

# PRINCIPLES-BASED APPROACH TO ASSISTED DYING IN CANADA

(Background)

## Supreme Court decision in “Carter” physician-assisted death case

On Oct. 15, 2014 the Supreme Court of Canada (SCC) heard an appeal in the Carter case which concerns the legality of physician-assisted death in Canada. On Feb. 6, 2015 the Court rendered a [unanimous decision](#) striking down the Criminal Code absolute prohibition on providing assisted dying.

The Court suspended that decision for 12 months meaning that the current law remains in force. This allows legislators and regulators time to respond, should they so choose, with legislation. Federal Justice Minister Peter MacKay initially indicated that the federal government might take the full year of the suspension to provide a legislative response. He has also indicated that no laws will be considered prior to the October 2015 federal election.

Some key elements of particular interest to the Canadian Medical Association (CMA) are highlighted below.

## Highlights of the decision from the physician perspective

- The Court quoted [CMA’s policy statement](#) about supporting the rights of physicians to follow their conscience when deciding whether or not to provide medical aid in dying and recognized that there is a diversity of views within the physician community (para. 131 of the decision).
- The Court recognized that its decision does not compel physician participation in any regulatory scheme (para. 132).
- The category of patients described by the Court as eligible for medical aid in dying is arguably not narrow. Patients do not have to suffer from a terminal illness. Rather, in the words of the decision, they “must be competent adults who clearly consent to the termination of life, and have a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual” (para. 127).
- The Court expressed confidence that the informed consent model could be used to assess competency and voluntariness in this type of end-of-life decision (para. 115)—“already part and parcel of medical practice”.
- The Court rejected arguments that physicians would have a bias against quality of life for the disabled (para. 107).

## Recent CMA activities

A series of draft [fundamental principles](#) were approved by the CMA Board in May 2015 (see Schedule A). These include:

- 1) Respect for patient autonomy
- 2) Equity
- 3) Respect for physician values
- 4) Consent and capacity
- 5) Clarity
- 6) Dignity of life
- 7) Protection of vulnerable persons
- 8) Accountability
- 9) Solidarity

CMA has a comprehensive communications and engagement strategy with the membership, provincial and territorial medical associations and other stakeholders (e.g., Canadian Medical Protective Association) about its approach and initiatives on physician-assisted death. There is also an advocacy strategy to advance CMA's position on behalf of its members and patients in the development of the [legislative principles/framework](#).

CMA's Committee on Ethics discussed the ruling and its implications at its Apr. 26–27, 2015 meeting. The framework is informed by CMA policy, including the [December 2014 update](#) approved by the CMA Board. CMA will use the framework to work with the federal government and others in drafting legislation and regulations. CMA has been researching international and national experience to inform the principles/framework for several months in anticipation of the SCC decision. Schedule B contains charts that set out legislative criteria across different jurisdictions vis-à-vis strategic questions. In addition, CMA is developing action plans based on at least four potential scenarios:

1. Legislation is developed in consultation with stakeholders and keeping with the spirit of the SCC decision
2. Legislation is developed behind closed doors, no consultation
3. Legislation is proposed that contradicts SCC decision or physician/patient interests
4. No federal legislation is developed or it fails to pass the federal Parliament (*Morgentaler* precedent)

CMA will undertake focused stakeholder and member consultations on its revised principles/framework, in particular, during June and July 2015. General Council delegates will discuss and debate the principles/framework and any associated issues in August 2015 in Halifax.

As part of its advocacy strategy to advance CMA's position in the forthcoming legislation, CMA will engage the federal and provincial/territorial governments to influence the development of legislation on assisted dying. This advocacy strategy will require key elements such as proposed legislative options for adoption by government, and securing support for CMA's advocacy position from key stakeholders including other orders of government.

## Strategic questions

With reference to the nine principles, delegates are asked to consider the following strategic questions for discussion and debate:

1. What should be the process followed after the patient requests medical aid in dying?
2. What oversight and data reporting mechanism should exist?
3. For those physicians who refuse to participate in assisted dying for reasons of conscience, how do we reconcile this refusal with their obligation to ensure equitable access? What mechanisms can physicians employ to ensure this access?
4. The Supreme Court of Canada has laid out in broad terms which patients will qualify for assistance in dying (i.e., those with grievous and irremediable suffering). Should there be other clinical specifications or requirements?

## SCHEDULE A – DRAFT PRINCIPLES-BASED RECOMMENDATIONS FOR A CANADIAN APPROACH TO MEDICAL AID IN DYING

On Feb. 6, 2015, the Supreme Court of Canada unanimously struck down the law prohibiting medical aid in dying. The court suspended that decision for 12 months. This provides an opportunity for the Canadian Medical Association to build on its past work and pursue further consultation with provincial and territorial medical associations, medical and non-medical stakeholders, members, legislatures and patients for processes, whether legal, regulatory or guidelines, that respect patients' needs and reflects physicians' perspectives.

The goal of this process is twofold: (a) discussion and recommendations on a suite of ethical-legal principles and (b) input on specific issues that are particularly physician-sensitive and are worded ambiguously or not addressed in the Court's decision. The anticipated outcome is to ensure that physicians' perspectives are reflected as well as patients' views. The touch points are reasonable accommodation for all perspectives and patient-centeredness.

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

The CMA recommends adopting the following principles-based approach to medical aid in dying in Canada. CMA's policy [Euthanasia and Assisted Death \(Update 2014\)](#) defines medical aid in dying as follows:

Medical aid in dying refers to a situation whereby a physician intentionally participates in the death of a patient by directly administering the substance themselves, or by providing the means whereby a patient can self-administer a substance leading to their death.

### Foundational principles

The following foundational principles underpin CMA's recommended approach to medical aid in dying:

- 1) **Respect for patient autonomy:** Competent adults are free to make decisions about their bodily integrity. Strict criteria are warranted given the finality of medical aid in dying.
- 2) **Equity:** To the extent possible, all those who meet the criteria for medical aid in dying should have access to this intervention. Physicians will work with relevant parties to support increased resources and access to high quality palliative care, and medical aid in dying. There should be no undue delay to accessing medical aid in dying, either from a clinical, system or facility perspective.

- 3) **Respect for physician values:** Physicians can follow their conscience when deciding whether or not to provide medical aid in dying without discrimination. This must not result in undue delay for the patient to access these services. No one should be compelled to provide assistance in dying.
- 4) **Consent and capacity:** All the requirements for informed consent must clearly be met. Consent is seen as an evolving process requiring physicians to continuously communicate with the patient.
- 5) **Clarity:** All Canadians must be clear on the requirements for qualification for medical aid in dying. There should be no “grey areas” in any legislation or regulations.
- 6) **Dignity:** All patients, their family members or significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life.
- 7) **Protection of vulnerable persons:** Laws and regulations, through a carefully designed and monitored system of safeguards, should address issues of vulnerability and potential coercion.
- 8) **Accountability:** An oversight body and reporting mechanism should be identified and established in order to ensure that all processes are followed. Physicians participating in medical aid in dying must ensure that they have appropriate technical competencies as well as the ability to assess decisional capacity, or the ability to consult with a colleague to assess capacity in more complex situations.
- 9) **Solidarity:** Patients should be supported by physicians and health care providers, sensitive to issues of culture and background, throughout the dying process regardless of the decisions they make with respect to assisted dying.

## Recommendations

Based on these principles and a review of other jurisdictions’ experiences, CMA makes the following recommendations for potential statutory and regulatory frameworks with respect to medical aid in dying. We note that this document is not intended to address all potential issues with respect to medical aid in dying, and some of these will need to be captured in subsequent regulations.

### 1. Patient qualifications for access to medical aid in dying

1.1 The patient must be a competent adult.

1.2 Capacity

- The attending physician must be satisfied that:

- the patient is mentally capable of making an informed decision at the time of the request(s)
- the patient is capable of giving consent to medical aid in dying
- communications include exploring the priorities, values and fears of the patient, providing information related to the patient’s diagnosis and prognosis, treatment options including palliative care interventions and answering the patient’s questions
- If either or both the attending physician or the consulting physician determines that the patient is incapable, the patient must be referred for further capacity assessment.
- The patient him or herself must make the request. Substitute decision-makers carrying out advance directives or the wishes of currently incompetent patients are not acceptable proxies.

### 1.3 Voluntariness

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

### 1.4 Informed decision

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

## 2. Process map for decision-making in medical aid in dying

### Stage 1: Requesting medical aid in dying

1. The patient submits the first oral request for medical aid in dying to the attending physician.
2. The patient must then wait for at least 15 days.
3. The patient then submits the second oral request for medical aid in dying to the attending physician.
4. The patient must then wait for at least 7 days.
5. The patient then submits a written request for medical aid in dying to the attending physician. The written request must be completed via a special declaration form that is

developed by the government/department of health/regional health authority/health care facility.

6. In cases of terminal illness where time is of the essence, CMA recommends that shorter timelines be considered.

### **Stage 2: Before undertaking medical aid in dying**

7. The attending physician must wait no longer than 48 hours, or as soon as is practicable, after the written request is received.
8. The attending physician must then assess the patient for capacity and voluntariness or refer the patient for a specialized assessment in more complex situations.
9. The attending physician must inform the patient of his/her right to rescind the request at any time.
10. A second, independent, consulting physician must assess the patient for capacity and voluntariness.
11. The attending physician must fulfill the documentation requirements.

### **Stage 3: After undertaking medical aid in dying**

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

## **3. Role of the physician**

3.1 Patient assessment: The attending physician must determine if the patient qualifies for medical aid in dying under the parameters stated above in Section 1.

### **3.2 Consultation requirements**

- The attending physician must consult a second physician, independent of both the patient requesting medical aid in dying and the attending physician, before the patient is considered qualified to undergo medical aid in dying.
- The consulting physician must
  - Be qualified by specialty or experience to render a diagnosis and prognosis of the patient's illness.

### **3.3 Counselling**

- The attending physician must offer the patient an opportunity to rescind the request at the time of the second oral request; the offer must be documented.

### 3.4 Documentation requirements

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

### 3.5 Oversight and reporting requirements

There should be a formal oversight and reporting mechanism that will gather data.

- Following the provision of medical aid in dying, the attending physician must submit all of the following items to the oversight body:
  - Attending physician report
  - Consulting physician report
  - Medical record documentation
  - Patient's written request for medical aid in dying

## 4. Responsibilities of the consulting physician

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

## 5. Moral opposition to medical aid in dying

### 5.1 Moral opposition by a health care facility or health authority

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

### 5.2 Conscientious objection by a physician

- Physicians are not obligated to fulfill requests for medical aid in dying. There should be no discrimination against a physician for their refusal to participate in medical aid in dying. In



order to reconcile physicians' conscientious objection with patient access to care, a system should be developed whereby referral occurs by the physician to a third party that will provide assistance and information to the patient.

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## SCHEDULE B – LEGISLATIVE CRITERIA ACROSS JURISDICTIONS

### Q1: Process to follow after patient requests medical aid in dying

|                     | Inform patient of:   | Consult   | Second consult and/or counselling  | Cooling off period   |
|---------------------|--|---|--|--|
| Netherlands         | <ul style="list-style-type: none"> <li>– The situation and prospects</li> </ul>  | <ul style="list-style-type: none"> <li>– At least one other physician</li> </ul>  |  | None   |
| Belgium             | <ul style="list-style-type: none"> <li>– Condition and life expectancy</li> <li>– Possible therapeutic and palliative courses of action</li> <li>– Several conversations spread out over a reasonable period of time</li> </ul>  | <ul style="list-style-type: none"> <li>– Another physician</li> </ul>   | <ul style="list-style-type: none"> <li>– Second consult is required if the patient is not terminal</li> <li>– By physician who is a psychiatrist or specialist in the disorder in question</li> </ul>              | <ul style="list-style-type: none"> <li>No – If terminal</li> <li>Yes – One month if patient is not terminal</li> </ul>   |
| Oregon              | <ul style="list-style-type: none"> <li>– Diagnosis, prognosis</li> <li>– Potential risks and probable results of medication</li> <li>– Feasible alternatives including comfort, hospice, pain control</li> </ul>   | <ul style="list-style-type: none"> <li>– Another physician</li> </ul>   | <ul style="list-style-type: none"> <li>– Counseling, if person appears to be suffering from impaired judgement</li> </ul>  | <ul style="list-style-type: none"> <li>Yes – Two oral requests at least 15 days apart and one written request</li> <li>Yes – Minimum 48 hrs between written request and writing prescription, the latter cannot occur prior to the second oral request.</li> </ul> |
| Washington          | <ul style="list-style-type: none"> <li>– Diagnosis, prognosis</li> <li>– Potential risks and probable result of medication</li> <li>– Feasible alternatives including comfort, hospice, pain control</li> </ul>  | <ul style="list-style-type: none"> <li>– another physician</li> </ul>   | <ul style="list-style-type: none"> <li>– Counseling if person appears to be suffering from impaired judgement</li> </ul>   | <ul style="list-style-type: none"> <li>Yes – Two oral requests at least 15 days apart and one written request</li> <li>Yes – Minimum 48 hrs between written request and writing prescription, the latter cannot occur prior to the second oral request.</li> </ul> |
| Vermont             | <ul style="list-style-type: none"> <li>– Diagnosis, prognosis</li> <li>– Treatment options</li> <li>– Feasible options for end of life including palliative care, comfort, hospice, pain control</li> <li>– Potential risks and probable result of taking medications</li> </ul> | <ul style="list-style-type: none"> <li>– Another physician</li> </ul>   | <ul style="list-style-type: none"> <li>– Physician or referral required to psychiatrist, psychologist or clinical social worker to confirm that patient is capable and does not have impaired judgement</li> </ul> | <ul style="list-style-type: none"> <li>Yes – Two oral requests at least 15 days apart and one written request</li> <li>Yes – Minimum 48 hrs between written request and writing prescription, the latter cannot occur prior to the second oral request.</li> </ul> |
| Quebec Bill 52      | <ul style="list-style-type: none"> <li>– Of the prognosis for the illness and of other therapeutic</li> <li>– Possibilities and their consequences</li> <li>– Talk with person at reasonably spaced intervals</li> </ul>   | <ul style="list-style-type: none"> <li>– Another physician</li> </ul>   |  | No   |
| Senate Bill 225     | <ul style="list-style-type: none"> <li>– Diagnosis, prognosis</li> <li>– Consequences of request</li> <li>– Feasible alternative treatments including comfort, palliative or hospice care and pain control</li> </ul>  | <ul style="list-style-type: none"> <li>– Another physician</li> <li>– Must be qualified by specialty or experience re person's condition</li> </ul> |  | Yes – Minimum 14 days  |
| Carter SCC decision | Silent other than reference to informed consent is required  | N/A   | N/A  | N/A  |

**Q2: What oversight and data reporting mechanisms should exist?**

|                   | Euthanasia, assisted dying or both? | Does the law create a new oversight entity? | If so, what?*         | If so, what is the process?  | If not, what is there?  | Who do physicians report to for the purpose of record-keeping?* | Are they required to publish a report? |
|-------------------|-------------------------------------|---|-----------------------|--|---|---|--|
| Netherlands       | Both                                | Yes →                                       | 5 regional committees | Commission makes <b>determination on compliance</b> >>> if there's an issue, goes to prosecution     |   | Committees →  | Yes                                    |
| Luxembourg        | Both                                | Yes →                                       | Commission            | Commission makes <b>determination on compliance</b> >>> if there's an issue, goes to Medical College |   | Commission →  | Yes                                    |
| Belgium           | Both                                | Yes →                                       | Commission            | Commission makes <b>determination on compliance</b> >>> if there's an issue, goes to prosecution     |   | Commission →  | Yes                                    |
| Oregon            | Assisted dying                      | No  | →                     | →  | Special reporting requirements and pre-existing mechanisms for professional conduct | State health authority →  | Yes                                    |
| Washington        | Assisted dying                      | No  | →                     | →  | Special reporting requirements and pre-existing mechanisms for professional conduct | State department of health →                                    | Yes                                    |
| Vermont           | Assisted dying                      | No  | →                     | →  | Special reporting requirements and pre-existing mechanisms for professional conduct | State department of health →                                    | Not clear yet                          |
| Quebec Bill 52    | Medical aid in dying                | Yes →                                       | Commission            | Commission makes <b>determination on compliance</b> >>> if there's an issue, goes to Medical College |   | Commission →  | Yes                                    |
| Senate Bill S-225 | Both                                | No  |                       |  | Not specified   | Minister of health →  | Not specified                          |

**Key Point:** It appears as though only those jurisdictions that have legalized euthanasia have set up a separate, specialized oversight structure. The States, which have legalized assisted dying only, rely mostly on additional reporting requirements and professional regulation practices already in place.

**\*Key Point:** Commissions are typically composed of appointed individuals from the medical, legal and ethics communities.

**\*\*Key Point:** Regardless of the level of review involved, these bodies all serve as the final destination for all documentation required throughout the process.

### Q3: Reconcile refusal and equitable access?

|                       | Is there a duty to refer to another physician?<br>YES/NO or SILENT | Evidence   | Is participation mandatory?<br>YES/NO or SILENT | Evidence   | Other   |
|-----------------------|--|--|---|--|---|
| Netherlands           | Silent   |  | Silent  |  |   |
| Luxembourg            | Not really   | Should the physician refuse, then he/she must inform patient with reasons within 24 hrs.   | No  | No doctor is obliged to perform euthanasia or assisted death.  | Timely disclosure requirement.  |
| Belgium               | Not really   | Should the physician refuse, then he/she must inform patient with reasons. At the request of the patient, the physician (who refuses to perform euthanasia) must communicate the medical record to the physician designated.   | No  | No physician may be compelled to perform euthanasia.   |   |
| Oregon                | Not really   | If unable or unwilling to carry out a patient's request the provider shall transfer, upon request, a copy of the patient's medical records to the new provider. Participation in physician-assisted death does not include providing a patient with a referral to another physician. | No  | No health care provider is under any duty to participate.  | Upon request, transfer record to new provider.                        |
| Washington            | Not really   | There is a requirement to transfer records. Participation in physician-assisted death does not include referral of a patient to another physician.   | No  | Only willing providers shall participate in the provision of medication to end life in a humane and dignified manner.  | Upon request, transfer record to new provider.                        |
| Vermont               | Silent   |  | No  | No person shall be under any duty to participate in the provision of a lethal dose of medication.  | Silent  |
| Quebec Bill 52        | Modified YES – to Executive Director                               | To the Executive Director of the institution or local authority.   | No  | May refuse because of personal convictions; in such a case, must ensure that continuity of care is provided to the patient, in accordance with their code of ethics and the patient's wishes.              | Continuity of care obligation.  |
| Senate Bill S-225     | Silent   |  | Silent  |  |   |
| Carter Trial decision |  | Trial level – quotes from Royal Society of Canada Report "...if unwilling should refer the individual... to another professional."   |   |  |   |
| Carter SCC decision   | Silent   | In making their observation (see quote to the right), the court said that the rights of patients and physicians will need to be reconciled.  | No  | "Nothing in the declaration of invalidity would compel physicians to provide assistance in dying"... "we note...that a physician's decision to participate in assisted dying is a matter of conscience..." | Charter rights of both patients and physicians need to be reconciled. |