Principles-based Recommendations for a Canadian Approach to Assisted Dying

On Feb. 6, 2015, the Supreme Court of Canada unanimously struck down the law prohibiting assisted dying. The court suspended that decision for 12 months. This has provided an opportunity for the Canadian Medical Association (CMA) 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 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 principles are not designed to serve as a tool for legislative compliance in a particular jurisdiction or provide a standard of care. Rather, the CMA wishes to provide physicians with guidance and a vision of what physicians might strive for to further their professional and legal obligations in a complex area.

The CMA recommends adopting the following principles-based approach to assisted dying in Canada:

Foundational principles

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

1. **Respect for patient autonomy:** Competent adults are free to make decisions about their bodily integrity. Specific criteria are warranted given the finality of assisted dying.

2. **Equity:** To the extent possible, all those who meet the criteria for assisted 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 assisted dying. There should be no undue delay to accessing assisted dying, either from a clinical, system or facility perspective. To that end, the CMA calls for the creation of a separate central information, counseling, and referral service.

3. **Respect for physician values:** Physicians can follow their conscience when deciding whether or not to provide assisted 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, including the requirement that the patient be capable of making that decision, with particular attention to the context of potential vulnerabilities and sensitivities in end of life circumstances. Consent is seen as an evolving process requiring physicians to continuously communicate with the patient.

5. **Clarity:** All Canadians must be clear on the requirements for qualification for assisted dying. There should be no "grey areas" in any legislation or regulations.

6. **Dignity:** All patients, their family members or significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life.

7. **Protection of patients:** Laws and regulations, through a carefully designed and monitored system of safeguards, should aim to minimize harm to all patients and should also address issues of vulnerability and potential coercion.

8. **Accountability:** An oversight body and reporting mechanism should be identified and established in order to ensure that all processes are followed. Physicians participating in assisted 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 and not abandoned 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.

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

Recommendations

Based on these principles, the Supreme Court decision in *Carter v. Canada* (2015)[1] and a review of other jurisdictions' experiences, CMA makes the following recommendations for potential statutory

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

and regulatory frameworks with respect to assisted dying. We note that this document is not intended to address all potential issues with respect to assisted dying, and some of these will need to be captured in subsequent regulations.

1. Patient eligibility for access to assisted dying

1.1 The patient must be a competent adult who meets the criteria set out by the Supreme Court of Canada decision in *Carter v. Canada* (2015.

1.2 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.

1.3 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 assisted dying, paying particular attention to the potential vulnerability of the patient in these circumstances
  - 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 and other possible 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.
- Only patients on their own behalf can make the request while competent.

1.4 Voluntariness

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

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

Stage 1: Requesting assisted dying

1. The patient submits at least two oral requests for assisted dying to the attending physician over a period of time that is proportionate to the patient's expected prognosis

(i.e., terminal vs non-terminal illness). CMA supports the view that a standard waiting period is not appropriate for all requests.

2. CMA recommends generally waiting a minimum of 14 days between the first and the second oral requests for assisted dying.
3. The patient then submits a written request for assisted dying to the attending physician. The written request must be completed via a special declaration form that is developed by the government/department of health/regional health authority/health care facility.
4. Ongoing analysis of the patient's condition and ongoing assessment of requests should be conducted for longer waiting periods.

Stage 2: Before undertaking assisted dying

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

Stage 3: After undertaking assisted dying

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

3. Role of the physician

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

3.2 Patient assessment

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

3.3 Consultation requirements

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

- The consulting physician must
  - Be qualified by specialty or experience to render a diagnosis and prognosis of the patient's illness and to assess their capacity as noted in Stage 2 above.

3.4 Opportunity to rescind request

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

3.5 Documentation requirements

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

3.6 Oversight body and reporting requirements

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

4. Responsibilities of the consulting physician

- The consulting physician must verify the patient's 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 assisted dying

5.1 Moral opposition by a health care facility or health authority

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

5.2 Conscientious objection by a physician

- Physicians are not obligated to fulfill requests for assisted dying. There should be no discrimination against a physician who chooses not to participate in assisted dying. In order to reconcile physicians' conscientious objection with a patient's request for access to assisted dying, physicians are expected to provide the patient with complete information on all options available to them, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service.