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Submission to the College of Physicians and Surgeons of Ontario

Re: *Medical Assistance in Dying* (2022)

Abstract

The College of Physicians and Surgeons of Ontario (CPSO) has invited comment on a draft revision of its euthanasia/assisted suicide policy, *Medical Assistance in Dying* (*CPSO MAID 2022*). The focus of this submission is on issues related to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral in relation to euthanasia and assisted suicide (EAS, “medical assistance in dying”, MAID).

The CPSO has indicated that it does not consider EAS requests to be emergencies. However a source cited in *CPSO MAID 2022* indicates otherwise, and *CPSO MAID 2022* is silent on the issue. *CPSO MAID 2022* should explicitly confirm CPSO statements that MAID is not a treatment option in an emergency, requests for MAID are not emergencies, and physicians are never required to assess patients for or provide the service.

Failed self-administration of lethal EAS medication can bring patients to hospital emergency rooms. Requiring EAS practitioners to be present and remain with patients self-administering EAS drugs until death ensues would prevent this and other problems, like delayed discovery of corpses in circumstances that would trigger police and coroner investigations.

CPSO MAID 2022 requires EAS practitioners to falsify death certificates. This is contrary to accepted international standards and can be considered deceptive, unethical or professionally ill-advised. EAS practitioners unwilling to falsify death certificates should not be compelled to do so.

Practitioners who believe that a patient is ineligible for MAID must refuse to provide euthanasia or assisted suicide or do anything to facilitate the services. Prominent medical practitioners insist that it is impossible to establish that mental illness is irremediable. The CPSO has no basis to proceed against them if they refuse to do anything to further an EAS request based on mental illness alone.

Patients can sign a waiver authorizing euthanasia if they lose capacity to consent before the time appointed for the procedure. They may later express ambivalence, or having apparently lost capacity, express ambivalence about proceeding with euthanasia at the appointed time. However, the benchmark set by the *Criminal Code* is refusal. EAS practitioners may legally proceed if the patient expresses only ambivalence. *CPSO MAID 2022* should provide ethical direction or guidance in relation to the response expected from EAS practitioners in such circumstances.

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Introduction

The College of Physicians and Surgeons of Ontario (CPSO) has invited comment on a draft revision of its euthanasia/assisted suicide policy, *Medical Assistance in Dying* (*CPSO MAID 2022*)[1] and on two companion resources: *Advice to the Profession: Medical Assistance in Dying*[2] and *Medical Assistance in Dying: Legal Requirements*.[3]

The Protection of Conscience Project does not take a position on the acceptability of euthanasia and practitioner-assisted suicide (EAS). The Project's interest is confined to issues related to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral.

I. Avoiding conflicts in urgent situations

"Emergency" requests

I.1 "*Ideally*," the Canadian Association of MAID Assessors and Providers (CAMAP) advised a parliamentary committee, "MAID should never be done as an emergency" (emphasis added).[4] CAMAP's concern was that many patients were so late in requesting the procedure that euthanasia/assisted suicide had to be expedited because natural death or loss of capacity was imminent. In such circumstances, euthanasia/assisted suicide was apparently considered an emergency.

CPSO position

I.2 *CPSO MAID 2021* states that the College "does not consider a request for medical assistance

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[1] College of Physicians and Surgeons of Ontario, "Medical Assistance in Dying Draft" (ca September, 2022), *College of Physicians and Surgeons of Ontario* (website), online: <http://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Medical-Assistance-in-Dying_Draft-Policy.pdf> [*CPSO MAID 2022*].

[2] College of Physicians and Surgeons of Ontario, "Advice to the Profession: Medical Assistance in Dying Draft" (ca September, 2021), *College of Physicians and Surgeons of Ontario* (website), online: <https://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Medical-Assistance-in-Dying_Draft-Advice.pdf> [*CPSO Advice: MAID 2022*].

[3] College of Physicians and Surgeons of Ontario, "Medical Assistance in Dying: Legal Requirements Draft" (ca September, 2021), *College of Physicians and Surgeons of Ontario* (website), online: <https://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Medical-Assistance-in-Dying_Draft-Legal-Requirements.pdf> [*CPSO MAID:Law*].

[4] Canadian Association of MAID Assessors and Providers, "Written Brief to the Standing Committee on Justice and Human Rights House of Commons Canada" (5 November, 2020), *Parliament of Canada* (website), online: <https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR10946104/br-external/CanadianAssociationOfMaidAssessorsAndProviders-e.pdf> [*CAMAP Brief*] at 3.

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in dying to be an emergency."[5] A similar — not equivalent — statement is intended for a footnote in the draft *Human Rights in the Provision of Health Services* policy (*CPSO Human Rights 2022*):

> For clarity, MAID would never be a treatment option in an emergency and physicians are not required to assess patients for or provide MAID under any circumstances.[6]

I.3 However, *CPSO MAID 2022* — the College's central policy on euthanasia/assisted suicide (EAS) — does not state that physicians will not be required to provide or directly assist in euthanasia or assisted suicide under any circumstances, nor does it state that the College does not consider a request for the procedures to be an emergency.

Requests for "emergency continuation"

I.4 The absence of this explicit assurance is troubling because *CPSO MAID 2022* recommends a CAMAP paper (*CAMAP: Complications*)[7] as an authoritative resource for EAS practitioners.[8] The paper advises Canadian EAS practitioners attempting euthanasia in patients' homes to call 911 for ambulance personnel to help if they are unable to obtain IV access when it is immediately required, or if they are unable to provide "intraosseous infusion emergently." They are advised, or to transport the patient to hospital if need be so that an intravenous line can be inserted by emergency room (ER) staff.[9] According to *CAMAP: Complications*, 3 of over 300 Canadian ER practitioners had encountered such cases.[10,11] The recommendation to call 911 for help with emergency lethal infusion is inconsistent with the view that requests for EAS cannot be considered an emergency.

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[5] "Medical Assistance in Dying" (April, 2021), College of Physicians and Surgeons of Ontario (website), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying> [*CPSO MAID 2021*] at endnote 20.

[6] "Human Rights in the Provision of Health Services Draft" (ca September, 2022), College of Physicians and Surgeons of Ontario (website), online: <http://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Human-Rights-in-the-Provision-of-Health-Services_Draft-Policy.pdf> [*CPSO Human Rights 2022*] at footnote 16.

[7] F Bakewell, VN Naik, "Complications with Medical Assistance in Dying (MAID) in the Community in Canada: Review and Recommendations" (28 March, 2019), Canadian Association of MAiD Assessors and Providers (website) [*CAMAP: Complications*] online: <https://camapcanada.ca/wp-content/uploads/2022/02/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf>.

[8] *CPSO MAID 2022*, *supra* note 1 at footnote 14.

[9] *CAMAP: Complications*, *supra* note 7 at Executive Summary para 7-10; p 7; Summary Flowchart.

[10] *Ibid* at 5, "Canadian experience".

[11] *CAMAP: Complications*, *supra* note 6 refers to 3 of 335 surveyed physicians, but the published report (by one of the authors of the CAMAP paper) states that there were 303 responses to the survey. cf F Bakewell, "Medical assistance in dying – a survey of Canadian emergency physicians" (2019) 21:S1 CJEM, 21(S1) S66 at S66, online: <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/D96B1D187CDFDED97DAA905ED08FA2B2/S1481803519002008a.pdf/p009-medical-assistance-in-dying-a-survey-of-canadian-emergency-physicians.pdf>.

I.5 Further, paramedic regulators in British Columbia,[12] Saskatchewan,[13] Nova Scotia[14] and Alberta[15] acknowledge that paramedics may be called by EAS practitioners to insert an intravenous line. Alberta Health Services has a detailed Emergency Medical Services protocol that anticipates 911 calls by practitioners seeking paramedic assistance in providing EAS.[16] EAS practitioners on Vancouver Island, which has the highest regional EAS death rate in the world,[17] have made arrangements with hospitals to admit patients "as an emergency for continuation of the procedure" should difficulties arise with EAS provision outside hospital settings.[18] The protocol is available on British Columbia's General Practice Services Committee website, a committee representing physicians, Ministry of Health, Doctors of BC, BC Family Doctors and regional health authorities.[19] And calling 911 for help with EAS and taking EAS candidates to hospital emergency departments was suggested in Ontario even before publication of the CAMAP paper recommending it.[20] In sum, it appears that requests for active assistance in providing EAS are treated as emergencies by mainstream actors in Canada's public healthcare system, not excluding Ontario.

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[12] "BC Emergency Health Services Clinical Practice Guidelines 2021" (February, 2021), BC Emergency Health Services (website), online: <https://handbook.bcehs.ca/Content/cpgmedia/BCEHS_ClinicalPracticeGuidelines.pdf> at P08: Medical Assistance in Dying (MAID).

[13] Saskatchewan College of Paramedics, "Medical Assistance in Dying (MAID): Guidelines for Paramedic Practitioners" (2 May 2017), Saskatchewan College of Paramedics (website), online: <https://collegeofparamedics.sk.ca/wp-content/uploads/2019/11/2017-MAID-Guidelines.pdf>.

[14] College of Paramedics of Nova Scotia, "CPNS Guidance on Medical Assistance in Dying (MAiD)", College of Paramedics of Nova Scotia (website), online: <https://www.cpns.ca/public/download/files/196033>.

[15] Alberta College of Paramedics, "Position Statement: Medical Assistance in Dying" (October, 2017), Alberta College of Paramedics (website), online: <https://abparamedics.com/wp-content/uploads/2020/02/Position-Statement-MAID-October-2017.pdf>.

[16] Alberta Health Services, "EMS requests related to medical assistance in dying events" (12 June, 2019), Alberta Health Services (website), online: <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-ems-req-med-assist-dying-events-ps-ems-09.pdf>.

[17] Canadian Association of MAID Assessors and Providers, "Written Brief to the Standing Committee on Justice and Human Rights House of Commons Canada" (5 November, 2020), Parliament of Canada (website), online: <https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR10946104/br-external/CanadianAssociationOfMaidAssessorsAndProviders-e.pdf> [*CAMAP Brief*] at 3.

[18] Jonathan Reggler, Tanja Daws, "Medical Assistance in Dying (MAID) Protocols and Procedures Handbook 2017 2nd edition",General Practice Services Committee (website), online: <https://divisionsbc.ca/sites/default/files/51936/Medical%20Assistance%20in%20Dying%20(MAID)%20Protocols%20and%20Procedures%20Handbook%20Comox%20Valley%202017%20-%202nd%20edition_0.pdf> at 16.

[19] General Practice Services Committee, "Who We Are" (2020), General Practice Services Committee (website), online: <https://gpscbc.ca/who-we-are >.

[20] Julie Campbell, "Taking the Mystery Out of MAID" (Powerpoint presentation delivered at the meeting of the Elgin South West Primary Care Alliance, 7 June, 2018), South West Primary Care Alliance (website), online: < https://swpca.ca/Uploads/ContentDocuments/Elgin_PCA_Meeting_Jun_7_2018.pdf> at slide 25.

Expedited EAS and ER presentation

I.6 Beyond requests for "emergency continuation" of EAS, the Project's 2016 and 2021 CPSO submissions noted that the condition of a patient approved and scheduled for EAS may suddenly and unexpectedly deteriorate, triggering an "emergency" request for EAS before the appointed time.[21] The same scenario was proposed in a 2018 article within the context of hospital emergency room practice.[22] Further, according to *CAMAP: Complications*, in 1 of 13 known cases of self-administration of EAS drugs, a patient was taken to hospital by emergency medical services "as a result of adverse effects or a delayed death."[23]

I.7 It is almost inconceivable that an ER physician in such circumstances would be in a position to fulfil the legal obligations associated with the provision of EAS for a pre-approved and capable patient.[24] When EAS remains a legal option, one of the authors of *CAMAP: Complications* suggested in 2016 that it would likely be more appropriate to ask the initial EAS practitioner to come and "administer a lethal medication in the ED."[25] In any case, CAMAP warns, "No clinician should administer life-ending medications who was not involved in the MAID assessment and consent process."[26]

Issues

I.8 The Project's concern is that practitioners willing to withhold treatment or alleviate a patient's distress by palliative interventions may be unwilling to kill the patient or assist with suicide. Widespread description of requests for EAS or assistance in EAS as emergencies will likely lead to demands that they provide or facilitate EAS, especially if patients arrive at emergency rooms with requests for completion of or assistance with euthanasia or assisted suicide.

I.9 In addition, the Project shares concerns expressed by others that the cases discussed in I.4 to I.6 "are difficult and emotionally distressing for physicians, patients, and families"[27] and that they

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[21] "Protection of Conscience Project Submission to the College of Physicians and Surgeons of Ontario re: Medical Assistance in Dying (December, 2018 update) " (27 April, 2021), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-030-001-cpso.aspx#I.> [*Project 2021 Submission*] at I.

[22] Thara Kumar, Richard Hoang, "Dying to Know More: Death and Dying in the ED in the Era of MAiD" (20 September, 2018) EM Ottawa (blog), online: <https://emottawablog.com/2018/09/dying-to-know-more-death-and-dying-in-the-ed-in-the-era-of-maid/> [Kumar & Hoang] at Case 3.

[23] *CAMAP: Complications*, *supra* note 7 at 8, "Canadian experience".

[24] *Criminal Code*, RSC 1985, c C-46 (18 October, 2022), Government of Canada (website) online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-33.html#h-119953> [*Criminal Code*] at s 241.2(3).

[25] F Bakewell, "Medical Assistance in Dying (MAID) in the ED: Implications for EM Practice" (22 June, 2016) CanadiEM (blog), online: <https://canadiem.org/medical-assistance-dying-maid-ed-part-ii/>.

[26] *CAMAP: Complications*, *supra* note 7 at 7.

[27] *Kumar & Hoang*, *supra* note 22.

"frustratingly require making rapid decisions with limited information and challenging emotions."[28] It is in the interests of all concerned to prevent such situations from arising.

Recommendations

Policy clarification

I.10 The Project recommends that relevant statements in *CPSO MAID 2021* and *CPSO Human Rights 2022* be combined and incorporated explicitly into *CPSO MAID 2022* as follows:

> The College does not consider a request for MAID to be an emergency or a treatment option in an emergency. Physicians are not required to assess patients for or provide MAID under any circumstances.[29]

Measures to prevent urgent requests and conflict

I.11 *CPSO MAID 2022* introduces requirements for technical proficiency of EAS practitioners and a contingency plan to address complications.[30] However, it does not include measures recommended by the Project in 2016[31] and repeated here, two of which are now supported by CAMAP in whole or in part:

> i) In all cases, a practitioner who agrees to provide euthanasia or assisted suicide (the most responsible EAS practitioner) should personally administer the lethal drug or be personally present when it is self-administered, and remain with the patient until death ensues.
>
> **cf CAMAP:** "We strongly recommend that clinicians should be present with patients during oral self-administration of MAID, and should remain present until the patient's death."[32]
>
> ii) The most responsible EAS practitioner must be continuously available to promptly provide the service from the time the EAS agreement is made to the time that the procedure is performed, unless the patient withdraws the request for the service.
>
> **cf CAMAP:** "If a patient refuses the presence of a clinician in a province/territory where clinician attendance is not mandatory, the

[28] David H Wang, "No Easy Way Out: A Case of Physician-Assisted Dying in the Emergency Department" (2018) 72(2) Annals of Emergency Medicine:206-210 [*Wang 2018*] at 206, online: <https://www.annemergmed.com/article/S0196-0644(17)31540-8/fulltext>.

[29] cf *CPSO MAID 2021*, *supra* note 5 at endnote 20 and *CPSO Human Rights 2022*, *supra* note 6 at footnote 16.

[30] *CPSO MAID 2022*, *supra* note 1 at §2(c) and §7, lines 31–32, 69--70.

[31] *Project 2021 Submission*, *supra* note 21 at I.8, online: <https://www.consciencelaws.org/publications/submissions/submissions-030-001-cpso.aspx#I-rec>.

[32] *CAMAP: Complications, supra* note 7 at 9.

clinician prescribing the MAID medications should be readily available to be called by the patient or any other persons."[33]

iii) The most responsible EAS practitioner must arrange for a second EAS practitioner to promptly provide the service if the most responsible EAS practitioner cannot be continuously available or is unable to act promptly in response to an urgent request.

iv) The second EAS practitioner must be continuously available to act promptly in the place of the most responsible EAS practitioner.

I.12 Arguments by the Project, CAMAP and others have thus far failed to convince the CPSO to require physicians to be present when EAS drugs are self-administered. Particularly in view of the pending legalization of euthanasia and assisted suicide as treatments for mental illness, four purely pragmatic arguments may be more persuasive.

i) It is well attested that hospital emergency rooms across the country are frequently understaffed and are sometimes unable to provide timely treatment to patients in need of urgent interventions.[34] Similarly, difficulties caused in emergency rooms by patients presenting after unsuccessful self-administration of EAS drugs have been documented and can be foreseen.[35] Requiring physicians to be present for self-administration of EAS drugs will prevent already overloaded emergency rooms from being needlessly burdened by complications from self-administration of EAS drugs.

ii) Assisted suicide that does not comply with the terms of the *Carter* decision and *Criminal Code* remains a serious criminal offence, as does counselling suicide. Pressures brought to bear on a patient by others present (who may have personal interests in ensuring the death of the patient) may vitiate legal criteria for voluntariness, or those present may explicitly counsel suicide. These crimes are of particular concern in the case of suicide by people who are mentally ill.

iii) A patient may decide to commit suicide alone, either in a private place or in a public place. Assuming the suicide is successful, the corpse might not be found in a private place for some time. Presumably the corpse would be found much sooner in a public place, especially if the deceased chose to consume lethal medication while watching the sunset at Toronto Island Park. People who discover

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[33] *CAMAP: Complications*, *supra* note 7 at 9.

[34] Jennifer Lee, "Teen's 'nightmare' hospital wait a symptom of Alberta's health-care breakdown, doctors warn", CBC News (29 September, 2022), online: <https://www.cbc.ca/news/canada/calgary/teen-s-nightmare-hospital-wait-a-symptom-of-alberta-s-health-care-breakdown-doctors-warn-1.6599216>.

[35] *Kumar & Hoang*, *supra* note 22; *Wang 2018*, *supra* note 28; CAMAP: Complications, supra note 7 at 9.

corpses are not infrequently distressed by the experience, especially if the corpse is in an apartment and badly decomposed, or if they come across a corpse while walking in a park with their children.

iv) The discovery of a corpse in such circumstances would trigger investigations by the police and coroner. It might take several days to identify the deceased, establish that the death was the result of a legal assisted suicide, and rule out the possibility that, notwithstanding the legal involvement of a physician, the death was not actually a homicide. This process would involve many man-hours and significant associated expense, including (in many cases) a forensic autopsy. It would, in addition, probably delay or hinder other active death investigations.

II. Falsifying death certificates

Classification of death

II.1 The *International Statistical Classification of Diseases and Related Health Problems* (*ICD*) was originally designed "to classify causes of mortality as recorded at the registration of death." It now serves a broader purpose: "to permit systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times."[36] However, it remains the key international standard for identifying causes of death in death certificates,[37] and it is explicitly recognized as an authoritative standard for this purpose by the government of Canada[38] and government of Ontario.[39]

II.2 For purpose of statistical coding of external causes of injuries and death, the *ICD* includes homicide in the category of assault: "injuries inflicted by another person with intent to injure or kill, by any means."[40] The point of this categorization is to identify and distinguish the sources of lethal acts, not to reflect their legal status. For example, the *ICD* category "assault" would include injuries inflicted in a mixed martial arts competition (cage-fighting), even though such consensual fights may not be considered assaults in law.

II.3 Euthanasia that conforms to the Medical Assistance in Dying provisions in the *Criminal Code* is legal in Canada (non-culpable homicide). Practitioner-administered MAID (euthanasia) is identifiable as "homicidal poisoning" in the *ICD*.[41] Note that it is not a death caused by a "legal intervention" within the meaning of the *ICD*, which explicitly limits legal interventions to actions by the police, military "or other law-enforcing agents" during some kind of law enforcement action[42] under some kind of permanent or temporary "ruling authority."[43]

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36 World Health Organization, *International Statistical Classification of Diseases and Related Health Problems: 10th Revision*, 5th ed, vol 2 (Geneva, Switzerland: 2016) [*ICD 2016*], online: <https://icd.who.int/browse10/Content/statichtml/ICD10Volume2_en_2016.pdf > at 2.1.

37 *Ibid* at 4.1.1

38 Government of Canada, "Statistics Canada, Canadian Vital Statistics - Death database (CVSD)" (23 September, 2020), *Government of Canada* (website), online: <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3233>.

39 Ontario Ministry of Government and Consumer Affairs, Office of the Registrar General, "Handbook on Medical Certification of Death & Stillbirth: Prepared for Physicians and Coroners (December, 2019), *Government of Ontario* (website), online: <https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf> [*Death Certification 2019*] at footnote 2 and p 8.

40 World Health Organization, *International Statistical Classification of Diseases and Related Health Problems: 10th Revision*, 5th ed, vol 1 (Geneva, Switzerland: 2019) [*ICD 2019*] , online: <https://icd.who.int/browse10/2016/en#/X85-Y09> at X85-Y09.

41 *Ibid* at X85.

42 *Ibid* at XY35.

43 *Ibid* at Y35.5.

II.4 Self-administration of a lethal substance that conforms to the Medical Assistance in Dying provisions in the *Criminal Code* is identifiable as suicide by "purposeful self-inflicted poisoning" under the *ICD*. The *ICD* explicitly states that suicide must not be attributed to any other cause.[44,45]

Cause of death

II.5 The *Criminal Code*'s definition of medical assistance in dying[46] is incorporated into the definition in *CPSO MAID 2022* (i.e., a practitioner administers medications "that *cause* a patient's death" or patients self-administers prescribed medication "to *cause* their own death").

II.6 *Criminal Code* provisions allowing practitioners to "*cause* the death" of patients who have lost capacity[47] are also reflected in *CPSO MAID 2022*, which states that patients should be warned that practitioners cannot administer drugs "to *cause* their death" unless patients provide advance written consent in the required form.[48]

II.7 In one of the publications recommended by *CPSO MAID 2022*,[49] CAMAP recommends that practitioners and patients should agree that supplementary IV MAID medications will be used "to *cause* death" in the event of failed self-administration.[50] The association also recommends that practitioners be present during self-administration to verify consent and "ensure the lethal dose of medication is delivered securely, ingested safely, and successfully *causes* death."[51]

II.8 Elsewhere it appears that CAMAP prefers to discuss *inducing* rather than *causing* death, (e.g., "death *inducing*" mixtures or medication,[52] "likelihood of *inducing* death,"[53] "dosages to *induce* death,"[54] "drugs that will effectively *induce* death"[55]), the focus in this respect being an

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[44] *Ibid* at X60-X84.

[45] *ICD 2016*, *supra* note 36 at 4.2.3B(m).

[46] *Criminal Code, supra* note 24 at s 241.1

[47] *Ibid* at 241.2(3.2).

[48] *CPSO MAID 2022*, *supra* note 1 at §4(c), lines 52–56.

[49] *Ibid* at footnote 13.

[50] C Harty *et al*, "The Oral MAiD Option in Canada Part 2: Processes for Providing - Review and Recommendations" (18 April 2018), *CAMAP* (website), online: <https://camapcanada.ca/wp-content/uploads/2022/02/OralMAiD-Process.pdf> [*Oral MAID 2*] at Executive Summary, recommendation 9.

[51] C Harty *et al*, "The Oral MAiD Option in Canada Part 1: Medication Protocols - Review and Recommendations" (18 April, 2018) *CAMAP* (website), online: <https://camapcanada.ca/wp-content/uploads/2022/02/OralMAiD-Med.pdf> [*Oral MAID 1*] at 6.

[52] *Ibid* at 11, 13.

[53] *Ibid* at 15.

[54] "Intravenous MAiD Medication Protocols in Canada: Review and Recommendations (CAMAP White Paper on Intravenous MAID)" (April, 2020), *CAMAP* (website), online: <https://camapcanada.ca/wp-content/uploads/2022/02/IV-protocol-final.pdf> [*IV MAID*] at Executive Summary

intervention "that reliably results in the rapid death of the patient."[56]

II.9 Nonetheless, the *ICD* and the text of the *Criminal Code*, *CPSO MAID 2022* and CAMAP publications make it abundantly clear that lethal medication administered by practitioners or self-administered by patients in accordance with the Medical Assistance in Dying provisions in the *Criminal Code* is the cause of death in those cases. This should be obvious, since, were that not the case, there would have been no need for the constitutional challenge in the *Carter* case and the amendments to the homicide and assisted suicide provisions in the *Criminal Code*.

Falsification of causes of death

II.10 Clearly, direction from the government of Ontario[57] and in *CPSO MAID 2022*[58] requires falsification of the cause of death by EAS practitioners. Falsification of death certificates is contrary to international standards for identifying causes of death that are acknowledged by the governments of Canada and Ontario.

II.11 The contradiction becomes apparent if one compares death by lethal injection administered by legally authorized medical or nurse practitioners and death by lethal injection by unauthorized practitioners in identical circumstances following exactly the same procedural guidelines and otherwise in accordance with law and CPSO policy. The death of a patient from a lethal injection would be considered

> a) a natural death caused by blindness if the injection were given by a nurse or medical practitioner legally providing euthanasia for blindness;[59]
>
> b) a homicide caused by injection of a toxic substance if the injection were given by a registered nurse providing euthanasia for blindness.[60]

II.12 The falsification of death certificates as directed by the Ontario government and CPSO reflects the definition of forgery, though falsification of documents "at the request" of the government or CPSO is *not* forgery.[61] However, within the present context, it is relevant that the *Code* uses the word "request" — not "direction." Thus, the exemption in criminal law does not

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Recommendation 8.

[55] *Ibid*.

[56] *Ibid* at 25.

[57] *Death Certification 2019*, *supra* note 39 at 23.

[58] *CPSO MAID 2022*, *supra* note 1 at §11, lines 96–100.

[59] *Death Certification 2019*, *supra* note 39 at 23, online: <https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf#page=24>.

[60] *Ibid* at p 38–40, online:<https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf#page=39>.

[61] *Criminal Code*, *supra* note 24 at s 366, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-50.html#h-122291>.

imply that governments have the authority to require unwilling practitioners to falsify death certificates.

Issues

Falsification “inappropriate”

II.13 Falsification of death certificates was one factor enabling a British medical practitioner, Dr. Harold Shipman, to murder at least 215 and as many as 260 patients between 1974 and 1998.[62] The Chairman of the Shipman Inquiry commented unfavourably upon practitioner “modification” of the cause of death in death certificates so as not to “distress relatives” or “involve the coroner,” describing the practice as “inappropriate.”[63]

Falsification reflects corruption

II.14 Professor Carolyn McLeod of the University of Western Ontario was cited as an authority by the CPSO in defence of its policy of effective referral,[64] and the CPSO has adopted wording *verbatim* from one of her papers[65] in its proposed revision of its human rights policy.[66] In an early paper she referred to falsification of death certificates as an example of the corruption of professional norms.[67]

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[62] United Kingdom, The Shipman Inquiry, *First Report: Death Disguised* (London: HMSO, 19 July 2002) vol 1 (Dame Janet Smith) at para 14.2, online: <https://webarchive.nationalarchives.gov.uk/ukgwa/20090809051504/http://www.the-shipman-inquiry.org.uk/fr_page.asp?ID=187>.

[63] United Kingdom, The Shipman Inquiry, *Third Report. Death Certification and Investigation of Deaths by Coroners* (London: HMSO, 14 July 2003) (Dame Janet Smith) at 5.39—5.40, online: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf>.

[64] The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2018 ONSC 579 (CanLII) (Evidence, Affidavit of Andréa Foti at para 130-131), online: <https://www.consciencelaws.org/archive/documents/cpso/2016-10-18-foti pohr affidavit.pdf>.

[65] Jocelyn Downie, Carolyn McLeod & Jacquelyn Shaw, “Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons” (2013) 21 (3) Health Law Review 28-32 at Section 5.2, online: <https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1479&context=philosophypub>.

[66] *CPSO Human Rights 2022*, *supra* note 6 at §11(b), lines 120–121.

[67] Carolyn McLeod, “Demanding Referral in the Wake of Conscientious Objection to Abortion” in JC Cohen and JE Keelan eds *Comparative Program on Health Law and Society, Lupina Foundation Working Papers Series 2004–2005.* (Toronto: University of Toronto, Munk Centre for International Studies, 2006) at 136–137.

Deception undesirable

II.15 The Ontario government and College apparently believe that legal euthanasia and assisted suicide are beneficial forms of medical treatment. However, beneficial medical treatments do not require a bureaucracy of medical deception. Deception increases the likelihood of conflict and controversy. Indeed, some EAS supporters may worry that mandating deceptive practices is counterproductive.

Falsification breeds mistrust, may fuel Covid controversy

II.16 Some EAS practitioners may be uncomfortable lying or dissembling to families about how their loved ones died, which would seem to be unavoidably associated with falsifying causes of death. Others may be concerned that falsifying records and lying to families is likely to undermine the trust essential to the practice of medicine. And some may believe that falsifying death certificates is likely to strengthen the convictions of those who claim public authorities are misrepresenting Covid death numbers, further inflaming public controversy.[68,69]

Falsification wrong in principle

II.17 EAS practitioners may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Compelling these physicians to falsify documents is a direct attack on their integrity and freedom of conscience.

Falsification compromises health statistics

II.18 Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. For example, blindness is not considered a terminal illness, so certifying blindness as a cause of death would introduce anomalies into important vital statistics records.

Recommendations

Accommodate objecting practitioners and coroners

II.19 If the government and the CPSO insist that death certificates should be falsified, practitioners should not be compelled to participate in or support what they consider to be deceptive, unethical or professionally ill-advised practices. Objecting practitioners should be accommodated. This can be managed through the existing reporting system, which requires every that every case of MAID be reported to the Office of the Chief Coroner (OCC).

II.20 *CPSO MAID 2022* should be revised to the following effect:

> **§11.** When completing the medical certificate of death, *the*

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68 Patrick Boyle, "How are COVID-19 deaths counted? It's complicated." (18 February, 2021), *Association of American Medical Colleges* (blog), online: <https://www.aamc.org/news-insights/how-are-covid-19-deaths-counted-it-s-complicated>.

69 David Oliver, "Mistruths and misunderstandings about covid-19 death numbers" (10 February, 2021) BMJ 372 (352), online: <https://www.bmj.com/content/372/bmj.n352>.

government has requested that physicians:

a. ~~must~~ list the illness, disease, or disability leading to the request for MAID as the cause of death; and

b. ~~must~~ not make any reference to MAID or the medications administered on the certificate.

Practitioners who object to this for reasons of conscience or professional judgement should note their refusal/objection in the reports they are required to submit to the OCC about each MAID death. The OCC can then arrange for a willing coroner to complete the death certificate as requested by the government.

II.21 Note that the recommendation presumes accommodation of coroners who object to falsifying death certificates.

III. Criminal law limits on College policy

Requirement to conform to criminal law

III.1 *CPSO MAID 2022* states:

> **§1.** Physicians who assess patients for and/or provide MAID **must** comply with the relevant legal requirements for MAID, including those pertaining to the eligibility criteria, safeguards, and reporting. . .[emphasis in original].[70]

III.2 This reflects the focus of *CPSO MAID 2022* on the provision of EAS services. It is correct as far as it goes, but it does not go far enough. *All* physicians — not just those assessing for or providing the services (as implied in *CPSO Advice:MAID 2022* in relation to eligibility[71]) — are required to comply with relevant legal requirements.

Criminal law and eligibility

III.3 The law on murder, manslaughter, criminal negligence and assisted suicide applies to practitioners in relation to a patient described in s 241.2(1) and (2) of the *Criminal Code* who makes a request for assisted suicide or euthanasia in one respect only: eligibility. Practitioners are exempt from prosecution for these offences if they believe the patient *is eligible* under the terms of the law.[72]

EAS when patients are believed eligible

III.4 When practitioners provide euthanasia or assisted suicide in accordance with the *Criminal Code's* MAID provisions, they are invariably of the opinion that the patient *is* eligible for the service. It is difficult to imagine how the contrary might ever be proved, short of an admission by an accused.

III.5 Practitioners who believe that a patient *is* eligible who *knowingly fail or refuse* to adhere to procedural safeguards *cannot* be charged for murder or manslaughter. At most, they can be charged for an offence punishable on indictment or summary conviction for which the maximum penalty is imprisonment for five years:[73] the same penalty provided for assault.[74]

EAS when patients are believed ineligible

III.6 Practitioners who believe that a patient is *not* eligible under the *Code's* MAID provisions could be charged for murder, manslaughter, or assisting suicide were they to lethally inject the patient or assist with suicide. However, their legal liability of would extend beyond personally

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[70] *CPSO MAID 2022*, *supra* note 1 at §1, lines 17–19.

[71] *CPSO Advice: MAID 2022*, *supra* note 2 at lines 65–68.

[72] *Criminal Code*, *supra* note 24 at s 227, s 241.3.

[73] *Ibid* at s 241.3.

[74] *Ibid* at s 266.

providing the services to include being parties to offences, counselling offences and conspiracy.

III.7 One can be guilty of counselling an offence even if the offence is not committed[75] and a party to a conspiracy whether or not an offence is committed.[76] Further, one can be a party to an offence by aiding or abetting[77] even if the principal party (the practitioner who actually provides euthanasia or assisted suicide) is not criminally liable, not charged or is acquitted.[78] All of these offences are relevant when a practitioner believes that a patient is *not* eligible.

III.8 The fact that practitioners having a different view of eligibility may later provide euthanasia or assisted suicide and may not be criminally responsible, charged or convicted is not relevant to decision-making by practitioners obliged to comply with the criminal law in relation to a patient they consider *ineligible* for these services. The obligation to comply with the law is binding whether or not one is likely to be charged and convicted for an offence. An exemption from this obligation in relation to the law on murder, manslaughter, etc. is available only to practitioners who are satisfied that a patient is eligible. Those who consider a patient ineligible are obliged to act accordingly. The alternative — that physicians who believe that patients are ineligible for euthanasia/assisted suicide must nonetheless provide or facilitate the services — would eviscerate what is supposed to be a safeguard for patients.

III.9 This applies to all practitioners, not just EAS providers. Even prior to a formal EAS eligibility assessment, a conviction that a patient is ineligible with respect to criteria like voluntariness or capacity may be grounded in professional judgement arising from a clinical relationship, or from a thorough and sensitive exploration of the reasons underlying a patient's interest in EAS.

Patient ineligibility must lead to practitioner refusal

III.10 In any case, practitioners who believe that a patient does not meet the *Criminal Code's* MAID criteria are obliged to refuse to provide the service, and to refuse to become parties to an offence by doing anything to further the request. They would otherwise betray the trust reposed in them by Joseph Arvay, lead counsel for the plaintiffs in *Carter*. "[I]t is an irrefutable truth," he told the Supreme Court of Canada, "that all doctors believe it is their professional and ethical duty to do no harm."

> Which means, in almost every case, that they will want to help their patients live, not die. It is for the very reason that we advocate only physician assisted dying and not any kind of assisted dying because we know physicians will be reluctant gatekeepers, and only agree to it

[75] *Ibid* at s 464.

[76] *Ibid* at s 465.

[77] *Ibid* at s 21(b) or (c).

[78] *R v Johnson*, 2017 NSCA 64 at para 78 (CanLII). online: <https://canlii.ca/t/hrj8h>. However, it is not clear if a homicide or assisted suicide must be shown to have occurred in relation to potential criminal responsibility for aiding or abetting.

as a last resort.[79]

Eligibility and "irremediable" medical conditions

Revisiting *Carter*

III.11 That a patient must suffer from a "grievous and irremediable" medical condition are two of the primary eligibility criteria set by the *Carter* decision:

> [127] The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (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. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought (emphasis added).[80]

III.12 The terms "irremediable" and "incurable" are often used interchangeably, but sometimes a distinction is possible. When the effects of a medical condition can be alleviated or relieved, it may be considered remediable to that extent, even if it cannot be fully cured. However, while accepting the criterion of irremediability in the first sentence of this paragraph, the Supreme Court affirmed patient freedom in the second (underlined). "Irremediable" appears in both sentences, but there are two different issues here, not one.

III.13 This appears to be the approach taken by the Ontario High Court of Justice in a practice direction applying the *Carter* decision, which describes the evidence required from a physician supporting an application for EAS:

> 10. The application record should include an affidavit from the applicant's attending physician addressing whether,
>
> a) the applicant has *a grievous irremediable* medical condition (illness, disease, or disability) that causes suffering; (emphasis added)
>
> b) as a result of his or her medical condition, the applicant is suffering

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[79] Carter v Canada (Attorney General), 2015 SCC 5, [2015] 1 SCR 331 (Oral argument, Appellant, at 00:20:02 - 00:20:40), Supreme Court of Canada (website), online: <https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2014/2014-10-15--35591&date=2014-10-15&fp=n&audio=n>.

[80] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do> at para 127.

> enduring intolerable pain or distress *that cannot be alleviated by any treatment acceptable to the applicant*; . . . (emphasis added)[81]

Conflation of irremediability and patient freedom

III.14 The direction maintains the distinction between irremediability and patient freedom. The distinction is significant for both practitioner and patient. On the one hand, it prevents a practitioner's clinical judgement that a condition is not irremediable from being reversed by a patient's refusal to accept potentially beneficial treatments. On the other, the physician's determination does not force a patient to accept unwanted interventions, and EAS might be accessed through a different practitioner.

III.15 However, the criterion of irremediability and recognition of patient freedom have been conflated in implementing the *Carter* decision, to the point that the distinction has been erased in the *Criminal Code.* The *Code* defines "grievous and irremediable medical condition" as "a serious and incurable illness, disease or disability" that has caused "an advanced state of irreversible decline in capability" resulting in intolerable "enduring physical or psychological suffering. . . that cannot be relieved under conditions that they consider acceptable."[82] It appears that the Supreme Court's criterion of irremediability has been displaced by incurability *as determined by the will of the patient*. This is reflected in *CPSO Advice:MAID 2022*.[83]

III.16 This position was neatly summed up by psychiatrist Dr. Derryk Smith at a 2022 parliamentary committee hearing into euthanasia and assisted suicide as treatments for mental illness:

> Now, "irremediable" is a term that's used when there are no more treatments available that are "acceptable" to the patient. Under law, the patient cannot be forced to take any types of treatments that are available. They must agree. If a person refuses additional treatment, I would, therefore, consider them to be irremediable. . . I think the law is quite clear. The patient must agree. If they don't agree and there are no other treatments available, then the person has an irremediable condition.[84]

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[81] Heather J. Smith CJ, "Application for Judicial Authorization of Physician Assisted Death", Practice Advisory on *Carter v. Canada (Attorney General)*, 2016 SCC 4 (29 January, 2016), Ontario Superior Court of Justice (website), online: <https://www.ontariocourts.ca/scj/practice/application-judicial-authorization-carter/> at para 10.

[82] *Criminal Code*, *supra* note 24 at s 241.2(2).

[83] *CPSO Advice: MAID 2022*, *supra* note 2 at lines 55–56.

[84] House of Commons, *Special Joint Committee on Medical Assistance in Dying*, 44th Parl, 1st Sess, No 008, (25 May, 2022) at 3 (Dr. Derryk Smith), online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11814179/AMADEV08-E.PDF>.

Irremediability and mental illness

III.17 Dr. Smith was among witnesses who believed that some mental illnesses can be considered irremediable and EAS services should be available as a treatment option when it is. Among those disagreeing with Dr. Smith was psychiatrist Dr. Sonu Gaind, physician chair of the Humber River Hospital's MAID committee. Dr. Gaind, who does not object to euthanasia/assisted suicide in principle, described the criterion of irremediability as "the primary safeguard" in the law.

> . . . The whole premise of what our MAID framework has been based on. . . is that MAID is being offered for a predictable, irremediable condition. That, fundamentally, cannot be met for mental illnesses.[85]
>
> [what counts as] grievous and irremediable conditions. . . should be a scientific decision. On that there is no question that we cannot make those predictions in mental illness. . . if we're not providing MAID for an irremediable condition, one we can predict in a person to be irremediable, then what are we providing it for? . . . We are providing [mentally ill patients] false, in my opinion, unscientific assessments claiming that they may have irremediability when no one can actually make that determination.[86]

III.18 Complicating things further, the co-chair of the Canadian Psychiatric Association's MAID Working Group stated "there is no generally agreed definition of *incurability*" for mental illness, nonetheless adding that patients who refuse treatments "without good reason" are "unlikely to have met the eligibility criterion for *incurable*" (emphasis added).[87] How can a criterion of incurability be established without a definition? "How many treatments do we have to try?" she asked. She suggested that this must be negotiated by a practitioner and patient.[88]

Determining irremediability

III.19 The question and suggested answer demonstrate the problem that arises when the criterion of irremediability is conflated with patient freedom. The question, "How many treatments do we have to try?" may be discussed, but the answer is not negotiable. The law is clear that the patient does not have to accept any treatment, and need not have what a practitioner considers a "good reason" to refuse. Thus, even if a practitioner believes that a determination of irremediability or incurability can be arrived at by negotiation, it is unclear how a practitioner could negotiate except by using the desired diagnosis as a bargaining chip (i.e., "I will conclude the condition is

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[85] House of Commons, *Special Joint Committee on Medical Assistance in Dying*, 44th Parl, 1st Sess, No 003, (25 April, 2022) at 28 (Dr. Sonu Gaind), online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11721028/AMADEV03-E.PDF>.

[86] *Ibid* at 29.

[87] House of Commons, *Special Joint Committee on Medical Assistance in Dying*, 44th Parl, 1st Sess, No 009, (26 May, 2022) at 12 (Dr. Alison Freeland), online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11816254/AMADEV09-E.PDF>.

[88] *Ibid* at 23.

irremediable only if you accept treatments X, Y or Z and they don't work").

III.20 In contrast, practitioners like Dr. Gaind, believe that determinations of irremediability or incurability must be established by evidence-based medical criteria: that they are independent of and cannot be established by patient refusal to accept treatment. This is a reasonable and plausible position that informs current medical practice. Their further argument that there is no evidentiary basis for determining that mental illness is irremediable/incurable is also supportable.[89]

III.21 The critical point is that practitioners who determine that a patient's mental illness is not irremediable must conclude that the patient is ineligible for EAS for mental illness alone. They are thus constrained by criminal law to refuse to provide the service, and to refuse to become parties to an offence by doing anything to further a request for it.

III.22 The problematic conflation of irremediability and patient freedom has been overlooked in the implementation of the *Carter* ruling, but may be impossible to ignore when euthanasia and assisted suicide become legal treatments for mental illness in March, 2023.

Limits on College authority

III.23 In view of the foregoing, the Project's position is that the College has no basis to proceed against practitioners who, having the opinion that a patient is *not* eligible for euthanasia or assisted suicide, refuse to do anything to further a request for the services.

III.24 Moreover, if practitioners are of the opinion that a patient is *not* eligible for euthanasia or assisted suicide under, it would seem that the College would commit the offence of counselling[90] if it were to advise them or attempt to persuade or coerce them to become parties to an apparent offence. *CPSO Advice:MAID 2022* seems to stop just short of this.[91]

Counselling suicide

III.25 Practitioners are clearly able to provide information about legal assisted suicide in response to a patient's request or enquiries.[92] However, counselling (recommending) suicide remains a criminal offence.[93] Practitioners may be criminally liable if they suggest assisted suicide as a treatment option to a patient who has not expressed an interest in it or MAID, which includes both euthanasia and assisted suicide.

[89] Marie E Nicolini et al, "Irremediability in psychiatric euthanasia: examining the objective standard" (28 October, 2022) Psychological Medicine 1-19, doi:10.1017/S0033291722002951, online: <https://www.cambridge.org/core/journals/psychological-medicine/article/irremediability-in-psychiatric-euthanasia-examining-the-objective-standard/39CF3F03E81053EA152C63F332478CB4>.

[90] *Criminal Code*, *supra* note 24 at s 464.

[91] *CPSO Advice:MAID 2022*, *supra* note 2 at lines 72–77.

[92] *Criminal Code*, *supra* note 24 at s 241(5.1).

[93] *Ibid* at s 241(1)a.

Issues

III.26 *CPSO MAID 2022* does not give sufficient attention to the issue of criminal responsibility. Specifically, the policy does not make clear that

a) practitioners may incur criminal liability if

i) they do anything in furtherance of providing euthanasia or assisted suicide for patients they believe to be ineligible;

ii) they suggest assisted suicide to patients who have not expressed an interest in it, euthanasia or MAID (which includes both).

b) persons in authority may incur criminal liability for counselling an offence if they attempt to persuade or compel a practitioner

i) to be a party to euthanasia or assisted suicide when the practitioner has concluded that a patient is ineligible (a particularly important point for preceptors, clinical supervisors and hospital authorities);

ii) to suggest assisted suicide to a patient who has not expressed an interest in it, in euthanasia or in MAID.

Recommendations

Re: practitioners

III.27 *CPSO MAID 2022* and the related document, *Advice to the Profession: Medical Assistance in Dying* should explicitly caution practitioners that they may be criminally liable if they

(a) support, encourage or facilitate euthanasia/assisted suicide of a patient whom they believe to be ineligible;

(b) suggest assisted suicide to patients who have not expressed an interest in it, in euthanasia or MAID.

Re: persons in authority

III.28 *CPSO MAID 2022* and the related document, *Advice to the Profession: Medical Assistance in Dying* should explicitly caution persons in authority that they may be criminally liable for counselling an offence if they attempt to persuade or compel a practitioner

(a) to provide or facilitate euthanasia or assisted suicide when the practitioner has concluded that a patient is ineligible;

(b) to suggest assisted suicide to a patient who has not expressed an interest in it, or in euthanasia or MAID.

IV. Criminal law and ethical norms

Waivers of express consent

IV.1 Patients must ordinarily be asked by EAS practitioners to confirm their "express consent" immediately prior to the administration of lethal medication.[94] "*Express* consent"can be understood to mean unambivalent and unambiguous consent to proceed.

IV.2 However, the *Criminal Code* permits practitioners and patients to enter into written agreements to waive the requirement for "express consent" if the patient loses capacity before the scheduled date for the procedure or after a failed attempt at self-administration. *CPSO MAID 2022* takes note of the amendments.[95]

IV.3 Even if a waiver exists, the *Criminal Code* states that EAS practitioners must not proceed if a patient with whom they have an agreement and who has lost capacity demonstrates "by words, sounds or gestures, *refusal* to have the substance administered or resistance to its administration" (emphasis added).[96] Note that the *Code* requires practitioners to desist *only* if what the patient expresses at the point of administering a lethal injection amounts to a *refusal*. An expression of ambivalence — second thoughts or doubts — does not reach that threshold.

Patient ambivalence

IV.4 A patient who has signed a waiver may express ambivalence to family, friends or other health care professionals before losing capacity, which may be communicated to the most responsible EAS practitioner prior to or at the time appointed for the procedure. Alternatively, having apparently lost capacity, a patient may express ambivalence about proceeding at the appointed time.

IV.5 While EAS practitioners are allowed by the *Criminal Code* to proceed with euthanasia for an incapacitated patient who has expressed ambivalence about proceeding, there is room for an ethical judgement that they ought not to do so. This could give rise to a conflict of conscience on the part of some EAS practitioners or colleagues or other health care workers assisting them. *CPSO MAID 2022* provides no guidance on this point.

CPSO options

IV.6 If the CPSO is of the opinion that it would be unethical for a practitioner to provide euthanasia to an incapacitated patient who has expressed ambivalence about proceeding, *CPSO MAID 2022* could supplement the *Criminal Code* provisions by providing that direction. That would support physicians unwilling to provide or assist in EAS in those circumstances, who may face pressure to proceed on the grounds that it would be legal to do so.

IV.7 If the CPSO believes that EAS practitioners may ethically provide euthanasia to

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[94] *Ibid* at s 241.2(3)h and s 241.2(3.1)k.

[95] *CPSO MAID 2022*, *supra* note 1 at §3(a)iii, §4(c), lines 40–41, 52–56.

[96] *Criminal Code*, *supra* note 24 at s 241.2(3.2)c.

incapacitated patients who have expressed ambivalence about proceeding, *CPSO MAID 2022* could provide guidance on that point, in the form of a direction to proceed or a framework for decision-making. Silence on the issue would indicate that the criminal law is sufficient, and that physicians may proceed with euthanasia in those circumstances.

IV.8 Practitioners left in conflict on this issue by the final version *CPSO MAID 2022* would have to rely on the CPSO human rights policy for protection, unless they considered the patient ineligible for EAS. In that case, as discussed above, they are obliged to refuse to provide or to become a party to providing the service.

Recommendations

IV.9 *CPSO MAID 2022* should provide direction or guidance in relation to the response expected from EAS practitioners should they become aware that an incapacitated patient who signed a waiver has expressed ambivalence about proceeding with euthanasia up to and including the time appointed for the procedure.

APPENDIX "A"

Summary of Recommendations

"Emergency" requests

The Project recommends that relevant statements in *CPSO MAID 2021* and *CPSO Human Rights 2022* be combined and incorporated explicitly into *CPSO MAID 2022* as follows:

> The College does not consider a request for MAID to be an emergency or a treatment option in an emergency. Physicians are not required to assess patients for or provide MAID under any circumstances.

Self-administration, continuity of responsibility

The Project recommends the following addition to CPSO MAID 2022:

> In all cases, a practitioner who agrees to provide euthanasia or assisted suicide (the most responsible EAS practitioner) should personally administer the lethal drug or be personally present when it is self-administered, and remain with the patient until death ensues.
>
> The most responsible EAS practitioner must be continuously available to promptly provide the service from the time the EAS agreement is made to the time that the procedure is performed, unless the patient withdraws the request for the service.
>
> The most responsible EAS practitioner must arrange for a second EAS practitioner to promptly provide the service if the most responsible EAS practitioner cannot be continuously available or is unable to act promptly in response to an urgent request.
>
> The second EAS practitioner must be continuously available to act promptly in the place of the most responsible EAS practitioner.

Falsification of death certificates

The Project recommends that CPSO MAID 2022 should be revised to the following effect:

> §11. When completing the medical certificate of death, the government has requested that physicians:
>
> a. ~~must~~ list the illness, disease, or disability leading to the request for MAID as the cause of death; and
>
> b. must not make any reference to MAID or the medications administered on the certificate.
>
> Practitioners who object to this for reasons of conscience or professional judgement should note their refusal/objection in the reports they are required to submit to the OCC about each MAID death. The OCC can then arrange for a willing coroner to complete the death certificate as requested by the government.

Criminal law and limits on College policy

The Project recommends that *CPSO MAID 2022* and *CPSO Advice: MAID 2022* should explicitly caution **practitioners** that they may be criminally liable if they

(a) support, encourage or facilitate euthanasia/assisted suicide of a patient whom they believe to be ineligible;

(b) suggest assisted suicide to patients who have not expressed an interest in it, in euthanasia or MAID.

The Project recommends that CPSO MAID 2022 and the related document, Advice to the Profession: Medical Assistance in Dying should explicitly caution persons in authority that they may be criminally liable for counselling an offence if they attempt to persuade or compel a practitioner

(a) to provide or facilitate euthanasia or assisted suicide when the practitioner has concluded that a patient is ineligible;

(b) to suggest assisted suicide to a patient who has not expressed an interest in it, or in euthanasia or in MAID.

Criminal law and ethical norms

When a patient has signed a waiver of express consent and later becomes incapacitated, the *Criminal Code* prohibits euthanasia only if the patient expresses refusal at the point of administering a lethal injection. An expression of ambivalence does not reach that threshold.

CPSO MAID 2022 should provide direction or guidance in relation to the response expected from EAS practitioners should they become aware that an incapacitated patient who signed a waiver has expressed ambivalence about proceeding with euthanasia up to and including the time appointed for the procedure.