Submission to the Council of Canadian Academies: Expert Panel on Medical Assistance in Dying in Canada

College of Physicians and Surgeons of Ontario

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The College of Physicians and Surgeons of Ontario (College) appreciates the opportunity to make a submission to the Council of Canadian Academies' Expert Panel on Medical Assistance in Dying in Canada.

As Canada's largest medical regulatory authority, the College has a legal mandate to serve and protect the public interest. All of our work, including that on medical assistance in dying (MAID), is undertaken with a view toward fulfilling our mandate. Core College responsibilities include:

- Issuing certificates of registration to physicians to allow them to practice medicine in Ontario;
- Monitoring and maintaining standards of practice through peer assessment and remediation;
- Investigating complaints about physicians on behalf of the public;
- Conducting discipline hearings when physicians may have committed an act of professional misconduct or may be incompetent;
- Articulating expectations for physician conduct on professionalism, medico-legal and other issues that are relevant to the practice of medicine through the Practice Guide and over fifty College policies.

With respect to the last listed core responsibility, the College has articulated expectations for physician conduct in relation to MAID in our *Medical Assistance in Dying* policy. This policy was finalized in June 2017 and reflects the federal law pertaining to MAID along with relevant Ontario law and existing College policies. The *Medical Assistance in Dying* policy is supplemented by numerous supporting documents posted on the College's website. This includes Frequently Asked Questions for Physicians , an information resource for the Public, a Fact Sheet relating to effective referrals, and an Early Lessons Learned document developed in collaboration with the Office of the Chief Coroner of Ontario.

The College has considered carefully each of the three topics that are the subject of the Expert Panel's independent review: mature minors, advance requests and mental illness as a sole underlying condition. In this submission, the College does not take an explicit position on any of the three topics, but rather highlights for the Panel the key issues and considerations that the College believes should form part of the Panel's analysis. The comments set out in this submission are consistent with the College's work on MAID to date, including our

Submission to the Senate Standing Committee on Legal and Constitutional Affairs that considered Bill C-14, and our mandate to protect and serve the public interest.

Our submission is in two parts. First, we identify core principles or considerations that we believe are applicable to all three topics. Second, we highlight key considerations specific to each topic of independent review.

I. Core Principles and Considerations

Four core principles or considerations have grounded the College's thinking on the three topics under review.

1. Capacity

The College recognizes the central role that capacity plays in healthcare decision making and how under both federal legislation relating to MAID and Ontario's *Health Care Consent Act, 1996*[1] *(HCCA),* capable individuals are entitled to make their own healthcare decisions. We also recognize that under the *HCCA* and common law, the prior capable wishes of incapable patients can directly inform decisions made by substitute decision makers and clinicians. These may be wishes expressed verbally or in written advance directives.[2]

2. Consistency

We believe it is essential to locate MAID within the broader context of healthcare so that the Expert Panel is able to consider the three topics of study comprehensively to ensure consistency in relation to respect for patient autonomy, applicable safeguards and requirements for healthcare decision making.

3. Clinician[3] Competence

The College is aware that in relation to MAID to date, questions have emerged from clinicians about the competence required to assess patient eligibility for MAID and to provide MAID. The Expert Panel may wish to consider whether the three topics under review have implications for clinician competence; specifically whether there should be

[1] S.O. 1996, c. 2, Sched. A.
[2] Section 5(2) of the *HCCA*.
[3] 'Clinician' is used in this submission to be inclusive of both nurse practitioners and physicians, as both are authorized to provide MAID under federal law. The College's jurisdiction is limited to physicians and the comments included in this submission represent those of the College alone, and not the College of Nurses of Ontario.

specific professional competencies or areas of expertise and experience that are required as prerequisites for clinician involvement. In doing so, however, the Panel should equally consider the impact that setting such prerequisites may have on the number of willing providers available as this will directly impact access to care for eligible patients.

4. Clarity and Confidence of Clinicians

In accordance with the federal legislation, and as affirmed in the recent decision, *A.B. v. Canada (Attorney General)*[4] , the responsibility for determining patient eligibility for MAID has been assigned to clinicians. There remains much in the current federal legislation that is unclear. The issues that the Expert Panel is considering could add additional complexity. It is essential that regardless of the position the federal government ultimately takes in relation to the topics under review, careful consideration needs to be given to the challenges facing clinicians in interpreting and applying legislation and efforts made to ensure that any resulting legislative provisions are clear.

II. Key Issues and Considerations

In our remarks on each topic, the College will touch on the core principles outlined above and identify additional key issues for the Expert Panel's consideration.

1. Mature Minors

The *HCCA* and the Supreme Court of Canada's decision in *AC v. Manitoba (Director of Child and Family Services)*[5], ('*AC*') will be instructive to the Expert Panel on the issue of mature minors.

Under the *HCCA*, capacity is determined by a functional test, not chronological age. Patients are deemed to have capacity to consent to treatment if they are: able to understand the information that is relevant to making a decision about the treatment, and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.[6] Patients are presumed to have capacity under the *HCCA* unless there are reasonable grounds to believe

[4] 2017 ONSC 3759.
[5] 2009 SCC 30, [2009] 2 SCR 181.
[6] Section 4(1) of the *HCCA*.

otherwise[7], and findings of incapacity can be challenged by application to the Consent and Capacity Board (CCB)[8], an independent, multidisciplinary board created under the *HCCA*[9].

In the *AC* decision, the Supreme Court of Canada recognized that minors may have the capacity to make treatment decisions, that they have the right to prove they are capable, and that a rigid statutory framework based on age would fail to reflect the realities of child development.[10]

As alluded to the College's Submission to the Senate Standing Committee, linking capacity to age for the purposes of MAID gives rise to an inconsistency between federal legislation and the *HCCA*. Patients under eighteen may be deemed capable of making healthcare decisions by virtue of the *HCCA*, (including decisions comparable to MAID such as withdrawal of life-sustaining treatment) but may be ineligible to access MAID simply because of their age.

We would encourage the Expert Panel to consider:

- First, whether the inconsistency created between the federal legislation and the *HCCA* with respect to age and capacity is appropriate and the supporting justification or rationale; and
- Second, the potential human rights implications that may be associated with limiting the autonomy of a capable patient solely on the basis of that patient's age.

The College acknowledges that an important part of the Expert Panel's evaluation of mature minors will likely entail a consideration of whether existing safeguards included in the federal legislation are sufficient or whether additional safeguards, specific to mature minors are required. We would note for the Panel that individuals referred to as mature minors can vary

[7] Section 4(2) and 4(3) of the *HCCA.*
[8] Section 32 of the *HCCA.*
[9] The CCB is created under the *HCCA* and it conducts hearings under the *Mental Health Act*, the *HCCA*, the *Personal Health Information Protection Act*, *2004*, the *Substitute Decisions Act* and the *Mandatory Blood Testing Act*, *2006*. The Board is multidisciplinary, comprised of psychiatrists, lawyers and members of the general public appointed by the Lieutenant Governor in Council. For more information see Part V of the *HCCA.*
[10] See, for example, Justice Abella's comments at paragraph 87: "If, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgment, the court is persuaded that the necessary level of maturity exists, it seems to me necessarily to follow that the adolescent's views ought to be respected." Additionally, Justice Abella's comments at paragraph 107: "Given the significance we attach to bodily integrity, it would be arbitrary to assume that no one under the age of 16 has capacity to make medical decisions. It is not, however, arbitrary to give them the opportunity to prove that they have sufficient maturity to do so."

significantly in terms of life experience, and maturity. Some may have limited life experiences, some may be emancipated minors, and some may have dealt with illness their entire lives to date. As such, the safeguards required, including whether and when parental consent should be required, may indeed vary widely from patient to patient. While safeguards are an important part of the system, safeguards must not, without adequate justification, limit the autonomy of capable patients, and/or frustrate access to MAID for eligible patients.

With respect to clinician competence, it is an expectation of the College that Ontario physicians provide care within the scope of their knowledge, skill and judgement.[11] The College acknowledges that clinicians trained and experienced in providing pediatric and adolescent care have a unique skill set and perspective. We encourage the Expert Panel to seek the input of pediatric specialists and societies such as the Canadian Pediatric Society and the Pediatric Chairs of Canada to get expert advice as to whether only those with training and experience in pediatrics or adolescent care should provide MAID to mature minors. Through these discussions, the College encourages the Expert Panel to also examine the availability and accessibility of pediatricians across different communities, particularly those outside of large urban centres and their willingness to be involved in MAID. Should the number of willing providers be low, this may pose very real challenges to access to care for eligible patients.

2. Advance Requests

We note that the term 'advance requests' has not been defined in the Expert Panel's Call for Input and that there are two distinct scenarios (each with distinct implications) that could be captured by this language:

- Scenario #1: a capable patient makes a request for MAID but loses capacity at some point before MAID is provided;
- Scenario #2: a substitute decision maker requests MAID on behalf of an incapable patient, on the basis of the patient's prior capable wish or advance directive.

[11] Section 2(1)(c) of O.Reg. 865/93, Registration, enacted under the *Medicine Act, 1991,* S.O. 1991, c.30.

For the purposes of this submission, the College will assume that both Scenario #1 and #2 are contemplated by 'advance requests'. It will be essential for the Expert Panel to clarify how it is using the term and what specific scenarios 'advance requests' will capture.

On a related point, the Expert Panel may also wish to consider and clarify the intersection of advance requests with the two other topics for review: mature minors and mental illness as a sole underlying condition. That is, whether it is contemplated that the incapable patient making an advance request could be a mature minor and/or could be a patient whose sole underlying condition is mental illness. The College notes that with respect to mature minors, the *HCCA* refers to prior capable wishes as those made by individuals sixteen (16) years of age or older.[12]

Requirements with respect to healthcare decision making for incapable patients are set out in the *HCCA.* The College highlights the following elements of the statute for the Expert Panel's information:

- When making a decision for an incapable patient, substitute decision makers must do so either in accordance with the patient's prior capable wish, if applicable, or with the patient's best interests.[13]
- Substitute decision makers are entitled to make treatment decisions on behalf of incapable patients[14]. 'Treatment' is defined broadly in the *HCCA*[15] and can include decisions that are comparable to MAID such as those to refuse or to withdraw life-sustaining treatment.
- The *HCCA* sets out those individuals who can act as a substitute decision maker.[16] Included in this list are individuals who have a close relationship with the patient, and who therefore are likely to be involved in the patient's personal care and/or likely to be listed as a beneficiary in the patient's will.[17]

[12] Section 21(1) of the *HCCA*.
[13] Section 21(1) and (2) of the *HCCA.*
[14] Section 10(1) of the *HCCA.*
[15] Section 2(1) of the *HCCA.*
[16] Section 20 of the *HCCA.*
[17] The Panel may wish to note that the individuals who can act as a substitute decision maker under the *HCCA* would be precluded from even acting as a witness to a capable patient's request for MAID by virtue of section 241.2(5) of the *Criminal Code* R.S.C., 1985, c. C-46.

- Should the health practitioner believe that the substitute decision maker is not acting in accordance with the patient's prior capable wishes or the patient's best interests, the health practitioner can challenge the substitute decision maker's decision by making an application to the CCB.[18]

In light of these provisions, the Expert Panel may wish to consider the inconsistency that exists between the federal law and the *HCCA* with respect to decision making for incapable patients. Similar to our comments in relation to mature minors, the Expert Panel may wish to consider this inconsistency with the following factors in mind:

- First, whether the inconsistency created between the federal legislation, the *HCCA* and common law related to advance directives is appropriate and the supporting justification or rationale;
- Second, if prior capable wishes or advance directives of patients are deemed not applicable or not binding on MAID, the potential implications this may have on public and physician clarity and comprehension of advance care planning in relation to other treatment decisions;
- Third, the potential impact on clinicians if there are different requirements with respect to healthcare decision making for MAID and for other treatments; and
- Fourth, the implications for patients, specifically access to care, and respect for patient autonomy and prior capable wishes.

A key objective underpinning the federal legislation on MAID is the protection of vulnerable populations. The College supports that objective and acknowledges that risks to incapable patients and appropriate corresponding safeguards should form part of the Expert Panel's study. As with mature minors, the Panel may wish to consider the safeguards included in the *HCCA* to determine whether its provisions related to substitute decision making and the CCB strike an appropriate balance between ensuring sufficient protections for incapable patients, respect for patient autonomy through prior capable wishes or advance directives, and access to care for eligible patients.

With respect to the practical application of advance requests and the need for clinician clarity and confidence, the College anticipates that clinicians will need clarity regarding the individuals

[18] Section 37 of the *HCCA*. See also sections 35 and 36 of the *HCCA* where substitute decision makers or health practitioners can apply to the CCB to seek direction in relation to prior capable wishes (s.35), and direction to depart from wishes (s.36).

who can act as a substitute decision maker in relation to MAID. This will be particularly vital if the individuals who can act as substitute decision makers for MAID differ from those who can act in relation to other healthcare decisions. Second, should the federal government opt to allow for MAID to be requested on behalf of an incapable patient (scenario #2 noted above), it will be essential that the patient's wishes are expressed clearly. We understand that often in practice, advance directives are not clearly written and questions arise as to their enforceability due to ambiguous language or concerns as to whether the advance directive represents the current views or wishes of the patient.

Finally, we flag a practical issue. In practice, there can be a striking contrast between a patient's prior capable wish and the patient's conduct when incapable. Specifically, there may be situations where a patient has expressed a prior capable wish to receive a particular treatment, but then physically recoil or verbally protest when clinicians attempt to provide that very treatment. Clinicians will need clarity about how to proceed in these instances in relation to MAID.

3. Mental Illness as sole underlying condition

The College recognizes that individuals with mental illness who meet the criteria in the federal legislation are currently eligible for MAID. That said, the consideration of mental illness as a sole underlying condition raises a number of complex issues to be considered.

The College strongly encourages the Expert Panel to seek the input of individual experts in psychiatry and relevant organizations such as the Canadian Psychiatric Association , along with individuals in jurisdictions who currently offer MAID to patients with mental illness.

We note there are a range of illnesses, conditions and disorders that can be understood as mental illness and they may each give rise to unique considerations in relation to MAID. The Expert Panel may wish to consider clarifying how mental illness is to be understood and defined in relation to MAID.

As we have noted in our remarks on the two previous topics, capacity is a key element of healthcare decision making. We note that although mental illness can render a patient incapable, many patients with mental illness do have decision making capacity. We have

provided elsewhere links to the *HCCA* and note that that statute explicitly acknowledges the nuances associated with capacity: that capacity is specific to the treatment proposed; that capacity, when lost, can return; and that capacity or incapacity is not global in all areas of a patient's decision making.[19] The College suggests that those provisions and their underlying principles regarding capacity and incapacity form part of the Expert Panel's deliberations on this topic.

Related to capacity and respect for patient autonomy, should the Expert Panel consider the possibility of granting patients with mental illness as a sole underlying condition access to MAID, the College believes it is essential that patients be informed of means available to relieve the suffering caused by their illness, such as mental healthcare and psycho-social supports. Doing so will demonstrate respect for patient autonomy and will enable patients to make an informed decision about MAID.

Related to the clarity and confidence of clinicians, we would note that important interpretive issues arise when thinking about the application of the current eligibility criteria for MAID to patients who have mental illness as a sole underlying condition. We flag below issues related to 'incurable' 'irremediable' and 'reasonably foreseeable death'.

In relation to the concepts of 'incurable' and 'irremediable', we note that,

- Mental illness is typically assessed through subjective means which rely heavily on the patient's own experience or perception of the illness. The patient's perception, however, can be directly impacted by the mental illness itself.
- Mental illness can affect the patient's willingness to try treatments or to continue complying with existing treatment.
- Mental illness can also impact the patient's emotional regulation. Impaired emotional regulation can shape the patient's views of the future, and the extent to which the patient will have a sense of hope or despair about living with their condition and the prospect of recovery.
- We understand that in treating mental illness, the philosophical approach that underpins psychiatric treatment is one of 'recovery' as opposed to 'cure'.

[19] Sections 4, 15, and 16 of the *HCCA.*

In relation to the requirement that the patient's 'natural death be reasonably foreseeable', the College notes that many mental illnesses may carry a risk of suicide. If a patient has a mental illness that carries a risk of suicide, but is otherwise eligible for MAID could his or her death be considered 'reasonably foreseeable'? That is, could the risk of suicide associated with the illness itself be sufficient to satisfy this criterion?

Consideration must be given to what if any, changes may be required to eligibility for MAID or how existing eligibility criteria, if retained, are to be interpreted in relation to mental illness. For instance, it would be important to consider on what standard mental illness would be considered 'incurable' for the purposes of MAID: subjective (patient's views), objective (clinician's views) or a subjective/objective standard.

Should the federal government permit individuals with mental illness as a sole underlying condition to access MAID, it will be important to consider how patient autonomy can be respected and balanced with appropriate safeguards when the patient's wishes and beliefs are linked so inexorably with the mental illness. Safeguards are an important part of the system, yet it is essential to ensure that the autonomy of capable patients is respected and that the safeguards or process steps implemented do not have a discriminatory effect on those with mental illness.

The College offers two comments in relation to clinician competence. First, consistent with our earlier comments regarding mature minors, the College encourages the Expert Panel to evaluate whether it is essential that only those with training and experience in psychiatry and mental health issues provide MAID to those with mental illness as a sole underlying condition. The Canadian Psychiatric Association may be able to assist the Panel in evaluating this matter. Through these discussions, the College encourages the Expert Panel to also examine the availability and accessibility of psychiatrists across different communities, particularly those outside of large urban centres and their willingness to be involved in MAID. Should the number of willing providers be low and yet desired safeguards require the involvement of a psychiatrist, this may pose very real challenges to access to care for eligible patients.

We trust our comments and suggestions are useful to the Expert Panel as it proceeds with its independent reviews of these three topics. We would be happy to provide any further assistance that may be helpful.