December 21, 2015

College of Physicians and Surgeons of Ontario
80 College Street
Toronto ON M5G 2E2

Re: CPSO Draft Interim Guidance on Physician-Assisted Death

The Canadian Medical Protective Association ("CMPA") appreciates the opportunity to comment on the College's draft document entitled, "Interim Guidance on Physician-Assisted Death".

The CMPA is supportive of efforts to develop advice and guidance for physicians in advance of changes to the law with respect to physician-assisted dying ("PAD"). The CMPA is generally supportive of the guidance being proposed by the CPSO. We appreciate the opportunity to comment on some aspects of the draft interim guidance document in the interest of clarifying the expectations on physicians in this regard.

Consistent Regulatory Approach

The CMPA has consistently stated that physicians and patients will benefit from a uniform regulatory and legislative response to the decision of the Supreme Court of Canada in Carter v. Canada. The CMPA is aware of the work of the Provincial and Territorial Expert Advisory Group on Physician Assisted Dying, which recently released its report aimed at providing recommendations on provincial/territorial legislation in response to the Carter decision. The CPSO's statement published on 14 December 2015 in response to the Advisory Group's report is timely and helpful for members. Recently, the Canadian Medical Association ("CMA") issued recommendations concerning PAD in an effort to encourage a uniform response. It had been our hope that the efforts of the CMA and the Advisory Group would result in medical regulatory authorities across Canada adopting a concerted approach and uniformity in the regulatory response to this issue.

To date, the CMPA is aware that the Colleges in Saskatchewan, Alberta, Manitoba, New Brunswick and Québec have approved guidance for their respective members. Unfortunately, these initiatives reveal that a varying approach to PAD may already be developing across the country. The CMPA is concerned that a patchwork of policies will likely result in varying considerations and rules applicable to physicians and PAD, which will not be in the interests of the public or the profession. In so far as the CPSO has an opportunity to discuss these issues with other medical regulatory authorities, including through FMRAC, we hope that those discussions will include some consideration of the importance of a uniform national approach to PAD, in the interests of all involved.
Conformity with Legislation

It is important that the draft interim guidance accurately reflect the parameters of the Carter decision and any eventual legislation that is passed both federally and in Ontario. The CMPA is concerned that inconsistency generally between the legal and regulatory expectations exposes physicians to unnecessary uncertainty and medical-legal risk.

The interim label given to the document suggests that the CPSO is aware of the need to adapt the guidance to accord with any eventual legislation passed in this area. This is confirmed by statements in the document, which state that in the event that legislation is adopted that is inconsistent with the College's guidance, the legislation will prevail. The CMPA assumes that in such circumstances, the College would review its published guidance to ensure that it continues to conform with the applicable laws as they develop.

Consent

The CMPA urges the College to clearly define the term “adult” in the draft document. Currently, reference is made to the Health Care Consent Act, 1996 in the context of the discussion of capacity. This Act deems mature minors to be generally capable of consenting to treatment. In this regard, we are concerned that the draft interim guidance document, as currently worded, may lead physicians to misunderstand that PAD can be administered to mature minors.

The CMPA also encourages the College to more clearly delineate at page 3 in the document between the issues of capacity to consent and informed consent. Currently, these two issues appear to overlap, resulting in a blurring of two distinct legal concepts and the different stages at which they are intended to be considered.

Conscientious Objection

The College might consider clarifying its expectations on physicians who conscientiously object to providing PAD and the corresponding duty to refer, as discussed in the document. The section of the document concerning conscientious objection currently states that an “effective referral” means a referral made in good faith to a non-objecting, available, and accessible physician or agency. However, the term “agency” is not used elsewhere in the document when referring to an effective referral. Rather, it is defined as meaning a referral to another healthcare provider and makes no reference to the possibility of making a referral to an agency. As you know, the CMA and other medical regulatory authorities in Canada have, to date, suggested that an effective referral can include more that only a referral to another physician.

Process Map

The process map suggests a waiting period of 15 days prior to the patient submitting a second request for PAD death. However, a shorter timeline may be considered in situations where time is of the essence. This advice appears to be based on the CMA’s initial draft framework, which has since been
amended to suggest that patients submit at least two oral requests over a period of time that is proportionate to the patient’s expected prognosis. Although the CMA states that a standard waiting period is not appropriate for all requests for PAD, it generally recommends a minimum waiting period of 14 days between the first and second oral requests.

The College might also consider clarifying the role of witnesses in the context of the second request. The process map currently states that patients must submit a written request for PAD, and that such request must include the signature of two witnesses who can attest the patient is capable, acting voluntarily and free from coercion. Generally, the role of witnesses is simply to confirm the identity of the patient who signed the document and that the person’s mental state at the time appeared to allow for an understanding of what was signed. Witnesses generally do not have the required knowledge and background information about the patient to assess his/her capacity and voluntariness to consent. This assessment will presumably already have been done by physicians.

The CMPA also recommends that consideration be given to including in the document guidance on what physicians should indicate is the cause of death on the death certificate of a patient that received PAD.

Conclusion

I trust that these comments will be of assistance in finalizing the draft interim guidance document. The CMPA appreciates the opportunity to provide comments and we would be pleased to provide additional input at a later time on further revisions to the document.