

February 4, 2016

Hon. Kenneth Ogilvie, P.C.
Co-Chair
Special Joint Committee on Physician-Assisted Dying

Robert Oliphant, M.P.
Co-Chair
Special Joint Committee on Physician-Assisted Dying

Re: Correcting misinformation about the position of the Canadian Medical Association

Dear Senator Ogilvie and Mr. Oliphant:

On behalf of Canada's physicians, I am writing to correct misinformation provided to the Special Joint Committee on Physician-Assisted Dying (Special Joint Committee) regarding the position of the Canadian Medical Association (CMA) by some witnesses in their appearances.

The CMA is concerned that the Special Joint Committee was provided incorrect information as part of the testimonies of witnesses during its eighth and tenth meetings. During these meetings, witnesses misrepresented the CMA's position with respect to the role of the physician and conscientious objection.

Prior to proceeding with the development of the report of the Special Joint Committee, we are writing to provide clarification on critical aspects of the CMA's *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (CMA's recommendations).

The Special Joint Committee was incorrectly informed that the CMA "has essentially said there should be a requirement to refer." This statement is categorically untrue and misrepresents the CMA's recommendations.

Below is an excerpt of the relevant section of the CMA's recommendations:

"5.2 Conscientious objection by a physician

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

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chooses not to provide or participate in assisted dying.

Physicians are obligated to respond to a patient's request for assistance in dying. There are two equally legitimate considerations: the protection of physicians' freedom of conscience in a way that respects differences of conscience and the assurance of effective patient access to a medical service. In order to reconcile physicians' conscientious objection with a patient's request for access to assisted dying, physicians are expected to provide the patient with complete information on all options available, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service.

Physicians are expected to make available relevant medical records (i.e., diagnosis, pathology, treatment and consults) to the attending physician when authorized by the patient to do so; or, if the patient requests a transfer of care to another physician, physicians are expected to transfer the patient's chart to the new physician when authorized by the patient to do so.

Physicians are expected to act in good faith, not discriminate against a patient requesting assistance in dying, and not impede or block access to a request for assistance in dying."

A second area at issue is with respect to the information provided to the Special Joint Committee during its tenth meeting in response to the CMA's testimony that access would not be constrained based on a system that does not impose mandatory referral requirements on physicians that may conscientiously object. As set out in the CMA's recommendations, physicians would be required to provide their patient with information on all options available including advising their patients how to access a separate central information service. Further, the CMA clearly outlines objecting physicians' positive – and well-accepted – obligations not to abandon their patients and transfer care at the patient's request.

The CMA's member surveys indicate that approximately 30% of physicians will provide assisted dying following the Carter ruling. While this may seem like a minority, in actuality it represents more than 24,000 physicians. Further, this proportion significantly exceeds the proportion of physicians that participate in assisted dying where it is in place in other jurisdictions. In the Netherlands this figure is 12%, in Belgium it is less than 2.5% and in Oregon it is less than 0.6%.

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Based on the experiences in other jurisdictions, it is the CMA's position that access will not be impeded based on the proportion of physicians that may choose not to participate based on conscience. We must re-emphasize that the arguments being advanced to suggest otherwise are unnecessarily creating conflict and forcing legislators and regulators to take a decision based on a false dichotomy.

The CMA encourages the Special Joint Committee to ensure the CMA's recommendations are accurately represented as part of its final report to Parliament. To this end, the CMA welcomes the opportunity to provide any further information that may support the Special Joint Committee in its study on this critical matter.

Yours sincerely,



Cindy Forbes, MD, CCFP, FCFP
President



Dr. Jeff Blackmer, MD, MHSc, FRCPC
Vice President, Medical Professionalism

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Principles-based Recommendations for a Canadian Approach to Assisted Dying

Principles-based Recommendations for a Canadian Approach to Assisted Dying

In February 2015, the Supreme Court of Canada released its decision in *Carter v. Canada* that challenged the constitutional validity of Criminal Code provisions prohibiting physician-assisted dying in Canada. In a unanimous decision, the Supreme Court SCC ruled that the Criminal Code provisions on voluntary euthanasia (section 14) and assisted suicide (section 241(b)) are constitutionally invalid in that they violated the right to life, liberty and security of the person under the Canadian Charter. The Supreme Court suspended its decision for 12 months to give governments time to consider the development of legislation and/or regulations; they additionally granted a four-month extension on Jan. 15, 2016. Following the 16-month suspension, assisted dying will be legal in Canada, and no longer a criminal act, even if legislation is not enacted in response to the Supreme Court's ruling.

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

The goal of this process was two-fold: to foster discussion and develop recommendations on a suite of ethical-legal principles; and to provide input on specific issues that are particularly physician-sensitive and are worded ambiguously or not addressed in the Supreme Court's decision.

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

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

Foundational principles

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

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

10. **Mutual respect:** There should be mutual respect between the patient making the request and the physician who must decide whether or not to perform assisted dying. A request for assisted dying is only possible in a meaningful physician-patient relationship where both participants recognize such a request. There should be mutual respect among physicians who hold different perspectives on the appropriateness of assisted dying.

Recommendations

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

1. Patient eligibility for access to assisted dying

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

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

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

1.2 Informed decision

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

1.3 Capacity

- The attending physician must be satisfied, on reasonable grounds, that all of the following conditions are fulfilled:
 - The patient is mentally capable of making an informed decision at the time of the request(s).
 - The patient is capable of giving consent to assisted dying, with particular attention being paid to the potential vulnerability of the patient in these circumstances.
 - Communications include exploring the priorities, values and fears of the patient in significant depth, providing information related to the patient's diagnosis and prognosis, treatment options including palliative care and other possible interventions and answering the patient's questions.
- If the attending physician and/or the consulting physician determines that the patient is incapable, the patient must be referred for further capacity assessment.
- Only patients on their own behalf can make the request while competent.

1.4 Voluntariness

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

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

Stage 1: Requesting assisted dying

1. The patient submits at least two oral requests for assisted dying to the attending physician over a period of time that is proportionate to the patient's expected prognosis (i.e., terminal vs non-terminal illness).
2. The CMA supports the view that a standard waiting period is not appropriate for all requests. The patient's prognosis is the critical factor. The CMA recommends generally waiting a minimum of 14 days between the first and the second oral requests for assisted dying. This is a benchmark. In some cases, depending on the patient's situation, this could be shorter.

3. The patient then submits a written request for assisted dying to the attending physician. The written request must be completed via a special declaration form that is developed by the government/department of health/regional health authority/health care facility. If the patient is unable for whatever reason to submit a written request, he or she may make an oral request that must be documented in writing by a proxy via an established declaration form.
4. Ongoing analysis of the patient's condition and ongoing assessment of requests should be conducted for longer waiting periods.

Stage 2: Before undertaking assisted dying

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

Stage 3: After undertaking assisted dying

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

3. Role of the physician

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

3.2 Patient assessment

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

3.3 Consultation requirements

- The attending physician must consult a second physician, independent of both the patient and the attending physician, before the patient is considered eligible to undergo assisted dying.
- The consulting physician must

- Be qualified by specialty or experience to render a diagnosis and prognosis of the patient’s illness and to assess the patient’s capacity as noted in Stage 2 above.

3.4 Opportunity to rescind request

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

3.5 Documentation requirements

- The attending physician must document the following in the patient’s medical record:
 - All oral and written requests by a patient for assisted dying;
 - The attending physician’s diagnosis and prognosis, and his/her determination that the patient is capable, acting voluntarily and has made an informed decision;
 - The consulting physician’s diagnosis and prognosis, and verification that the patient is capable and acting voluntarily, and has made an informed decision;
 - A report of the outcome and determinations made during counselling;
 - The attending physician’s offer to the patient to rescind the request for assisted dying;
 - A note by the attending physician indicating that all requirements have been met and indicating the steps taken to carry out the request.

3.6 Oversight body and reporting requirements

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

4. Responsibilities of the consulting physician

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

review.

5. Moral opposition to assisted dying

5.1 Institutional objection by a health care facility or health authority

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

5.2 Conscientious objection by a physician

- Physicians are not obligated to fulfill requests for assisted dying. This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or to participate in it or to refer the patient to a physician or a medical administrator who will provide assisted dying to the patient. There should be no discrimination against a physician who chooses not to provide or participate in assisted dying.
- Physicians are obligated to respond to a patient's request for assistance in dying. There are two equally legitimate considerations: the protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience and the assurance of effective patient access to a medical service. In order to reconcile a physician's conscientious objection with a patient's request for access to assisted dying, physicians are expected to provide the patient with complete information on all options available, including assisted dying, and advise the patient on how to access any separate central information, counselling and referral service.
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