

**CMA's Submission to the College of Physicians
and Surgeons of Ontario (CPSO)**

**Consultation on CPSO Interim Guidance on
Physician-Assisted Death**

January 13, 2016



Helping physicians care for patients
Aider les médecins à prendre soin des
patients

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is helping physicians care for patients.

On behalf of its more than 80,000 members and the Canadian public, the CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 51 national medical organizations.



The Canadian Medical Association (CMA) is pleased to provide this submission in response to the Draft Interim Guidance on Physician-Assisted Death (Draft Interim Guidance) developed by the College of Physicians and Surgeons of Ontario (CPSO). The CMA is pleased to emphasize that the Draft Interim Guidance captures what we deem to be all the key principles and safeguards central to the implementation of physician-assisted dying.

The CMA notes that the guidance on conscientious objection is largely consistent with our view of physicians' positive obligations in instances where a physician declines to provide or participate in assistance in dying on grounds of conscience. However, the CMA has significant concerns with the requirement that physicians must provide an effective, i.e., a mandatory, referral. Given the significant risks associated with this approach, the CMA's submission in response to CPSO's Draft Interim Guidance will focus primarily on this issue.

It is the CMA's view that both organizations ultimately share the same objective on the questions of conscientious objection and patient access to medical care: to both protect physician conscience rights and patient rights and, in doing so, achieve an appropriate balance, or an effective reconciliation, between physicians' freedom of conscience and the assurance of effective and timely patient access to a medical service. The one substantive difference between the CMA's position and the approach proposed by the CPSO lies in the understanding of what it means to respect conscience.

There are different notions of conscience that fall along a spectrum of morally acceptable involvement in any given act as, for example, opposition, procedural non-participation, non-interference, and participation. For the majority of physicians who will choose not to provide assistance in dying, referral is entirely morally acceptable; it is not a violation of their conscience. For others, referral is categorically morally unacceptable; it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. In other words, referral respects the conscience of some, but not others. From the CMA's significant consultation with our membership, it is clear that physicians who are comfortable providing referrals strongly believe it is necessary to ensure the system protects the conscience rights of physicians who are not.

It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience (i.e. the right not to participate in assisted dying), while wholly discounting another because one may not agree with it. As such, in seeking an approach that achieves an appropriate balance, the CMA sought to articulate a duty that achieves an ethical balance between conscientious objection and patient access *in a way that respects differences of conscience*. It is the CMA's position that the only way to authentically respect conscience is to respect differences of conscience.

The CMA is completely aligned with the CPSO in that the physician owes a fiduciary duty to their patients. The physician as fiduciary has long been enshrined in ethics and law on the view that the patient-physician relationship hinges on the physician's duty to act, among other fiduciary duties, to protect and further their patients' best interests. The fiduciary nature of the patient-physician relationship has been described as "*the most fundamental characteristic of the doctor-patient relationship*" by Madama Justice McLachlin in *Norberg v. Wynrib* (1992). Even as she recognized the fiduciary nature of the patient-physician relationship then, which she clearly understood would "provide the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires" (*Norberg v. Wynrib* [1992]), she asserted in *Carter v. Canada* (2015), as Chief Justice, that "nothing in the declaration of invalidity (...) would compel physicians to provide assistance in dying." This is because the physician's fiduciary obligation does not in any way mean that the physician must violate her moral integrity, in such a way that referral does for some objecting physicians.

Even on the basis of prioritizing patient interests, such that the fiduciary obligation requires and the CPSO Draft Interim Guidance affirms, it simply does not follow that putting patient interests first translates *de facto* to making a referral. The argument that *only* mandatory referral puts patients' interests first or respects patient autonomy – and that not making a referral does not – is fundamentally erroneous. There are many ways to conceptualize a physician's positive obligations to her patient that do not require the imposition of a duty to refer and thus uphold conscience rights, for example:

- a duty to inform by, e.g., providing complete information on all end-of-life options;
- a duty to care by, e.g., not being negligent or discriminating against the patient;
- a duty not to abandon the patient by, e.g., transferring care.

In short, articulating a physician's positive obligations of what she ought to do if she declines to provide or participate in an act on grounds of deeply held beliefs does not *de facto* translate to making a referral. It is the CMA's position that there is no logical or ethical basis for this argument.

Pitting conscience rights and patient rights against each other, as is done by the CPSO Draft Interim Guidance approach in not respecting conscience rights in their full integrity, creates a false dichotomy and an unnecessary trade-off. As many have argued, it is entirely possible not to compromise or limit patient access on any level without compromising the exercise of conscience. The argument to the contrary is not empirically supported internationally, where no jurisdiction has a requirement for mandatory effective referral, and yet patient access does not seem to be a concern.

The focus ought to be on the obligation to ensure effective access to the service. Enabling effective patient access by putting in place systems that facilitate access, as the Provincial-Territorial Expert Advisory Group has proposed and as we find in the Netherlands for example, emphasizes that it is a responsibility of the community to ensure access, rather than placing the burden of finding services solely on individual physicians.

The CMA's policy objective is to support those who will choose to provide or participate in assistance in dying and those who will not. To that end, the CMA has clearly outlined an objecting physician's positive obligations that respect differences of conscience, while proposing the creation of resources that effectively facilitate patient access. In doing so, the CMA's position articulates a duty that is widely morally acceptable and that allows physicians to act as moral agents without in any way impeding or delaying patient access to assisted dying.

It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, medical regulators ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience.

The CMA has significant concerns with the CPSO's divergence from the approach in other jurisdictions on mandatory referral. Further, it is the CMA's strongly held position that if the CPSO is to advance this position it will be a key

contributor to the emergence of a patchwork in Canada's pan-Canadian regulatory framework on physician-assisted death. As such, the CMA cannot emphasize strongly enough the need for the CPSO to revise its approach on referral to ensure alignment with other jurisdictions in Canada as well as internationally. This is imperative if Canada is to emerge with a consistent, pan-Canadian framework on assisted dying.

The CMA encourages the CPSO to review the CMA's framework entitled "Principles-Based Recommendations for a Canadian Approach to Assisted Dying", appended to this submission, for further details as to the CMA's recommended approach to respect the exercise of conscience.

We appeal to the CPSO to reconsider requiring mandatory referral to authentically respect the exercise of conscience. The CMA also encourages the CPSO to support the creation of systems and resources that would effectively facilitate access and, in doing so, truly put patients' interests first.

Principles-based Recommendations for a Canadian Approach to Assisted Dying

In February 2015, the Supreme Court of Canada (SCC) released its decision in *Carter v. Canada* that challenged the constitutional validity of Criminal Code provisions prohibiting physician-assisted dying in Canada. In a unanimous decision, the SCC ruled that the Criminal Code provisions on voluntary euthanasia (section 14) and assisted suicide (section 241(b)) are constitutionally invalid in that they violated principles of fundamental justice. The SCC suspended its decision for 12 months to give governments time to consider the development of legislation and/or regulations. Following the 12-month suspension, assisted dying will be legal in Canada, and no longer a criminal act, even if legislation is not enacted in response to the Court's ruling.

The SCC's reversal of the prohibition on assisted dying raises a host of complex issues that have implications for both practice and policy. In response to the Court's ruling, the CMA has developed principles-based recommendations to guide the implementation of assisted dying in Canada. This has been the product of extensive consultation with CMA members, provincial and territorial medical associations, and medical and health stakeholders.

The goal of this process was twofold: (a) discussion and recommendations on a suite of ethical-legal principles and (b) input on specific issues that are particularly physician-sensitive and are worded ambiguously or not addressed in the Court's decision.

This document is intended to serve as a framework for the development of legislation and/or regulations on issues of particular importance for the physicians of Canada, through the lens of the practicing physician, who will be tasked with carrying out these activities. While other stakeholders have important and valued perspectives, only physicians will be involved in the actual actions required to carry out assisted dying. Their views, accordingly, must be given special weight and consideration. The Charter rights of both physicians and patients must be respected and reconciled as part of this process.

For purposes of clarity, CMA recommends national and coordinated legislative and regulatory processes and systems. There should be no undue delay in the development of laws and regulations.

Foundational principles

The following foundational principles underpin CMA's recommended approach to assisted dying. Proposing foundational principles is a starting point for ethical reflection, and their application requires further reflection and interpretation when conflicts arise.

1. **Respect for persons:** Competent and capable persons are free to make informed choices and autonomous decisions about their bodily integrity and their care that is consistent with their personal values, beliefs and goals.

2. **Equity:** To the extent possible, all those who meet the criteria for assisted dying should have access to this intervention without discrimination. Physicians should work with relevant parties to support increased resources and access to high quality palliative care and assisted dying. There should be no undue delay to accessing assisted dying, either from a clinical, system or facility perspective. To that end, the CMA calls for the creation of a separate central information, counseling, and referral service to facilitate effective access.
3. **Respect for physician values:** Physicians can follow their conscience when deciding whether or not to provide assisted dying without discrimination. This must not result in undue delay for the patient to access these services. No one should be compelled to provide assistance in dying.
4. **Consent and capacity:** All the requirements for informed consent must clearly be met, including the requirement that the patient be capable of making that decision, with particular attention to the context of potential vulnerabilities and sensitivities in end of life circumstances. Consent is seen as an evolving process requiring physicians to communicate with the patient in an ongoing manner.
5. **Clarity:** All Canadians must be clear on the requirements for qualification for assisted dying. There should be no “grey areas” in any legislation or regulations.
6. **Dignity:** All patients, their family members or significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life.
7. **Protection of patients:** Laws and regulations, through a carefully designed and monitored system of safeguards, should aim to minimize harm to all patients and should also address issues of vulnerability and potential coercion.
8. **Accountability:** An oversight body and reporting mechanism should be identified and established in order to ensure that all processes are followed. Physicians participating in assisted dying must ensure that they have appropriate technical competencies as well as the ability to assess decisional capacity, or the ability to consult with a colleague to assess capacity in more complex situations.
9. **Solidarity:** Patients should be supported and not abandoned by physicians and health care providers, sensitive to issues of culture and background, throughout the dying process regardless of the decisions they make with respect to assisted dying.
10. **Mutual respect:** There should be mutual respect between the patient making the request and the physician who must decide whether or not to perform assisted dying. A request for assisted dying is only possible in a meaningful physician-patient relationship where both participants recognize such a request. There should be mutual respect among physicians who hold different perspectives on the appropriateness of assisted dying.

Recommendations

Based on these principles, the Supreme Court decision in *Carter v. Canada* (2015)¹ and a review of other jurisdictions' experiences, CMA makes the following recommendations for potential statutory and regulatory frameworks with respect to assisted dying. We note that this document is not intended to address all potential issues with respect to assisted dying, and some of these will need to be captured in subsequent regulations.

1. Patient eligibility for access to assisted dying

1.1 The patient must be a competent adult who meets the criteria set out by the Supreme Court of Canada (SCC) decision in *Carter v. Canada* (2015): "... who clearly consents to the termination of life and has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." The physician's role in making a determination of eligibility is to use appropriate medical judgment to assess the patient's capacity to give voluntary and informed consent and determine whether the condition, including an illness, disease or disability, is "grievous and irremediable":

- i. It is grievous in that it is serious or severe and the current or impending associated symptoms or prognosis are constant or enduring and cause severe physical or psychological suffering that is intolerable to the patient. What constitutes enduring and intolerable suffering; it is a matter of the patient's subjective interpretation.
- ii. It is irremediable in that it is not able to be cured or made right to alleviate the symptoms which make it grievous, or it is not amenable to further treatments or interventions that are acceptable to the patient, or it is not remediable by other means acceptable to the patient. A patient is not required to have tried all available standard of care interventions or possible therapies offered to them for this definition to apply. The patient must clearly accept or decline any of these interventions or therapies.
- iii. The person who determines the severity (i.e., the physician and/or the patient) is not addressed by the Court decision. As in other areas of medicine, the appropriateness of an intervention would generally be a joint decision as part of a deliberative process of decision-making, supported by the physician's disclosure of all available standard of care interventions or possible therapies.

1.2 Informed decision

- The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, and pain and symptom control.

1.3 Capacity

- The attending physician must be satisfied, on reasonable grounds, that all of the following conditions are fulfilled:

¹ *Carter v. Canada* (Attorney General), [2015] 1 SCR 331, 2015 SCC 5 (CanLII)

- the patient is mentally capable of making an informed decision at the time of the request(s)
- the patient is capable of giving consent to assisted dying, paying particular attention to the potential vulnerability of the patient in these circumstances
- communications include exploring the priorities, values and fears of the patient in significant depth, providing information related to the patient’s diagnosis and prognosis, treatment options including palliative care and other possible interventions and answering the patient’s questions
- If either or both the attending physician or the consulting physician determines that the patient is incapable, the patient must be referred for further capacity assessment.
- Only patients on their own behalf can make the request while competent.

1.4 Voluntariness

- The attending physician must be satisfied, on reasonable grounds, that all of the following conditions are fulfilled:
 - The patient’s decision to undergo assisted dying has been made freely, without coercion or undue influence from family members, health care providers or others.
 - The patient has a clear and settled intention to end his/her own life after due consideration.
 - The patient has requested assisted dying him/herself, thoughtfully and repeatedly, in a free and informed manner.

2. Patient eligibility for assessment for decision-making in assisted dying

Stage 1: Requesting assisted dying

1. The patient submits at least two oral requests for assisted dying to the attending physician over a period of time that is proportionate to the patient’s expected prognosis (i.e., terminal vs non-terminal illness).
2. CMA supports the view that a standard waiting period is not appropriate for all requests. The patient’s prognosis is the critical factor. CMA recommends generally waiting a minimum of 14 days between the first and the second oral requests for assisted dying. This is a benchmark. In some cases, depending on the patient’s situation, this could be shorter.
3. The patient then submits a written request for assisted dying to the attending physician. The written request must be completed via a special declaration form that is developed by the government/department of health/regional health authority/health care facility. If the patient is unable for whatever reason to submit a written request, he or she may make an oral request that must be documented in writing by a proxy via an established declaration form.
4. Ongoing analysis of the patient’s condition and ongoing assessment of requests should be conducted for longer waiting periods.

Stage 2: Before undertaking assisted dying

5. The attending physician must wait no longer than 48 hours, or as soon as is practicable, after the written request is received.
6. The attending physician must then assess the patient for capacity and voluntariness or refer the patient for a specialized capacity assessment in more complex situations.
7. The attending physician must inform the patient of his/her right to rescind the request at any time.
8. A second, independent, consulting physician must then also assess the patient for capacity and voluntariness.
9. Both physicians must agree that the patient meets eligibility criteria for assisted dying to proceed.
10. The attending physician must fulfill the documentation and reporting requirements.

Stage 3: After undertaking assisted dying

11. The attending physician, or a physician delegated by the attending physician, must take care of the patient until the patient's death.

3. Role of the physician

- 3.1 The attending physician must be trained to provide assisted dying.

3.2 Patient assessment

- The attending physician must determine if the patient qualifies for assisted dying under the parameters stated above in Section 1.
- The attending physician must ensure that all reasonable treatment options have been considered to treat physical and psychological suffering according to the patient's need, which may include, independently or in combination, palliative care, psychiatric assessment, pain specialists, gerontologists, spiritual care, and/or addiction counseling.

3.3 Consultation requirements

- The attending physician must consult a second physician, independent of both the patient and the attending physician, before the patient is considered eligible to undergo assisted dying.
- The consulting physician must
 - Be qualified by specialty or experience to render a diagnosis and prognosis of the patient's illness and to assess their capacity as noted in Stage 2 above.

3.4 Opportunity to rescind request

- The attending physician must offer the patient an opportunity to rescind the request at any time; the offer and the patient's response must be documented.

3.5 Documentation requirements

- The attending physician must document the following in the patient's medical record:
 - All oral and written requests by a patient for assisted dying
 - The attending physician's diagnosis and prognosis, and their determination that the patient is capable, acting voluntarily and has made an informed decision

- The consulting physician’s diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision
 - A report of the outcome and determinations made during counseling
 - The attending physician’s offer to the patient to rescind the request for assisted dying
 - A note by the attending physician indicating that all requirements have been met and indicating the steps taken to carry out the request

3.6 Oversight body and reporting requirements

- There should be a formal oversight body and reporting mechanism that collects data from the attending physician.
- Following the provision of assisted dying, the attending physician must submit all of the following items to the oversight body:
 - Attending physician report
 - Consulting physician report
 - Medical record documentation
 - Patient’s written request for assisted dying
- The oversight body would review the documentation for compliance
- Provincial and territorial jurisdictions should ensure that legislation and/or regulations are in place to support investigations related to assisted dying by existing provincial and territorial systems
- Pan-Canadian guidelines should be developed in order to provide clarity on how to classify the cause on the death certificate

4. Responsibilities of the consulting physician

- The consulting physician must verify the patient’s eligibility including capacity and voluntariness.
- The consulting physician must document the patient’s diagnosis, prognosis, capacity, volition and the provision of information sufficient for an informed decision. The consulting physician must review the patient’s medical records, and should document this review.

5. Moral opposition to assisted dying

5.1 Institutional objection by a health care facility or health authority

- Hospitals and health authorities that oppose assisted dying may not prohibit physicians from providing these services in other locations. There should be no discrimination against physicians who decide to provide assisted dying.

5.2 Conscientious objection by a physician

- Physicians are not obligated to fulfill requests for assisted dying. This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or participate in it or to refer the patient to a physician or a medical administrator who will provide assisted dying to the patient. There should be no

discrimination against a physician who chooses not to provide or participate in assisted dying.

- Physicians are obligated to respond to a patient's request for assistance in dying. There are two equally legitimate considerations: the protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience and the assurance of effective patient access to a medical service. In order to reconcile physicians' conscientious objection with a patient's request for access to assisted dying, physicians are expected to provide the patient with complete information on all options available, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service.
- Physicians are expected to make available relevant medical records (i.e., diagnosis, pathology, treatment and consults) to the attending physician when authorized by the patient to do so; or, if the patient requests a transfer of care to another physician, physicians are expected to transfer the patient's chart to the new physician when authorized by the patient to do so.
- Physicians are expected to act in good faith, not discriminate against a patient requesting assistance in dying, and not impede or block access to a request for assistance in dying.