



## **Physician-Assisted Dying Draft Guidance Document**

### **Background**

On February 6, 2015, the Supreme Court of Canada struck down the law prohibiting physician-assisted dying.<sup>1</sup> The court suspended that decision for 12 months. The effect of that decision is that, after February 6, 2016, it will not be illegal for a physician to assist a patient to die if:

- 1) The patient consents;
- 2) The patient has a grievous medical condition;
- 3) The condition is not remediable using treatments that the patient is willing to accept; and,
- 4) The patient's suffering is intolerable to the patient.

In the absence of federal, provincial or territorial legislation related to physician-assisted dying, it falls to the medical regulatory authorities in Canada to develop standards or guidance for physicians within their provinces or territories.

### **Introduction**

This document is based upon the recommendations of the Advisory Group on Physician-Assisted Dying that was struck by the Federation of Medical Regulatory Authorities (FMRAC) in response to the aforementioned. That document was, in turn, based upon a draft framework from the Canadian Medical Association (CMA).

The College recognizes that there may be legislation in future which addresses some of the matters addressed in this document. Where such legislation exists, the provisions of that legislation will take priority over the provisions in this document if there is any inconsistency between the two.

The intention of this document is to provide guidance to physicians who are willing to participate in physician-assisted dying and to provide guidance to patients who seek to access physician-assisted dying.

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<sup>1</sup> [Carter v. Canada \(Attorney General\)](https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html?resultIndex=1), 2015 SCC 5; <https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html?resultIndex=1>

**Definition of “Physician-assisted dying”** - For the purpose of this document, the College has adopted the definition of physician-assisted dying from the Supreme Court’s decision in *Carter v. Canada*<sup>2</sup> as, “the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient.”

### **Foundational Principles**

The foundational principles used by the College in developing this document include:

- 1) *Respect for patient autonomy*: Competent adults are free to make decisions about their bodily integrity. Given the finality of physician-assisted dying, significant safeguards and standards are appropriate to ensure that respect for patient autonomy is based upon carefully developed principles to ensure informed patient consent and consistency with the principles established by the Supreme Court of Canada.
  - 2) *Access*: Individuals who seek information about physician-assisted dying should have access to unbiased and accurate information. To the extent possible, all those who meet the criteria for physician-assisted dying and request it should have access to physician-assisted dying.
  - 3) *Respect for physician values*: This document does not address the extent to which individual physicians may be expected to ensure that patients seeking information about physician-assisted dying receive that information or the extent to which physicians may be required to refer patients to another provider if the physician is unwilling to provide physician-assisted dying. Within the bounds of existing standards of practice, and subject to the obligation to practise without discrimination as required by the *CMA Code of Ethics* and human rights legislation, physicians can follow their conscience when deciding whether or not to provide physician-assisted 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. Communications include exploring the priorities, values and fears of the patient, providing information related to the patient’s diagnosis and prognosis, providing treatment options including palliative care interventions and answering the patient’s questions. Consent must be express and voluntary. Given the context, a patient’s decisional capacity must be carefully assessed to ensure that the patient is able to understand the information provided and understands that the consequences of making a decision to access physician-assisted dying.
  - 5) *Clarity*: Medical Regulatory Bodies should ensure, to the extent possible, that guidance or standards which they adopt:
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- a) provide guidance to patients and the public about the requirements which patients must meet to access physician-assisted dying;
  - b) advise patients what they can expect from physicians if they are considering physician-assisted dying; and,
  - c) clearly express what is expected of physicians.
- 6) *Dignity*: All patients, their family members and 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) *Accountability*: Physicians participating in physician-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.
- 8) *Duty to Provide Care*: Physicians have an obligation to provide ongoing care to patients unless their services are no longer required or wanted or until another suitable physician has assumed responsibility for the patient. Physicians should continue to provide appropriate and compassionate care to patients throughout the dying process regardless of the decisions they make with respect to physician-assisted dying.

## **1. Requirements for access to physician-assisted dying:**

### 1.1 The attending physician in situations of physician-assisted dying must:

- Be qualified by specialty, training or experience to render a diagnosis and prognosis of the patient's illness, or be able to consult with a colleague who is so qualified to obtain the diagnosis and prognosis;
- Be qualified by specialty, training or experience to meet the requirements to provide physician-assisted dying;
- Be able to assess decisional capacity or be able to consult with a colleague to assess capacity in more complex situations; and,
- Have appropriate knowledge and technical competency to provide physician-assisted dying of the form to be administered.

### 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 requests and throughout the process; and,
  - Capable of giving consent to physician-assisted dying.
- If either the attending physician or the consulting physician is unsure whether the patient has capacity, the patient must be referred for further capacity assessment.

### 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 physician-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 or her own life after due consideration; and,
  - The patient has requested physician-assisted 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, the potential complications associated with the medication, and alternatives, including comfort care, palliative and hospice care, pain and symptom control and other available resources to avoid the loss of personal dignity. The physician must advise the patient of any counselling resources which are available to assist the patient. The attending physician must inform the patient of his or her right to rescind the request at any time. The attending physician has an obligation to take reasonable steps to ensure that the patient has understood the information that has been provided.

### 1.5 Consistency of Decision over time

- The attending physician must ensure that the patient has consistently expressed a desire for physician-assisted dying over a reasonable period of time. What is a reasonable period of time will be dependent on the patient's medical condition and other circumstances. As with any other medical intervention, the patient must consent to physician-assisted dying at the time that is provided by the physician.

### 1.6 Determining whether the **Carter** criteria are met

- A physician who assesses a patient for eligibility to access physician-assisted dying has an obligation to assess whether the patient meets the conditions established by the Supreme Court of Canada in the **Carter** decision. In addition to ensuring that the patient has provided informed consent to their death:
  - 1) The patient must have a grievous medical condition;
  - 2) That condition must not be remediable using treatments that the patient is willing to accept; and
  - 3) The patient's suffering must be intolerable to the patient.

- It is not possible to provide a practice guideline or treatment pathway which provides a detailed description of what a physician should do to ensure that those criteria are met. Patients will respond very differently to a grievous medical condition and will differ in the treatments which they are willing to accept. What is intolerable to a patient is subjective to the patient and what is intolerable suffering will significantly differ from one patient to another.
- However, physicians are expected to use appropriate medical judgment and follow a reasonable plan of assessment to ascertain whether the **Carter** criteria have been met for a specific patient.
- Physicians who are assessing a patient for eligibility for physician-assisted dying should consider whether to discuss the following matters with the patient to assist in the physician's determination.
- A physician should consider these issues from the patient's perspective and with reference to each dimension of suffering, both individually and in conjunction with each other. For most patients, suffering is not the simple sum of its parts but a complex constellation of different dimensions that serve to make it intolerable.

### **1) Current symptoms**

Consider the patient's physical symptoms. Some symptoms which may be relevant, or which may lead to a discussion of the treatments available for such symptoms include: anxiety, ascites, bladder retention, cachexia, confusion, constipation, coughing, dehydration, depression, diarrhea, dry mouth, dysphagia, fever, hiccups, intestinal obstruction, nausea, pain (localized/forms), pressure sores, pruritus, shortness of breath, sleeping disorders, urinary/fecal incontinence, other symptoms.

### **2) Loss of function**

Consider the patient's ability to function and the effect that loss of function may have on the specific patient. Some areas of loss of function which may be relevant to the patient include: the patient's ability to stand, walk, dress unassisted, wash, eat, drink, use the toilet, speak, hear, see, write, maintain consciousness and maintain concentration.

### **3) Expectation of progress of symptoms**

Which symptoms have worsened and which will get worse? How does the patient experience these declines?

### **4) Expectation of progress of Loss of function**

Which losses of function will stabilize and which will only decline further? How does the patient experience this?

## 5) Future suffering and available treatment

Which future suffering is anticipated? On what is this based? Is this realistic? Is this suffering treatable? If so, is it realistic to propose this treatment to the patient? If not, why? Does the patient wish to refuse treatment and is that refusal realistic in view of the anticipated consequences?

## 6) Suffering and personality

How does the patient describe his or her own character? Which symptoms trouble the patient the most, and why?

## 7) Suffering and personality-over-time (personal history)

What are the patient's religious beliefs and values? What was the patient's occupation? What are the patient's experiences with illness? What significance does his past have for the patient (loss of partners, experiences with violence)?

## 8) Environment

What is the patient's living situation? What care is available to the patient and what burden does the patient feel is placed on those who may provide care? What is the willingness and attitude of those who may assist the patient to obtain appropriate care? What length of time may caregivers be expected to provide care to the patient?

### Acknowledgement

Much of the content of this section has been adapted from a document *The role of the physician in the voluntary termination of life* published by Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG).

### 1.7 The requirement of a second assessment

- The attending physician must consult a second physician before providing the patient with physician-assisted dying.
- The second physician must interact with the patient in order to meet the requirements of paragraph 1.8.

### 1.8 Documentation of Patient Wishes and Physician Assessment

- The attending physician and the consulting physician must complete a prescribed form to confirm that the patient meets the requirements for physician-assisted dying.
- The prescribed form to be completed by the attending physician should contain confirmation that the physician has advised the patient of counselling resources

which are available to assist the patient and that the physician has informed the patient of his or her right to rescind the request at any time.

- The prescribed form to be completed by the attending physician and the consulting physician should contain the following:
  - The physician's diagnosis and prognosis;
  - The physician's determination that the patient has a grievous medical condition that is not remediable using treatments that the patient is willing to accept and that the patient's suffering is intolerable to the patient; and,
  - The physician's determination that the patient is capable, acting voluntarily and has made an informed decision to seek physician-assisted dying.
- The patient must complete a prescribed form confirming that the patient has given informed consent to physician-assisted dying and that the requirements for physician-assisted dying have been met. Where a patient is mentally competent but incapable of completing such a form, a third party, independent of the physician and the patient, may complete the form on the patient's behalf based upon confirmation from the patient.

#### 1.9 Documentation Requirements – the patient record

- The attending physician must document the following in the patient's medical record:
  - The information and documentation described in paragraph 1.8;
  - All oral and written requests by a patient for physician-assisted dying; and
  - A summary of discussions held with the patient relating to physician-assisted dying.

#### 1.10 Report to the Coroner

- **The Coroner's Act, 1999** requires certain deaths to be reported to a coroner. A physician-assisted death is a reportable death and a physician participating in a physician-assisted death must comply with the requirements of that Act.

## 2. Standards for physician-assisted dying

1. The College of Physicians and Surgeons will establish standards for the performance of physician-assisted dying. Those standards are not yet developed.
2. The attending physician must be available to care for the patient until the patient's death, if the patient so requests.