Submission by HealthCare*CAN* to the Parliamentary Special Joint Committee on Physician-Assisted Dying

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HealthCareCAN is the national voice of healthcare organizations and hospitals across Canada. We foster informed and continuous, results oriented discovery and innovation across the continuum of healthcare. We act with others to enhance the health of the people of Canada; to build the capability for high quality care; and to help ensure value for money in publicly financed, healthcare programs.

Introduction

HealthCare*CAN* - the national voice of Canadian healthcare organizations and hospitals – appreciates the opportunity to provide comments to inform the work of the Special Joint Committee on Physician-Assisted Dying. The implementation of physician-assisted dying services has far-reaching implications for healthcare institutions.

As a national organization representing Canada's health authorities and hospitals, HealthCare*CAN* would like to begin by emphasizing that there is a range of views among our members with respect to end-of-life care and physician-assisted dying. HealthCare*CAN* is continuing to engage with its members and other stakeholders on this important issue. All HealthCare*CAN* members are committed to ensuring the highest quality of care for patients and their families.

Harmonized Approach

HealthCare*CAN* strongly supports a coordinated, harmonized and consistent approach across the country, and clear parameters, policies and procedures around physician-assisted dying. We commend the important work of this Committee and support a clear federal legislative response to the *Carter v. Canada* decision that respects the Constitution, the Canadian Charter of Rights and Freedoms, and the priorities of Canadians.

Collaboration and coordination by federal, provincial and territorial governments, along with professional regulatory authorities and a range of relevant organizations, institutions and stakeholders, will be required to fully address physician-assisted dying in Canada.

Hospitals and Healthcare Organizations

The Supreme Court of Canada's ruling in *Carter v. Canada* was silent on the role of hospitals and healthcare organizations in assisted death. However, based on the experience of other jurisdictions, the *Carter* decision will have significant implications for hospitals, long-term care facilities, palliative care facilities etc. (where many physician-assisted deaths are likely to occur). The legal availability of physician-assisted dying presents many clinical, operational and ethical complexities for our members.

HealthCare*CAN* would like to emphasize that many healthcare institutions across Canada operate under a specific mission, vision, set of values and/or ethical framework. Our members will be seeking clarity regarding their ability to honour their missions and ethical frameworks while being respectful of the needs and wishes of an individual patient.

Palliative Care

HealthCare*CAN* would also like to emphasize the need for quality palliative care as an option for all patients in the end-of-life period. Far too few Canadians have access to high-quality palliative care when they need it. Canadians also need to be made more aware of the options currently available to them. HealthCare*CAN* strongly supports increased investment in, and enhancement of, high quality palliative and end-of-life care services.

According to a January 2016 study published in the Journal of American Medical Association, Canada has the highest proportion of people with cancer dying in acute care hospitals (52%) compared to other developed countries (for instance, 29.4% in the Netherlands). At the end-of-life, Canada also had the highest per capita hospital expenditures. This is related to Canada's relative lack of high quality palliative care and hospice care compared to other countries.

Canadians are united in their call for better access to quality palliative care. In this regard, HealthCare*CAN* applauds the federal government's plan to invest $3 billion over the next four years to prioritize home care services, including palliative care.

Patient-Centred Care

HealthCare*CAN* stresses the importance of patient-centred care and a patient-centred response. HealthCare*CAN*'s members are committed to providing quality health care services that are respectful and responsive to the preferences, needs and values of patients. This

includes ensuring that patients receive quality end-of-life care, and that treatment wishes are respected.

Processes and pathways for implementation of physician-assisted dying must be patient-centred. For instance, some have suggested a 15-day waiting period after an initial patient request in order to access physician-assisted dying services. However, there may be situations where longer or shorter waiting times may be in the best interests of the patient. Clear communication and ongoing dialogue regarding the patient's experience in managing his or her condition must also be emphasized.

Access to Care

Efforts will need to be made to ensure that access to physician-assisted dying and end-of-life care is reasonably similar across the country. There are many challenges in Canada with respect to the delivery of adequate health care in certain parts of the country. For instance, in many northern and geographically remote communities of Canada, there is an uneven distribution of healthcare providers.

Ensuring access to physician-assisted dying services will likely present similar issues. In some geographic areas and smaller communities, and in rural and remote regions, there may be a lack of providers who are willing and able to provide medical aid in dying. Inadequate training and the issue of conscientious objection by physicians may be factors.

Inter-professional Care

The *Carter v. Canada* decision refers only to *physician*-assisted dying – it is silent on the role of other health professionals. With respect to end-of-life care and physician-assisted dying, ongoing collaboration and inter-professional care - with a patient-centred focus - is essential. Expectations with respect to different health professionals will require clarification and legal safeguards will need to be articulated.

Inter-professional health teams are present in a variety of care settings and are integral to providing good care. There must be recognition that different health professionals may be involved (including nurse practitioners, registered nurses, pharmacists, psychologists, social workers, spiritual care workers or others) in fulfilling a patient's request for physician-assisted dying. A nurse, for instance, may be the first person that a patient turns to with respect to discussing the option of assisted dying. Medications for physician-assisted dying will most likely be dispensed by a pharmacist. Consideration of other health professionals may also be

necessary to ensure equal access (for example, in northern and remote communities of Canada) and high quality of care.

Need for Clarity

There are a number of areas of potential uncertainty with respect to physician-assisted dying that require clarification. For instance, hospitals and other healthcare organizations can anticipate difficult cases where medical aid in dying may be requested, and where the criteria outlined in the *Carter* case will need to be applied (for example: by patients who are "mature minors" – "adult" as used in the *Carter* decision does not necessarily mean age of majority; by patients with capacity but with significant underlying mental health issues; by patients with cognitive impairment; and so on). Clear definitions of terms used in the *Carter* decision (including "grievous and irremediable medical condition") are required. HealthCare*CAN*'s members – as well as all Canadians – will be seeking clarity around these and other areas.

Conscientious Objection

With respect to conscientious objection, the Supreme Court of Canada said that, "[n]othing in this declaration would compel physicians to provide assistance in dying. The Charter rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgement." Although the Supreme Court was silent on the role of other health professionals, it is clear that respect for conscientious objection will be relevant for the range of health providers that may be involved.

HealthCare*CAN* believes that physicians who are unwilling to provide physician-assisted dying services must communicate their perspectives in a manner that respects patient dignity, with sensitivity and without expressing personal moral judgment. Further, patients should be provided with information about all options that may be available or appropriate to meet the patient's needs, concerns and/or wishes. Efforts should be made to explore all factors that contribute to intolerable suffering and seek ways to assist in alleviating suffering.

HealthCare*CAN* recognizes that there is some controversy with respect to the issue of "effective referral" to another provider. We know that some physicians working in some of our institutions are concerned about the requirement to provide an effective referral to a provider willing to provide physician-assisted dying. Although many physicians (who choose not to provide assistance in dying) will not have a problem with referral, for others, the provision of a referral may be viewed as a violation of moral integrity. To maintain an ongoing therapeutic

relationship, a physician may prefer to provide further information about physician-assisted dying, rather than a direct referral.

As well, some physicians are concerned about having sufficient knowledge of referral pathways. Others are also concerned about the possibility of limited access to high quality end-of-life care and physician-assisted dying.

With these factors in mind, novel methods for referral and facilitating access may need to be explored in order to ensure access to physician-assisted dying and also respect for the right of a physician to conscientiously object. For example, the establishment of centralized bodies and information systems could be explored to ensure high quality information and continuity of care. The development of a separate and parallel system to provide information, counselling and referral that can be directly accessed by patients, families, health care professionals and institutions could be examined.

Conclusion

In conclusion, HealthCare*CAN* would like to thank the Committee for this opportunity to provide input on this important issue. HealthCare*CAN* will continue to engage with its members and other stakeholders. As the federal response to the *Carter v. Canada* decision unfolds, HealthCare*CAN* and its members would welcome the opportunity to provide further input to federal representatives.