THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

# NOTICE

# OF

# SPECIAL MEETING OF COUNCIL

A Special Meeting of The College of Physicians and Surgeons of Ontario to discuss the issue of Physician Assisted Death will be held at 3:00 p.m. on Tuesday January 26th, 2016 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

Rocco Gerace, MD
Registrar

January 18, 2016

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

# COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

## REQUISITION FOR A SPECIAL COUNCIL MEETING

From: Dr. Joel A. Kirsh, President

To: Dr. Rocco Gerace, Registrar

Date: January 18, 2016

I hereby ask that a Special Meeting of Council be convened at 3:00 p.m. on January 26, 2016 at the College to discuss the issue of physician-assisted death.

Joel A. Kirsh MD, MHCM, FRCPC
President



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# The College of Physicians and Surgeons of Ontario

**Special Meeting of Council - AGENDA**

**Tuesday January 26, 2016**

3:00 p.m. to 5:00 p.m., Council Chamber, 3rd Floor

Teleconference: 416-933-3853 or 1-855-342-6455, ID #: 9798599

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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| **3:00 p.m.** | **CALL TO ORDER** |
| | **President's Announcements** |
| **3:15 p.m.** | **DISCUSSION/DECISION** |
| **MOTION** | ***Interim Guidance of Physician-Assisted Death* – Consultation Report and Revised Draft Document** |

Pursuant to Council's direction, the draft *Interim Guidance on Physician-Assisted Death* ("Interim Guidance") was circulated for external consultation between December 2015 and January 2016.

Council is provided with a report on the consultation and the proposed revisions made to the draft Interim Guidance document in response to the feedback received.

Council is asked whether it approves the revised draft Interim Guidance document.

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| **4:45 p.m.** | **CLOSING REMARKS** |
| **5:00 p.m.** | **ADJOURNMENT** |

# INTERIM GUIDANCE ON PHYSICIAN-ASSISTED DEATH

## COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

January 26 2016

It is moved by .....,

and seconded by ....., that:

Council approves the "Interim Guidance on Physician-Assisted Death" (a copy of which forms Appendix " " to the minutes of this meeting).

January 2016

# COUNCIL BRIEFING NOTE

**TOPIC:** ***Interim Guidance of Physician-Assisted Death* – Consultation Report and Revised Draft Document**

**FOR DECISION – FINAL APPROVAL**

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## ISSUE:

- Pursuant to Council's direction, the draft *Interim Guidance on Physician-Assisted Death* ("Interim Guidance") was circulated for external consultation between December 2015 and January 2016.
- Council is provided with a report on the consultation and the proposed revisions made to the draft Interim Guidance document in response to the feedback received.
- Council is asked whether it approves the revised draft Interim Guidance document.

## BACKGROUND:

### (a) Supreme Court of Canada's *Carter* Decision

- On February 6, 2015, the Supreme Court of Canada (SCC) released its decision in *Carter v. Canada* (*Carter*).
- In a unanimous decision, the SCC found that the *Criminal Code* provisions that prohibit physician-assisted death are constitutionally invalid, in circumstances where a competent adult:

    1) Clearly consents to the termination of life; and
    2) 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 SCC suspended its decision for 12 months (until February 6, 2016) to allow the federal and/or provincial governments to design, if they so choose, a framework to govern the provision of physician-assisted death.
- In December 2015, the federal government applied to the SCC for an extension to allow the government additional time to develop a framework to govern the provision of physician-assisted death in Canada. In response to this request, the SCC granted a four-month extension. The *Carter* decision will now come into effect on June 6, 2016.

- The Court ruled that during the four-month extension period, an individual who is suffering intolerably from a grievous and irremediable medical condition, and wishes to seek assistance in dying, must obtain an exemption from the superior court in the individual's jurisdiction. This means that:
    - From February 6, 2016 to June 6, 2016: Physician-assisted death is only accessible to individuals if they receive an exemption from a superior court judge.
    - June 6, 2016 and beyond: Physician-assisted death will be legal in Canada.

### (b) CPSO Response to the *Carter* Decision

- A Working Group comprised of physician and public members of Council has been struck to inform and direct the College's activities with respect to physician-assisted death. This has included directing the development of the draft Interim Guidance document, which Council approved for consultation at its December 2015 meeting.[1]

- Council is reminded that the Interim Guidance document is intended to provide guidance to the profession on physician-assisted death in the absence of a government framework to govern the provision of physician-assisted death.

- Based on the SCC's decision regarding the extension, namely that effective February 6, 2016 individuals can seek an individual exemption to receive physician-assisted death, the College felt it was important to proceed with the Interim Guidance document, and specifically, to have a final version of the document available in early February 2016.

- Although it is unclear as to how applications for individual exemptions will be evaluated, it seems reasonable to conclude that physicians may be asked to assist the Court in some capacity. The College wanted to ensure that the Interim Guidance document would be available to those physicians as a resource.

## CURRENT STATUS:

- Council is provided with a report on the consultation regarding the draft Interim Guidance document, as well as a summary of the revisions undertaken in response to the feedback received.

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[1] The Working Group, together with the Executive Committee, has also approved College submissions to the Federal External Panel and the Provincial/Territorial Expert Advisory Group. Council received copies of these submissions at its meeting in December 2015.

## A. Report on Consultation

Consultation process

- The consultation on the draft Interim Guidance document was undertaken in accordance with the College's policy consultation process: a broad range of stakeholders were invited[2] to participate in the consultation and were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to a consultation specific webpage.

- The consultation period was abridged from the standard 60 day period to a 30 day period to ensure that the draft Interim Guidance document could be finalized in advance of February 6, 2016. The consultation was held from December 4, 2015 until January 13, 2016.

- 2194 submissions were received in response to the consultation. This included 341[3] comments posted on the website's discussion page, 546[4] online surveys, and a petition signed by 1307 individuals.

- In addition, 808 Ontario residents[5] were surveyed as part of the College's broader public engagement program. Questions were asked regarding support for physician-assisted death, and in particular, how physician conscientious objection should be managed in the physician-assisted death context. This brief focuses on the stakeholder feedback received. Key findings from the public polling will be highlighted for Council at its meeting on January 26, 2016.

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[2] Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire College membership and key stakeholder organizations. In addition, a general notice was posted on the College's website, and announced through social media. Notice of the consultation was also published in *Patient Compass*, the CPSO's public e-newsletter.

[3] Of which 180 (53%) were from physicians, 84 (25%) from members of the public, 53 (16%) from anonymous individuals, and 24 (7%) from organizations. The organizational respondents were: Advocacy Centre for the Elderly; BC Civil Liberties Association; Canadian Medical Association; Canadian Medical Protective Association; Catholic Civil Rights League; Catholic Health Sponsors of Ontario; Catholic Organization for Life and Family; Catholic Women League; Christian Legal Fellowship; Christian Medical and Dental Society; College of Nurses of Ontario; Dying with Dignity; Evangelical Fellowship of Canada; Hamilton Health Sciences Medical Advisory Committee and Office of Ethics; Margaret's Housing and Community Support Services Inc.; Medico-Legal Society of Toronto; Ontario Association of Social Workers; Ontario Hospital Association; Ontario Long Term Care Physicians; Ontario Medical Association; Professional Association of Residents of Ontario; Protection of Conscience Project; The Chinese Pastoral Council of the Archdiocese of Toronto; & Woodstock Hospital.

[4] Of which 202 (37%) were from physicians, 12 (2%) from medical students, 274 (50%) from members of the public, 46 (8%) from other health care professionals, 5 (1%) from organizations, and 7 (1%) from individuals preferring to remain anonymous. The organizational respondents were: Alliance for Life Ontario; Catholic Health Sponsors of Ontario; Chinese Canadian; Christian Medical and Dental Society; & Canadian Association for Community Living.

[5] The online panel was recruited randomly using an Interactive Voice Response system. Results can therefore be generalized to the online population of Ontario, which represents approximately 80% of the adult population. Findings are accurate to +3.5%, at the 95% level of confidence.

Feedback

- All stakeholder feedback has been posted publicly on the consultation discussion page and a report of the online survey results will be available on the College's website shortly.

General comments

- Broadly speaking, the nature and tone of the feedback received in response to the draft Interim Guidance document was thoughtful, constructive and frequently positive with criticism and/or suggestions for revision focusing on a few core issues.

- A number of notable stakeholders provided strong endorsements of the draft Interim Guidance document while suggesting minor changes to improve the clarity and/or accuracy of the document. For example:

    - A leading legal academic and member of the Provincial/Territorial Expert Advisory Group congratulated the College on "producing what is, in my opinion, the clearest, most useful, and most defensible position statement on the issue of physician-assisted dying of any College of Physicians and Surgeons in Canada. It is a model that I hope others follow."

    - Another member of the Provincial/Territorial Expert Advisory group commented, "This guidance is excellent and aligns nicely with the recommendations of the provincial-territorial expert advisory group on physician assisted dying."

    - Dying with Dignity commented, "We believe that the College has adopted the considered and compassionate approach necessary for the implementation of physician assisted dying." This group also noted that our position on conscientious objection "should be used as the gold standard for other medical colleges across the country."

    - A leading ethicist, who served as expert witness for Plaintiffs in *Carter*, expressed strong support for the draft Interim Guidance document, particularly its content on conscientious objection, stating, "I hope that the guidelines will serve as a model for all of the provinces and territories."

- In contrast, several other key organizational stakeholders continued to express concern regarding the effective referral requirement included in the document's guidance on conscientious objection. For example:

    - The Canadian Medical Association (CMA) reflected 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 referral."

- The Ontario Medical Association similarly maintained "that a physician cannot be forced to make an effective referral for PAD if making that referral is perceived by the physician as active participation in the activity to which he or she has a conscientious objection."

- A number of individual stakeholders, together with key organizational stakeholders including the British Columbia Civil Liberties Association, Canadian Medical Protective Association, College of Nurses, Medico-Legal Society of Toronto, Ontario Hospital Association, and Professional Association of Residents of Ontario, offered specific and constructive recommendations which are captured in the summary of "Substantive Comments" below.

Substantive Comments

*Carter Criteria: Competent Adult*

- A number of stakeholders sought additional guidance on what is meant by the term "adult" and whether the draft Interim Guidance document prevents the provision of physician-assisted death to "mature minors"[6].

- Stakeholders also expressed concern regarding some of the challenges relating to assessing capacity in the end-of-life care context and many expressed concerns about the specific challenge of assessing capacity of patients who seek assistance in dying due to a psychiatric condition or illness.

*Carter Criteria: Grievous and Irremediable & Intolerable Suffering*

- Some stakeholders, especially physicians, sought clearer definitions and/or objective standardized criteria regarding what constitutes a grievous and irremediable condition.

- Others sought enhanced clarity about who makes determinations (physician or patient) of whether a patient has a 'grievous and irremediable' condition, and is experiencing 'intolerable suffering'. Regarding the latter, some stakeholders called for the Interim Guidance document to clarify that 'intolerable suffering' is assessed from the patient's perspective.

[6] Mature minors are individuals who are not adults, typically adolescents, who have been found to have decision-making capacity, in accordance with legal requirements for capacity. In Ontario, these are set out in the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

- Stakeholders also sought advice on how to proceed when the attending physician and the patient or the attending and consulting physicians disagree about whether the *Carter* criteria have been satisfied.

*Criteria: Insured Persons*

- Some stakeholders voiced an objection to the requirement that physicians provide physician-assisted death to Ontario residents only. In light of the interprovincial reciprocal billing agreements, they called for the document to be amended to allow physicians to provide physician-assisted death to eligible patients within Canada who qualify for Canadian publicly-funded health services.

*Conscientious Objection*

- Stakeholders generally agreed with the principles and expectations set out regarding how to manage physician conscientious objections, with the exception of the requirement that an effective referral be made; this expectation garnered significant and discordant feedback.
    - Stakeholders in favour of this requirement noted that it represents the right balance between patients' right to access physician-assisted death and physicians' right to conscientious objection, often noting that self-referral is not feasible in this context. Some explicitly noted that the College's position on conscientious objection, including the effective referral requirement 'reconciles physician and patient rights', as the SCC directed in *Carter.*
    - Stakeholders opposed to this requirement often noted that it would, for example, make the physician complicit in physician-assisted death, morally culpable for the patient's death, and would infringe on physicians' *Charter* protected right to freedom of conscience and religion.
- Many stakeholders (both those opposed to and in favour of the effective referral requirement), recommended that the College or the Ministry of Health and Long-term Care develop a central database of physicians willing to provide physician-assisted death.
    - Stakeholders opposed to the effective referral requirement suggested that this would facilitate patient self-referral and avoid compelling physicians to refer against their conscience or religious beliefs.
    - Stakeholders in favour of the effective referral requirement noted that this database would facilitate the making of effective referrals, which may otherwise be difficult to provide.
- Some stakeholders suggested that instead of an effective referral, objecting physicians should be obliged to facilitate a "transfer of care". It was argued that this

may be a more palatable requirement to objecting physicians than an "effective referral".

*Incapable Patients*

- Some stakeholders objected to the requirement in the draft Interim Guidance document that patients be competent both at the time the request for physician-assisted death is made and at the time physician-assisted death is provided. Stakeholders argued this requirement would have a cruel impact: it would prevent individuals who met the *Carter* criteria at the time of the request, but later lose capacity due to their illness, from receiving their desired outcome: physician assistance in dying.

- A number of stakeholders also expressed support for permitting substitute decision-makers to consent to physician-assisted death on behalf of incapable patients when the patient has clearly articulated a wish for physician-assisted death, particularly in an advance directive. Stakeholders noted that substitute decision-makers make all other end-of-life decisions including when to withhold or withdraw life-saving or life-sustaining treatment and so should be permitted to consent to physician-assisted death on an incapable patient's request.

*Waiting Period*

- Many stakeholders commented on the requirement in the Sample Process Map for a 15 day waiting period. They argued that a 15 day period was arbitrary and may not be suitable in all circumstances: in some instances a longer waiting period may be more appropriate; in others a shorter time period may be warranted. Accordingly, stakeholders asserted that a specific time period not be set out, and a more principled position should be developed (i.e. until the physician is satisfied that the criteria for physician-assisted death have been met).

*Witnesses*

- A number of stakeholders commented on the requirement for witnesses in the Sample Process Map. They argued that the requirements were unnecessarily restrictive and may prove to be a barrier to access for some patients, particularly those patients who may not have family, or close friends to act as witnesses. Some stakeholders suggested that hospital employees otherwise not involved in the patient's care should be allowed to act as a witness.

- Stakeholders also commented on the requirement that the witness be able to attest to the patient's capacity, and to the fact that the patient is acting voluntarily, and free from coercion. They felt this was demanding too much of witnesses who may not have the knowledge or skill to do so.

*Drug Protocols*

- A number of stakeholders called for additional guidance to be provided regarding the appropriate drugs to administer or provide to the patient and many commented that the documents referenced by the Interim Guidance document were outdated or were inaccessible. Stakeholders encouraged the College to provide access to more up to date drug protocols from other jurisdictions (e.g. Quebec, Oregon, etc.).

*Certification of Death*

- Some stakeholders sought guidance on how to complete the medical certificate of death when physician-assisted death is provided. They also asked for clarification as to whether a death in these circumstances would warrant a mandatory report to the Coroner's Office.

## B. Revisions in Response to Feedback

- All the feedback received has been carefully reviewed. In considering how to revise the draft Interim Guidance document, the Working Group felt it was necessary and responsible to take a conservative approach, and not expand the criteria for physician-assisted death beyond that explicitly stated by the SCC in *Carter*.

- The revisions proposed by the Working Group have been incorporated into the revised draft Interim Guidance document, attached as **Appendix 1**. Key revisions are highlighted for Council's reference below.

<u>Key Revisions to the draft Interim Guidance document</u>

- Minor editorial changes were made to improve the clarity of the document and ensure consistency with the *Carter* decision and existing legislation (e.g. definition of capacity under the *Health Care Consent Act, 1996*; that intolerable suffering is determined by the patient, etc.).

- Revisions have been made in light of the SCC's decision to grant an extension.

    - The *Introduction* notes that until June 6, 2016, physician-assisted death can only be provided if a superior court judge grants an individual exemption. It also notes that following June 6, 2016, the *Carter* decision will take effect.

    - The preamble to the *Sample Process Map* notes that from February 6 to June 6, 2016, patients can access physician-assisted death through an exemption provided by the court. It signals that the Sample Process Map is an example of how to evaluate a patient request for physician-assisted death, but that any direction provided by the court during this extension period would take precedence.

- Under *Criteria*, revisions have been made to permit physicians to provide physician-assisted death to eligible patients within Canada who qualify for Canadian publicly-funded health services. This replaces the content in the consultation draft that limited the provision of physician-assisted death to Ontario residents only.

- A number of changes have been made to the *Sample Process Map*.

    - Content has been added to **Stage 1, First Request** to indicate that where the attending physician is not satisfied that the patient meets the *Carter* criteria, the patient is entitled to make a request for physician-assisted death of another physician. Similar content has been added to **Stage 2, Consulting Physician**.

    - In **Stage 1**, content was added to clarify that the attending physician would assess the patient as specified, unless they have made an effective referral. This was added to clarify that conscientious objectors are not required to assess whether the patient meets the criteria for physician-assisted death prior to making an effective referral.

    - In **Stage 1**, the requirement regarding witnesses has been significantly changed. The Interim Guidance document now states that only one witness is required and specifies that this witness be "independent". The Working Group felt these changes would address stakeholder concerns that the requirements related to witnesses were overly onerous and restrictive. The Working Group felt that having one independent witness, and two physicians involved in evaluating the patient's request was sufficient to ensure the patient was capable, acting voluntarily, and that he/she was not coerced to make a decision to request physician-assisted death.

    - In **Stage 1**, the **Waiting Period** has been renamed 'Reflection Period' and the suggested period of 15 days has been removed. The Interim Guidance document now recommends that a period of reflection take place during which the physician must satisfy him/herself that the criteria have been met and that the patient's request is enduring.

    - In **Stage 3**, the older resources for **drugs protocols** have been removed. Instead physicians are directed to the Members Portal of the College website where they can access drug protocols from Quebec and Oregon. Due to public safety considerations, the Working Group determined that drug protocols for physician-assisted death should be accessible only to physician members, through the Members Portal.

    - A new stage, '**Stage 4**' has been added on **Certification of Death**. Physicians are advised to contact the Ministry of Health and Long-term Care regarding how to complete the medical certificate of death. At this time, no specific contact information for the Ministry or details about death certificate

requirements was available from the Ministry. Additionally, no clarity was available as to whether deaths in these circumstances are reportable to the Coroner's Office.

Changes that were not made in response to the feedback

- Revisions have not been proposed in relation to three key issues raised in stakeholder feedback.

**a) Adult:**

- The Working Group opted not to expand on the definition of "adult". In arriving at this decision, the Working Group was informed by the fact that the SCC in *Carter* did not define adult; that generally health care decision-making legislation does not specify an 'age of consent', and that further, there is no consistent age of an adult that is specified in law. Accordingly the Working Group felt that any age limit it selected for the purposes of the Interim Guidance document would be arbitrary.

- The Working Group opted not to comment on whether physician-assisted death could be provided to mature minors. The Working Group noted that in *Carter,* the SCC specified that a patient must be adult in order to request physician-assisted death. Without legal clarity on this matter the Working Group felt it would be irresponsible to advise physicians that it would be permissible to provide physician-assisted death to mature minors.

**b) Capacity:**

- The Working Group opted to retain the requirement set out in the consultation draft, that patients must be competent both at the time they request physician-assisted death, and at the time they receive physician-assisted death.

- The Working Group felt that maintaining this requirement would enable physicians to assess the patient's wishes right up to the provision of physician-assisted death, and to respect the patient's choice should they wish to rescind their request for physician-assisted death.

**c) Conscientious Objection - Effective Referral**

- The Working Group has maintained the requirement for an effective referral. The Working Group believes that the content on conscientious objections, including the requirement to provide an effective referral reconciles physician and patient rights.

- The Working Group carefully considered the argument that an effective referral is equivalent to providing physician-assisted death. The Working Group could not accept the argument on its merits.

- The Working Group reflected that this position does not accord with the purpose or implications of referrals in clinical practice. An effective referral does not foreshadow or guarantee an outcome: that a treatment will or will not be provided. An effective referral connects a patient with a physician who is willing to provide a treatment should it be clinically suitable, legally available and should the patient consent.

- The Working Group also noted that this position does not reflect the requirements for how physician-assisted death can be accessed by patients, as set out in the *Carter* decision, and the draft Interim Guidance document. Both the *Carter* decision and the draft Interim Guidance document require that before a patient can receive physician-assisted death, the patient must provide consent in accordance with the legal requirements for consent, and the patient must satisfy the specified criteria: be a competent adult, have a grievous and irremediable condition; experience enduring suffering that is intolerable to the patient. By virtue of the Interim Guidance document, two physicians (attending and consulting) must be satisfied the patient meets this criteria.

## CONSIDERATIONS:

- The College has been involved in discussions with key organizational stakeholders regarding the development of educational tools and resources on physician-assisted death.

- Current information indicates that both Continuing Professional Development-Ontario (CPD-O) and the Centre for Effective Practice (CEP) will take a lead role, in collaboration with the College and others, to develop educational resources and tools for physicians in the coming weeks and months.

- The College has been assured these resources and tools will be consistent with the Interim Guidance document.

- Although the timelines for the completion of this work are currently unknown, links to any relevant resources and tools can be included in the Interim Guidance document as they become available.

## NEXT STEPS:

- Should Council approve the draft Interim Guidance document, as revised, it will be published in *Dialogue* and on the College's website.

- A number of steps will be taken to ensure that the public, Ontario physicians and key stakeholders are informed of the Interim Guidance document. This will include:

  - Distributing the Interim Guidance document to all College members through an email blast on February 1, 2016;
  - Developing a News Release;
  - Utilizing social media channels to communicate with College members, and the College's network about the Interim Guidance document and directing interested parties to the College website.

- A webpage for Physician-Assisted Death will be created on the *Consultations* tab of the College's website to highlight for stakeholders the steps that took place following the consultation, how stakeholder feedback helped to shape the final version of the Interim Guidance document, and the final decision made by Council.

- Between February 6, 2016 and June 6, 2016, the College will be actively monitoring the landscape for any relevant developments. This will directly inform any action the College takes following June 6, 2016 to provide guidance to the membership on this topic.

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## DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the revised draft Interim Guidance document?

2. Does Council approve the revised draft Interim Guidance document?

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**DATE:** January 21, 2016

**Attachments:**

Appendix 1: Revised draft – *Interim Guidance on Physician-Assisted Death* (changes are shaded for Council's reference)

# Interim Guidance on Physician-Assisted Death

## I. Introduction

Historically, it has been a crime in Canada to assist another person in ending his/her own life. This criminal prohibition has applied to circumstances where a physician provides or administers medication that intentionally brings about a patient's death, at the request of the patient. This is often termed physician-assisted death.

In the case of *Carter v. Canada*[1], the Supreme Court of Canada (SCC) considered whether the criminal prohibition on physician-assisted death violates the *Charter* rights of competent adults, who are suffering intolerably from grievous and irremediable medical conditions, and seek assistance in dying. The SCC unanimously determined that an absolute prohibition on physician-assisted death *does* violate the *Charter* rights of these individuals, and is unconstitutional. The SCC suspended its decision for 12 months (until February 6 2016) to allow the federal and/or provincial governments to design, if they so choose, a framework to govern the provision of physician-assisted death.

In December 2015, the federal government applied to the SCC for an extension to the 12-month suspension period. Upon consideration of the federal government's request, the SCC determined that a four-month extension was warranted. The SCC ruled that during the four-month extension period, an individual who is suffering intolerably from a grievous and irremediable medical condition, and wishes to seek assistance in dying, must obtain an exemption from the superior court in the individual's jurisdiction.

This means that from February 6 2016 to June 6 2016, physician-assisted death is accessible only to individuals who receive an exemption from a superior court judge. Following June 6 2016, physician-assisted death will be legal in Canada. At that time, subject to any prohibitions or restrictions that may be imposed in future legislation or policy, physicians will be legally permitted to assist competent adults who are suffering intolerably from grievous and irremediable medical conditions to end their lives.

## II. Purpose of Document

This document serves as interim guidance for the profession, in the absence of a framework to govern the provision of physician-assisted death. It articulates:

- Professional and legal obligations articulated in College policies and legislation that apply in the physician-assisted death context;
- The criteria for physician-assisted death as set out by the SCC; and
- Guidance for physicians on practice-related elements specific to the provision of physician-assisted death.

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

To the extent that there is any inconsistency between the guidance provided in this document and any future government framework developed to govern the provision of physician-assisted death, the latter would take precedence.

## III. Guiding Principles of Professionalism

The key values of medical professionalism, as articulated in the College's *Practice Guide*, are compassion, service, altruism and trustworthiness. The fiduciary nature of the physician-patient relationship requires that physicians prioritize patient interests. In doing so, physicians must strive to create and foster an environment in which the rights, dignity and autonomy of all patients are respected.

Physicians embody the key values of medical professionalism and uphold the reputation of the profession by, among other things:

- Respecting patient autonomy with respect to health-care goals and treatment decisions;
- Acting in the best interests of their patients, and ensuring that all patients receive equitable access to care;
- Communicating sensitively and effectively with patients in a manner that supports patients' autonomy in decision-making, and ensures they are informed about their medical care; and
- Demonstrating professional competence, which includes meeting the standard of care and acting in accordance with all relevant and applicable legal and professional obligations.

## IV. Interim Guidance on Physician-Assisted Death

### A. Criteria

In accordance with the SCC's decision in *Carter v. Canada,* for an individual to access physician-assisted death, he/she must:

1. Be a competent adult;
2. Clearly consent to the termination of life;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability); *and*
4. Experience enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

Physicians must use their knowledge, skill and judgment to assess an individual's suitability for physician-assisted death, against the above criteria.

At this time, the College advises that physicians should only provide physician-assisted death to eligible patients within Canada who qualify for Canadian publicly-funded health services.

The content that follows elaborates upon each element of the criteria for physician-assisted death.

### *1. Competent adult*

i) Adult

The wording of the SCC's decision indicates that physician-assisted death is available only to competent adults. The SCC did not expressly define the term "adult" in this context.

ii) Competence

The College interprets the requirement that the adult be 'competent' to refer to decision-making capacity. Under the *Health Care Consent Act, 1996*[2] (and as reflected in the College's *Consent to Treatment* policy), a patient is capable if they are able to understand the information that is relevant to making the decision, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. The patient must be able to understand and appreciate the history and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

In the context of physician-assisted death, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of medication. A patient's capacity is fluid and may change over time. Therefore, physicians must be alert to potential changes in the patient's capacity.

When assessing capacity in the context of a request for physician-assisted death, physicians are advised to rely on existing practices and procedures for capacity assessments.

### *2. Clearly consents to the termination of life*

A patient who seeks physician-assisted death must clearly consent to the termination of life. The SCC highlighted that the process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to physician-assisted death.

The College's *Consent to Treatment* policy outlines the legal requirements of valid consent as set out in the *Health Care Consent Act, 1996*[3]. In order for consent to be valid it must be related to the treatment, fully informed, given voluntarily, and not obtained through misrepresentation or fraud.

As part of obtaining informed consent, physicians must discuss all treatment options with the patient. With respect to physician-assisted death specifically, the treatment options discussed with the patient must include all reasonable and available palliative care interventions. The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's

[2] S.O. 1996, c. 2, Sched. A.
[3] S.O. 1996, c. 2, Sched. A.

expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

The physician must be satisfied, on reasonable grounds, that the patient's decision to undergo physician-assisted death has been made freely, without coercion or undue influence from family members, health-care providers or others. The patient must have a clear intention to end his/her own life after due consideration. The patient must have requested physician-assisted death him/herself, thoughtfully and in a free and informed manner.

During this time of regulatory uncertainty, requests for physician-assisted death must be made by the patient, and not through an advance directive, or the patient's substitute decision maker.

### *3. Grievous and irremediable medical condition*

The SCC indicated that a grievous and irremediable medical condition can include an illness, disease or disability. To determine whether the patient has a grievous and irremediable medical condition, the physician must assess the patient and render a diagnosis and prognosis of the patient's condition.

'Grievous' is a legal term that applies to serious, non-trivial conditions that have a significant impact on the patient's well-being. 'Irremediable' is a broad term capturing both terminal and non-terminal conditions. As stated by the SCC, 'irremediable' does not require the patient to undertake treatments that are not acceptable to the individual.[4]

For instance, the two lead plaintiffs in the SCC case of *Carter v. Canada* suffered from Amyotrophic Lateral Sclerosis (ALS), a terminal neurodegenerative disease, and spinal stenosis, a non-terminal degenerative condition involving progressive compression of the spinal cord. The SCC determined that the prohibition on physician-assisted death violated the constitutional rights of both plaintiffs.

### *4. Enduring suffering that is intolerable*

The criterion that an individual experience intolerable suffering is subjective, meaning it is assessed from the individual's perspective.

When a physician is determining whether a patient satisfies this element of the criteria, the physician must be satisfied that the patient's condition causes them enduring physical and/or psychological suffering that is intolerable to the patient. This may be demonstrated, in part, by communication, by the patient, of a sincere desire to pursue physician-assisted death, or through a dialogue with the patient about their personal experience managing their condition.

## B. Fees

The activities involved in both assessing whether a patient meets the criteria for physician-assisted death, and providing physician-assisted death, are currently insured services. These

[4] *Carter v. Canada (Attorney General)*, 2015 SCC 5 at para 127.

activities may include, for instance, counselling and prescribing. Accordingly, physicians must not charge patients directly for physician-assisted death, or associated activities. Physicians are advised to refer to the OHIP Schedule of Benefits for further information.

## C. Conscientious Objection

The SCC's decision in *Carter v. Canada* does not compel physicians to provide physician-assisted death. The SCC noted that the *Charter* rights of patients and physicians would have to be reconciled.

At this interim stage, and in the absence of a framework to govern the provision of physician-assisted death, physicians are directed to comply with the expectations for conscientious objections in general, set out in the *Professional Obligations and Human Rights* policy.

These are as follows:

- Where a physician declines to provide physician-assisted death for reasons of conscience or religion, the physician must do so in a manner that respects patient dignity. Physicians must not impede access to physician-assisted death, even if it conflicts with their conscience or religious beliefs.

- The physician must communicate his/her objection to physician-assisted death to the patient directly and with sensitivity. The physician must inform the patient that the objection is due to personal and not clinical reasons. In the course of communicating an objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.

- In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient's clinical needs, concerns and/or wishes. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.

- Where a physician declines to provide physician-assisted death for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency.[5] The referral must be made in a timely manner to allow the patient to access physician-assisted death. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.

[5] The College acknowledges that the number of physicians and/or agencies to which a referral would be directed may be limited, particularly at the outset of the provision of physician-assisted death in Ontario, and that this is relevant to any consideration of whether a physician has complied with the requirement to provide an effective referral. In light of these circumstances, the College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

### D. Documentation Requirements

The College's *Medical Records* policy sets out physicians' professional and legal obligations with respect to medical records. The policy requires that physicians document each physician-patient encounter in the medical record. This would include encounters concerning physician-assisted death. The medical record must be legible, and the information in the medical record must be understood by other health professionals. Where there is more than one health professional making entries in a record, each professional's entry must be identifiable.

Each record of a physician-patient encounter, regardless of where the patient is seen, must include a focused relevant history, documentation of an assessment and an appropriate focused physical exam (when indicated), including a provisional diagnosis (where indicated), and a management plan. Where a patient has requested physician-assisted death, the physician must document each element of the patient's assessment in accordance with the criteria outlined above. Further, all oral and written requests for physician-assisted death, as well as the dates of these requests, must be documented in the medical record. A copy of the patient's written request must also be included.

## V. Sample Process Map for Physician-Assisted Death[6]

****PLEASE NOTE: As explained above, from February 6 2016 to June 6 2016, patients who are suffering intolerably from a grievous and irremediable medical condition, and seek assistance in dying, must obtain an exemption from the superior court of the individual's jurisdiction. Where the court grants an exemption for physician-assisted death, any direction provided by the court in evaluating and/or granting this exemption takes precedence over the *'Sample Process Map for Physician-Assisted Death'* found below. Physicians who are involved in assisting the court to evaluate an individual exemption for physician-assisted death, or who are assisting a patient who is preparing to apply to the court, are advised to use this process map as an example for any element of the process in which they are participating.**

Physicians who are willing to provide physician-assisted death are advised to follow the process map outlined below. This process map, which has been adapted from guidance provided in jurisdictions outside of Ontario, sets out specific practice-related elements for the provision of

[6] This sample process map aligns with the processes in place in established jurisdictions such as Oregon and the Netherlands, along with the following draft guidance documents on physician-assisted death recently released by select Canadian medical regulators and the Canadian Medical Association: (1) College of Physicians and Surgeons of Alberta, *Appendix A: Informed Consent – The Special Case of Physician-Assisted Death (PAD) – Draft for Discussion* (Sept. 2015); (2) The College of Physicians and Surgeons of Saskatchewan, *Physician Assisted Dying Draft Guidance Document, Draft for Consultation* (Sept. 2015) (3) Canadian Medical Association, *Principles Based Recommendations for a Canadian Approach to Medical Aid in Dying* – Draft (Aug. 2015).

physician-assisted death.[7] As described above, where physicians are unwilling to provide physician-assisted death for reasons of conscience or religion, an effective referral to another physician or agency must be provided to the patient.

**Stage 1: Patient requests physician-assisted death**

**FIRST REQUEST**

- The patient makes the first request for physician-assisted death to the attending physician.
- Unless an effective referral to another physician or agency is provided to the patient, the attending physician must assess the patient to determine whether he/she meets the criteria for physician-assisted death. As described above, the patient must: (1) Be a competent adult; (2) Clearly consent to the termination of life; (3) Have a grievous and irremediable medical condition (including an illness, disease or disability); and (4) Experience enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
- In relation to the first two criteria, the attending physician must assess the patient for capacity and voluntariness, or refer the patient for a specialized capacity assessment where the patient's competence is in question.
- The attending physician must remind the patient of his/her ability to rescind the request at any time.
- Along with documenting the patient's assessment, the attending physician must document the date of the patient's first request for physician-assisted death in the medical record.
- If the attending physician concludes that the patient does not meet the criteria for physician-assisted death as outlined above, the patient is entitled to make a request for physician-assisted death to another physician who would again assess the patient using the above criteria.

**REFLECTION PERIOD**

- A period of reflection, between the first and second requests for physician-assisted death is required.
- The period of reflection is intended to provide both the patient and the attending physician an opportunity to consider the request for physician-assisted death.
- The length of the period of reflection will vary, and may depend, in part, on the rapidity of progression and nature of the patient's medical condition. It is essential that the patient has sufficient time to come to an informed and voluntary decision to end his/her life, and that the patient appreciates the consequences of this decision.

**SECOND REQUEST**

- The patient makes a second request for physician-assisted death to the attending physician. This second request for physician-assisted death by the patient requires

[7] The Ontario Ministry of Health and Long-Term Care (MOHLTC) is developing resources to support the provision of physician-assisted death. These resources may include forms to be completed by patients who request physician-assisted death, and physicians who provide physician-assisted death. Physicians are advised to consult the MOHLTC's website for further details.

formal documentation.

- The second request may be oral and transcribed by another party, or written by the patient.
- The written request, or the transcribed oral request, must be dated and signed by the patient, and countersigned by an independent witness and the attending physician.

**Stage 2: Prior to the provision of physician-assisted death**

**CONSULTING PHYSICIAN**

- A second consulting physician must ensure that the requisite criteria for physician-assisted death have been met. As described above, the patient must: (1) Be a competent adult; (2) Clearly consent to the termination of life; (3) Have a grievous and irremediable medical condition (including an illness, disease or disability); and (4) Experience enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
- In relation to the first two criteria, the consulting physician must assess the patient for capacity and voluntariness, or refer the patient for a specialized capacity assessment where the patient's competence is in question.
- If the consulting physician concludes that the patient does not meet the criteria for physician-assisted death as outlined above, the patient is entitled to have another consulting physician assess them against the criteria.
- Both the attending and consulting physician must independently document their opinion as to whether the requisite criteria for physician-assisted death have been met.
- The consulting physician must remind the patient of his/her ability to rescind the request for physician-assisted death at any time.

**Stage 3: Physician-Assisted Death - Self-Administration or Physician Administration**

- Physician-assisted death includes both instances in which the physician provides the patient with the means to end his/her own life, and voluntary euthanasia, where the physician is directly involved in administering an agent to end the patient's life.
- During this time of regulatory uncertainty, it is advised that the patient must be capable not only at the time the request for physician-assisted death is made, but also at the time of physician-assisted death.
- Where the patient plans to self-administer the fatal dose of medication at home, physicians must help patients and caregivers assess whether this is a manageable option. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.
- Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.
- Physicians must exercise their professional judgement in determining the appropriate

drug protocol to follow to achieve physician-assisted death. The goals of any drug protocol for physician-assisted death include ensuring the patient is comfortable, and that pain and anxiety are controlled.

- College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the College's website.

**Stage 4: Certification of Death**

- Where physician-assisted death is provided, physicians are advised to consult the Ontario government for guidance on the completion of death certificates and any mandatory reporting obligations associated with physician-assisted death.

## VI. Reporting and Data Collection

The College supports the establishment of a formal oversight and reporting mechanism that would collect data on physician-assisted death, and advocates that a data collection mechanism form part of any government framework. A central data collection agency would help ensure compliance with specific requirements related to physician-assisted death, and help ascertain the prevalence of and circumstances leading to physician-assisted death in Canada.