, and euthanasia/assisted suicide fees were still being worked out in Canada in the summer of 2017. Fees in Alberta, Saskatchewan and Manitoba were said to be satisfactory,[10] but, in Nova Scotia, Dr. Tim Holland said he had not yet been paid for services provided over the preceding year, and that the significant delay in payment was discouraging physician participation. [12] EAS practitioner fees there were capped at $292.20.[11]

Ontario physician Dr. James Downar observed that fees there were low and that "a physician could make more money doing almost anything else," but he conceded that, though the situation was not "ideal", it was not "problematic." However, he argued that EAS practitioners should not have to take a "financial hit" in addition to suffering from the stigma still associated with providing euthanasia/assisted suicide.[13]

Other "barriers" to physician participation

Dr. Downar was more concerned about barriers to physician participation caused by "administrative duties" ancillary to providing euthanasia or assisted suicide. Arranging for a patient to see specialists like psychiatrists or social workers and obtaining and returning supplies needed for lethal infusion could be "quite the deterrent," he explained, noting that these responsibilities often have to be fulfilled in addition to full-time practice.[13] According to Downar, many EAS practitioners were refusing to sign up for the coordination service launched by Ontario at the end of May, 2017 because,

unlike Alberta's system, it did not provide EAS practitioners with administrative support. Ontario physician Dr. Chantal Perrot dismissed the new scheme as a mere "matchmaking service" that connected patients with practitioners but did nothing to help the practitioners.[7]

Another Ontario EAS practitioner, Dr. Scott Anderson, identified the legal criterion that death be "reasonably foreseeable" as a problematic barrier.[14] Downar, with Dr. Jonathan Reggler of British Columbia, had previously criticized the criterion, as well as the legal requirement that euthanasia/assisted suicide be provided only to patients who have a "grievous and irremediable" medical condition. They said the terminology was uncomfortably vague and unfamiliar to physicians, causing them to "pull back" from providing the service. Downar, referring to Quebec's euthanasia oversight panel, seemed particularly annoyed that people who had never performed euthanasia and were mainly non-physicians were second-guessing the professional judgment of euthanasia practitioners.[9]

Other time-consuming or taxing barriers or disincentives identified by Canadian EAS practitioners included meeting with patients (perhaps more than once), reviewing their often "lengthy and complicated" medical histories, counselling family members (especially those opposed to or doubtful the procedures),[11] finding two independent witnesses to verify the voluntariness of a patient's request,[14] and "paperwork and bureaucracy involved,"[9] such as having to complete forms and fax reports to the coroner.[4,14] Dr. Anderson noted the inconvenience of having to respond to "urgent" calls for euthanasia or assisted suicide in the evenings and on weekends, adding that he had once even had to see a patient in "a filthy apartment filled with cat feces.[14]

The most striking assertion was that physicians and hospitals refusing to kill patients for moral or religious reasons were creating a barrier for patients wanting the service.[15] Against the backdrop of withdrawal or restriction of services by EAS practitioners, this implies that refusing to kill patients for financial reasons is acceptable, but refusing to kill patients for reasons of conscience or religion is not. Whether this accurately reflects Canadian values remains to be seen.

Preliminaries to "crisis" intervention

Coercion is legally and pragmatically problematic

In any case, it is unlikely that lightening the caseloads of euthanasia practitioners by forcing unwilling physicians to participate in killing patients could be legally justified. The *Charter of Rights* guarantees freedom of conscience and religion, not easily manageable euthanasia caseloads.

Nor is it likely that coercive policies would actually increase patient access to the procedures. In 2008, American bioethicist Holly Fernandez Lynch considered the case of conscientious refusal by "the last doctor in town." She concluded that coercion would be ineffective in securing patient access to services. Objecting physicians would probably face discipline rather than do what they believe to be wrong, she said, leaving patients "in precisely the same situation that they would have been had that doctor originally been permitted to refuse." She warned that a policy of coercion would cause objectors to relocate, change specialties or quit medical practice, making it more difficult for all patients to obtain even "morally uncontroversial services."[16]

Events in Canada have since demonstrated that Fernandez Lynch's pragmatic assessment is sound.

Objecting physicians, threatened with discipline by the College of Physicians and Surgeons of Ontario (CPSO) if they refuse to do what they believe to be wrong, have responded as she predicted. Some have announced retirement from medicine.[17] Some may leave specialties where they are badly needed;[18] in one city, every palliative care physician has reportedly stopped accepting patients.[19]

The Protection of Conscience Project believes that, with some good will and imagination, Canadian authorities can address concerns about patient access to euthanasia and assisted suicide without suppressing fundamental freedoms and punishing those who refuse to have any part in the procedures. Canadian EAS practitioners argue that more physicians will participate if incentives are provided and disincentives are reduced or eliminated. The two positions are not in conflict. To begin with, however, it is important to avoid unrealistic expectations about levels of physician participation.

Avoiding unrealistic expectations

Even where euthanasia or assisted suicide has been legal for years, only a minority of physicians — sometimes a small minority — personally provides the service. In Belgium, the nearest jurisdictional exemplar, the proportion of physicians practising euthanasia in the first year was only about 1%; for the next three years only about 2% of physicians were involved. 13 years after legalization less than 14% of Belgian physicians were providing the service.[3]

The Netherlands began with much higher rates once euthanasia was formally legalized, but twelve years later the proportion of all physicians providing euthanasia was still less than 10%.[20] Less than 1% of all physicians prescribe assisted suicide drugs in Oregon[21] and Washington state,[22] though assisted suicide has been legal in those jurisdictions for nine and almost 20 years respectively.

These are maximum estimates; actual numbers could be much lower, because one practitioner may be responsible for a number of cases.[23] Yet, as Dr. Jeff Blackmer of the Canadian Medical Association told parliamentarians, access to euthanasia/assisted suicide is not a problem in any of these jurisdictions.[24]

Four or five euthanasia cases per year is apparently considered a responsible maximum for a euthanasia practitioner in the Netherlands.[25] Applying the Netherlands rule of thumb, the 551 Ontario patients who died by euthanasia or assisted suicide in the first year of practice[26] could have been adequately serviced by roughly 110 to 137 practitioners willing to personally administer the lethal drugs — or about 0.4% of active Ontario physicians.[27]

Unsystematic news reports suggest that the number of Ontario physicians willing to personally administer lethal drugs fluctuated between 74 and 106 in 2017,[28] — about 0.3% of all active physicians.[27] The difference between 0.4% (with an annual caseload of about four patients) and 0.3% (with an annual caseload of about six) is insignificant. If we suppose that the EAS death rate in Ontario in the second half of the first year of legalization continues, without escalation, there will be 724 EAS deaths in the second year. These could be provided by 145 EAS practitioners with 5 cases each — about 0.5% of active physicians.

Finally, three Ontario practitioners were responsible for almost 13%[29] of the euthanasia/assisted suicide deaths reported to have occurred in the province,[26] which suggests that the demand for the service province wide could have been met by about 23 physicians working at the same rate. Of

course, that does not mean that an annual euthanasia caseload of almost 24 patients per practitioner would have been desirable, or that the travel involved would have been practicable. It only confirms what the preceding calculations demonstrate: that panic about the rate of physician non-participation in euthanasia/assisted suicide in Ontario was quite unwarranted.

Nor was panic justified in British Columbia, especially on Vancouver Island, notwithstanding Dr. Pewarchuk's concern that the pay was so bad that euthanasia/assisted suicide might become completely unavailable.[4] Between March and the end of June, 2017, when he announced his withdrawal of services, the number of Vancouver Island EAS practitioners had actually increased from 14 to 21:[30] to about 1% of Island physicians,[31] the same proportion as in Belgium during its first year of legalization.

Moreover, it was reported that Vancouver Island had one of the highest euthanasia/assisted suicide rates in Canada: 77 in 2016.[30] Yet over half of these appear to have been provided by just two physicians: Dr. Pewarchuk (more than 20)[5] and Dr. Daws (25).[30] Even if the number of Vancouver Island euthanasia deaths increases to 100 in 2017 and the number of EAS practitioners remains constant, the average individual caseload of 21 practitioners will not exceed the number recommended as a rule of thumb in the Netherlands.

None of the jurisdictions where euthanasia or assisted suicide is legal provide adequate statistics about actual physician participation. Given the controversy about "access" to the services in Canada — inflamed by unrealistic expectations and unwarranted allegations of a "crisis" — one would hope that Canadian authorities will do better than their counterparts in other jurisdictions in tracking actual rates of practitioner participation. The Project has encouraged provincial and federal Ministers of Health to demonstrate leadership in this regard.[32]

Notes

1. Health Canada. 2nd Interim Report on Medical Assistance in Dying in Canada. Ottawa: Health Canada, October, 2017: p. 5. (https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017/medical-assistance-dying-interim-report-sep-2017-eng.pdf) Accessed 2017-10-09 [Health Canada Rpt 2].

2. Health Canada Rpt 2, *supra* note 1, p. 8.

3. Murphy S. Euthanasia reported in Belgium: statistics compiled from the Commission Fédérale de Contrôle et d' Évaluation de l'Euthanasie Bi-annual Reports. Protection of Conscience Project. August, 2017 (http://www.consciencelaws.org/background/procedures/assist018.aspx).

4. Letter from Jesse A Pewarchuk, MD, FRCPC. Undated. "Dear referring physician." (https://assets.documentcloud.org/documents/3884668/Drletter.pdf) Accessed 2017-09-12.

5. Grant K. Canadian doctors turn away from assisted dying over fees. The Globe and Mail. 3 July, 2017

(https://www.theglobeandmail.com/news/national/payment-complications-turning-canadian-doctors-away-from-assisted-dying/article35538666/) Accessed 2017-09-12 [Grant-3 July].

6. Canadian Association of MAID Assessors and Providers. National Conference on Medical Assistance in Dying Program. 2-3 June, 2017 (http:www.maidconference.ca/Program.pdf) Accessed 2017-10-08.

7. Grant K. Ontario clinicians raise concerns over assisted-dying co-ordination service. The Globe and Mail. 5 July 2017 (https://beta.theglobeandmail.com/news/national/ontario-clinicians-raise-concerns-over-assisted-dying-co-ordination-service/article35569849/?) Accessed 2017-10-03 [Grant-5 July].

8. Dying With Dignity Canada, Physician Advisory Council. (http://www.dyingwithdignity.ca/physicians_advisory_council) Accessed 2017-10-09.

9. Kirkey S. "Take my name off the list, I can't do any more": Some doctors backing out of assisted death. National Post. 26 February, 2017 (http://news.nationalpost.com/news/0227-na-euthanasia) Accessed 2017-03-11.

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11. McIntyre C. Should doctors be paid a premium for assisting deaths? Macleans. 12 July, 2017 (http//www.macleans.ca/society/should-doctors-be-paid-a-premium-for-assisted-deaths/) Accessed 2017-09-12.

12. Davie E. Doctors raise alarm about long delays in getting paid for medically assisted deaths. CBC News. 4 July, 2017 (http://www.cbc.ca/news/canada/nova-scotia/doctors-raise-alarm-about-long-delays-in-getting-paid-for-medically-assisted-deaths-1.4189468) Accessed 2017-08-28.

13. Dunn T. Why don't more Ontario doctors provide medically assisted dying? It's not the money. CBC News. 10 July, 2017 (http://www.cbc.ca/news/canada/toronto/assisted-dying-ontario-1.4195368) Accessed 2017-08-28.

14. Lupton A. Meet 1 of only 2 London doctors willing to help their patients die. CBC News. 4 July, 2017 (http://www.cbc.ca/news/canada/london/doctor-anderson-medically-assisted-dying-1.4186223) Accessed 2017-09-14 [Lupton].

15. Whether the claim was made by the CBC or by Dr. Scott Anderson is not clear. The article appears to attribute it to Dr. Anderson, but it may have been interpolated it into the account of the

interview by the writer. See Lupton, *supra* note 14.

16. Fernandez-Lynch H. Conflicts of Conscience in Health Care: An Institutional Compromise. Cambridge, Mass: The MIT Press, 2008: 206.

17. Naylor NL. Response to Dr. Genuis Article, April 2016 (eLetter). Can Family Physician April 2016 62:4 (http://www.cfp.ca/content/62/4/293/tab-e-letters#response-to-dr-genuis-article-april-2016) Accessed 2016-09-22.

18. "Scarborough's palliative care system is grossly under serviced," wrote Dr. Mark D'Souza, but "half of our group is considering leaving the field" because of the coercive policy of the College of Physicians and Surgeons of Ontario. See D'Souza M. Fatal flaw in Ontario euthanasia bill. Toronto Sun. 7 April, 2017 (www.torontosun.com/2017/04/06/fatal-flaw-in-ontarios-euthanasia-bill) Accessed 2017-10-04.

19. Swan M. Health care workers bring case for conscience rights to Ontario legislature. The Catholic Register. 18 May, 2017 (https://www.catholicregister.org/item/25212-health-care-workers-bring-case-for-conscience-rights-to-ontario-legislature) Accessed 2017-10-05.

20. Murphy S. Euthanasia reported in Netherlands: statistics compiled from the Regional Euthanasia Review Committees' Annual Reports. Protection of Conscience Project. August, 2017 (http//www.consciencelaws.org/background/procedures/assist019.aspx).

21. Murphy S. Assisted suicide reported in Oregon, U.S.A.: statistics compiled from the Oregon Public Health Division annual Death with Dignity Act reports. Protection of Conscience Project. August, 2017. (http://www.consciencelaws.org/background/procedures/assist020.aspx).

22. Murphy S. Assisted suicide reported in Washington State, U.S.A.: statistics compiled from the Washington State Dept. of Health annual Death with Dignity Act reports. Protection of Conscience Project. August, 2017 (http://www.consciencelaws.org/background/procedures/assist021.aspx).

23. For example, by August, 2017, Dr. Lonny Shavelson of California was responsible for the deaths of 48 patients pursuant to the state's assisted suicide statute. See Nutik Zitter J. Should I Help My Patients Die? The New York Times. 5 August, 2017 (https://www.nytimes.com/2017/08/05/opinion/sunday/dying-doctors-palliative-medicine.html) Accessed 2017-08-23.

24. Canadian Medical Association. Oral submission to the Special Joint Committee on Physician Assisted Dying, Parliament of Canada. 27 January, 2016. Protection of Project (http://www.consciencelaws.org/background/procedures/assist014-002.aspx#cma-oral).

25. Hune-Brown N. How to End a Life. Toronto Life. 23 May, 2017 (https://torontolife.com/city/life/doctors-assist-suicide-like-end-life/) Accessed 2017-08-29 [Hune-Brown].

26. First and second half year totals =189+362=551. See Health Canada. Interim update on medical assistance in dying in Canada June 17 to December 31, 2016. Ottawa: Health Canada: Table 3.2: Profile of Medical Assistance in Dying by Jurisdiction/Region. (https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html#t3b) Accessed 2017-10-09; Health Canada Rpt 2, *supra* note 1, p 13.

27. There were about 29,500 MDs in active practice in the province. See College of Physicians and Surgeons of Ontario. 2016 Annual Report. Toronto: p. 7 (https://view.joomag.com/annual-report-2016/0566350001504028906?short) Accessed 2017-10-03.

28. Number reported to be willing to personally provide euthanasia in 2017 ranged from a high of 146 in May (see Grant, *supra* note 7) to a low of 74 in July (see Lupton, *supra* note 14).

29. Dr. Scott Anderson of London – 40 (see Lupton, *supra* note 14); Dr. Gerald Ashe of Brockville – 10 by May, 2017 (see Hune-Brown, *supra* note 25); Dr. Chantal Perrot of Toronto – 20 (see Grant, *supra* note 7).

30. Derosa K. Island MD, citing low fee, halts assisted dying. Victoria Times Colonist. 6 July, 2017. (http://www.timescolonist.com/news/local/island-md-citing-low-fee-halts-assisted-dying-1.20936835) Accessed 2017-08-10.

31. Based on 2015 census information compiled by the Canadian Medical Association. See Canadian Medical Association. Number of physicians by census metropolitan area or census agglomeration: Canada, 2015 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/13cma_ca.pdf) Accessed 2017-10-09.

32. Letter from Sean Murphy, Administrator, Protection of Conscience Project, to Canadian federal and provincial ministers of health. 5 September, 2017. Protection of Conscience Project. (http://www.consciencelaws.org/background/procedures/assist025en.aspx).