



Interim Guidance on Physician-Assisted Death

APPROVED BY COUNCIL: January 2016

PUBLICATION DATE: Issue 1, 2016

KEY WORDS: Physician-Assisted Death; Supreme Court of Canada; *Carter v. Canada*; Competent Adult; Decision-Making Capacity; Consent; *Canadian Charter of Rights and Freedoms*, Conscientious Objection; Reconciling Rights; Effective Referral; Sample Process Map.

RELATED TOPICS: The Practice Guide; Consent to Treatment; Medical Records; Planning for and Providing Quality End-of-Life Care; Professional Obligations and Human Rights.

LEGISLATIVE REFERENCES: *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK), 1982, c 11*; *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A.

REFERENCE MATERIALS: *Carter v. Canada (Attorney General)*, 2015 SCC 5; *Carter v. Canada (Attorney General)*, 2016 SCC 4.

COLLEGE CONTACTS: Public and Physician Advisory Service

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.

In December 2015, the federal government applied to the SCC for an extension to the 12-month suspension period. Upon consideration of the federal government's request, the SCC determined that a four-month extension was warranted. The SCC ruled that during the four-month extension period, an individual who is suffering intolerably from a grievous and irremediable medical condition, and wishes to seek assistance in dying, must obtain an exemption from the superior court in the individual's jurisdiction.²

This means that from February 6, 2016 to June 6, 2016, physician-assisted death is accessible only to individuals who receive an exemption from a superior court judge. Following June 6, 2016, physician-assisted death will be legal in Canada. At that time, 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.

To the extent that there is any inconsistency between the guidance provided in this document and any future government framework developed to govern the provision of physician-assisted death, the latter would take precedence.

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.

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

- Respecting patient autonomy with respect to health-care goals and treatment decisions;
- Acting in the best interests of their patients, and ensuring that all patients receive equitable access to care;
- Communicating sensitively and effectively with patients

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

2. *Carter v. Canada* (Attorney General), 2016 SCC 4.



in a manner that supports patients' 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 to the individual 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 physicians should only provide physician-assisted death to eligible patients within Canada who qualify for Canadian publicly-funded health services.

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*³ (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.⁴ The patient must be able to understand and appreciate the history and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

In the context of physician-assisted death, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of 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.

When assessing capacity in the context of a request for physician-assisted death, physicians are advised to rely on existing practices and procedures for capacity assessments.

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.⁵

3. *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A (hereinafter *HCCA*).

4. Section 4(1) of the *HCCA*.

5. Section 11(1) of the *HCCA*.

Interim Guidance on Physician-Assisted Death

As part of obtaining informed consent, physicians must discuss all treatment options with the patient. 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 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 patient must have requested physician-assisted death him/herself, thoughtfully and in a free and informed manner.

During this time of regulatory uncertainty, requests for physician-assisted death must be made by the patient, and not 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 capturing both terminal and non-terminal conditions. As stated by the SCC, 'irremediable' does not require the patient to undertake treatments that are not acceptable to the individual.⁶

For instance, the two lead plaintiffs in the SCC case of *Carter v. Canada* suffered from Amyotrophic Lateral Sclerosis (ALS), a terminal neurodegenerative disease, and spinal

stenosis, a non-terminal degenerative condition involving progressive compression of the spinal cord. The SCC determined that the prohibition on physician-assisted death violated the constitutional rights of both plaintiffs.

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, by the patient, 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, and 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.

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



These expectations are as follows:

- 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 physician-assisted death, even if it conflicts with their conscience or religious beliefs.
- The physician must communicate his/her objection to physician-assisted death to the patient directly and with sensitivity. The physician must 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 must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency.⁷ The referral must be made in a timely manner to allow the patient to access physician-assisted death. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.

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, as well as the dates of these requests, must be documented in the medical record. A copy of the patient's written request must also be included.

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 any government 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.

7. 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.

Interim Guidance on Physician-Assisted Death

VI. SAMPLE PROCESS MAP FOR PHYSICIAN-ASSISTED DEATH⁸

****PLEASE NOTE:** As explained above, from February 6, 2016 to June 6, 2016, patients who are suffering intolerably from a grievous and irremediable medical condition, and seek assistance in dying, must obtain an exemption from the superior court of the individual's jurisdiction. Where the court grants an exemption for physician-assisted death, any direction provided by the court in evaluating and/or granting this exemption takes precedence over the 'Sample Process Map for Physician-Assisted Death' found below. Physicians who are involved in assisting the court to evaluate an individual exemption for physician-assisted death, or who are assisting a patient who is preparing to apply to the court, are advised to use this process map as an example for any element of the process in which they are participating.

Physicians who are willing to provide physician-assisted death are advised to follow the process map outlined below. This process map, which has been adapted from guidance provided in jurisdictions outside of Ontario, sets out specific practice-related elements for the provision of physician-assisted death.⁹ As described above, where physicians are unwilling to provide physician-assisted death for reasons of conscience or religion, an effective referral to another physician or agency 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.
- Unless an effective referral to another physician or agency is provided to the patient, 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 to the individual in the circumstances of his or her condition.
- In relation to the first two criteria, 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.
- 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.
- If the attending physician concludes that the patient does not meet the criteria for physician-assisted death as outlined above, the patient is entitled to make a request for physician-assisted death to another physician who would again assess the patient using the above criteria.

REFLECTION PERIOD

- A period of reflection, between the first and second requests for physician-assisted death, is required.
- The period of reflection is intended to provide both the patient and the attending physician an opportunity to consider the request for physician-assisted death.
- The length of the period of reflection will vary, and may depend, in part, on the rapidity of progression and nature of the patient's medical condition. It is essential that the patient has sufficient time to come to an informed and voluntary decision to end his/her life, and that the patient appreciates the consequences of this decision.

8. In developing this Sample Process Map, the processes in place in established jurisdictions such as Oregon and the Netherlands were reviewed, along with the following guidance documents released by select Canadian medical regulators and the Canadian Medical Association: (1) College of Physicians and Surgeons of Alberta, *Advice to the Profession – Physician-Assisted Death* (January 2016); (2) College of Physicians and Surgeons of Saskatchewan, *Policy – Physician-Assisted Dying* (November 2015); (3) Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (January 2016).

9. The Ontario Ministry of Health and Long-Term Care (MOHLTC) is developing resources to support the provision of physician-assisted death. These resources may include forms to be completed by patients who request physician-assisted death, and physicians who provide physician-assisted death. Physicians are advised to consult the MOHLTC's website for further details.



SECOND REQUEST

- The patient makes a second request for physician-assisted death to the attending physician. This second request for physician-assisted death by the patient requires formal documentation.
- The second request may be oral and transcribed by another party, or written by the patient.
- The written request, or the transcribed oral request, must be dated and signed by the patient, and countersigned by an independent witness and the attending physician.

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

CONSULTING PHYSICIAN

- A second consulting physician must ensure that the requisite criteria for physician-assisted death have been met. 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 to the individual in the circumstances of his or her condition.
- In relation to the first two criteria, the consulting 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.
- If the consulting physician concludes that the patient does not meet the criteria for physician-assisted death as outlined above, the patient is entitled to have another consulting physician assess them against the criteria.
- Both the attending and consulting physician must independently document their opinion as to whether the requisite criteria for physician-assisted death have been met.
- The consulting physician must remind the patient of his/her ability to rescind the request for physician-assisted death at any time.

STAGE 3: Physician-Assisted Death - Self-Administration or Physician Administration

- 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.

- During this time of regulatory uncertainty, it is advised that the patient must be capable not only at the time the request for physician-assisted death is made, but also at the time of physician-assisted death.
- 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. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.
- 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 are advised to consult the College's Planning for and Providing Quality End-of-Life Care policy.
- Physicians must exercise their professional judgment in determining the appropriate drug protocol to follow to achieve physician-assisted death. The goals of any drug protocol for physician-assisted death include ensuring the patient is comfortable, and that pain and anxiety are controlled.
- College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available in the Members' section of the College's website.

STAGE 4: Certification of Death

- Where physician-assisted death is provided, physicians are advised to consult the Ontario government for guidance on the completion of death certificates and any mandatory reporting obligations associated with physician-assisted death.

Interim Guidance on Physician-Assisted Death



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