CPSO 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. On this date, 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.

Should government develop a framework to govern the provision of physician-assisted death, that framework will take priority over the guidance provided in this document.

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.

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

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

- 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 their 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 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 Ontario physicians should only provide physician-assisted death to residents of Ontario, who are insured under the Ontario Health Insurance Plan (OHIP).

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* (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 understand and appreciate the history and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

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 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 patient must understand and appreciate the certainty of death upon taking or having the physician administer the lethal 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.

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*. 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.

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 request for physician-assisted death must be non-ambivalent. The patient must have requested physician-assisted death him/herself, thoughtfully and in a free and informed manner.

During this time of regulatory uncertainty, the College advises physicians to decline requests for physician-assisted death when made 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 to capture both terminal conditions and chronic conditions that by their nature cannot be cured. As stated by the SCC,

'irremediable' does not require the patient to undertake treatments that are not acceptable to the individual.[2]

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

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 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 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, 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.

The following professional expectations are consistent with this policy:

- 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 care, even if that care conflicts with their conscience or religious beliefs.

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

- The physician must communicate his/her objection to the patient directly and with sensitivity, and 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 to another health-care provider must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency.[3] The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral.

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 must be documented, as well as the physician's determination that the patient is capable, acting voluntarily and has made an informed decision.

[3] 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.

IV. Sample Process Map for Physician-Assisted Death[4]

The following process map outlines the steps that physicians may elect to follow in circumstances where a patient requests physician-assisted death. This process map, which has been adapted from guidance provided in jurisdictions outside of Ontario, sets out specific practice-related elements for physicians who are willing to provide physician-assisted death. As described above, where physicians are unwilling to provide physician-assisted death for reasons of conscience or religion, an effective referral to another health-care provider 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.
- 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 in the circumstances of his or her condition.
- 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.

WAITING PERIOD

- A waiting period of 15 days, prior to the patient submitting a second request for physician-assisted death, is advised.
- In situations where time is of the essence, a shorter timeline may be considered.

SECOND REQUEST – DOCUMENTARY REQUIREMENT / WITNESSES

- The second request for physician-assisted death by the patient requires formal documentation. This follow-up request may be oral and transcribed by another party, or written by the patient.
- The written request must be dated and signed by the patient, and include the signature of two witnesses who can attest that the patient is capable, acting voluntarily, and free from coercion.
- The College advises that one of these witnesses not be someone who is: the attending or consulting physician; a relative; entitled to any portion of the estate; or an owner, operator, or employee of a health care facility where the patient is receiving treatment.

[4] 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).

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

CAPACITY ASSESSMENT AND SECOND OPINION BY CONSULTING PHYSICIAN

- 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.
- A second consulting physician must ensure that the requisite criteria for physician-assisted death have been met. This includes assessing the patient's capacity and voluntariness.
- Both the attending and consulting physician must independently document that the patient is competent and able to consent.
- If at any time the patient loses the mental capacity to rescind his/her decision, physician-assisted death ceases to be an option.

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Stage 3: Self-Administration or Physician Administration of Fatal Dose

- 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.

- 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. 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 should 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 when providing physician-assisted death. Physicians may wish to consult the following peer-reviewed journal articles for drug protocols used in jurisdictions where physician-assisted death is legalized:

    i. Willems, D.L., Groenewoud, J.H., van der Wal, G. (1999). Drugs used in physician-assisted death. *Drugs & Aging*. 15(5), 335-340.

    ii. Swarte, N.B. & Heintz, A.P. (2001). Guidelines for an acceptable euthanasia procedure. Best Practice & Research. *Clinical Obstetrics & Gynaecology*. 15(2), 313-321.

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V. 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 the federal and/or provincial legislative 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.