Protection of Conscience Project
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Submission to the College of Physicians and Surgeons of Saskatchewan

Re: *Physician-Assisted Dying Draft Guidance Document*

20 October, 2015

I. Introduction

I.1 The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience among health care workers. It does not take a position on the acceptability of morally contested procedures. For this reason, only a few points in the *Physician-Assisted Dying Draft Guidance Document* are addressed in this submission.

II. Scope of this submission

II.1 The Project makes some cautionary observations concerning the provision of information (Part III), specific recommendations concerning informed decision-making (Part IV) and one of the proposed standards (Part V), and offers a policy to ensure protection of physician freedom of conscience that can be applied to euthanasia and assisted suicide as well as other morally contested procedures (Part VI).

II.2 While it is outside the scope of Project interests, it seems prudent to point out that the draft document omits the Supreme Court of Canada requirement that candidates for euthanasia and physician assisted suicide must be *adults*.

III. Re: "unbiased and inaccurate information"

Guidance draft - Foundational Principles (2) Access

III.1 The draft document states: "Individuals who seek information about physician-assisted dying should have access to unbiased and accurate information."

III.2 Taken at face value, this is an entirely reasonable expectation. However, it must be understood that objecting physicians or health care workers who are explaining their own position to patients may make statements to the effect that they do not consider euthanasia and assisted suicide to be forms of medical treatment or palliative care. In the course of such conversations, they may also ethically distinguish

between withdrawal/refusal of treatment and killing patients or helping them to kill themselves.

III.3 Euthanasia/assisted suicide activists may take exception to statements or explanations of this kind, calling them biassed and inaccurate. The College must not use this policy to try to force objecting physicians to express and live by the ethical beliefs of euthanasia/assisted suicide activists rather than their own.

IV. "certainty of death"

Guidance draft - 1.4 Informed Decision

IV.1 According to the draft, the patient must be informed of "the certainty of death upon taking the lethal medication" and "the potential complications associated with the medication."

IV.2 However, death is not always certain. Euthanasia and assisted suicide drugs do not always cause death as expected.[1] It is for this reason that Quebec euthanasia kits are to include two courses of medication.[2]

IV.3 Discussion with patients should include discussion of options available in the event that a lethal injection or prescribed drug does not kill the patient, and the patient should be asked to provide direction on this point. The relationship of this issue to physician freedom of conscience is addressed in Part V.

V. Responsible physician obligations

V.1 Pending the development of standards for the performance of physician assisted suicide and euthanasia, the *Draft Guidance Document* makes only a single statement:

> The attending physician must be available to care for the patient until the patient's death, if the patient so requests.

V.2 "Attending physician" in this context appears to refer to the physician who has agreed to assist with the patient's suicide or provide euthanasia rather than (for example) a family physician who has declined to do so, but who continues to be responsible for other aspects of patient care in accordance with Foundational Principle (8) in the document.

V.3 It would be helpful to make this explicit. To avoid ambiguity, it would also be helpful to use a specific term when referring to the physician who has agreed to assist with the patient's suicide or provide euthanasia (such as, "responsible physician" or "PAD physician"). The term "responsible physician" is used in this part.

V.4 Assisted suicide vs. euthanasia

V.4.1 A 2014 survey of Canadian Medical Association members indicated that more physicians were willing to participate in assisted suicide (27%) than euthanasia (20%).[3,4,5,6]

V.4.2 However, a physician who agrees to help a patient commit suicide would seem to have accepted an obligation to do something that will result in the patient's death, and to do it according to accepted standards. This obligation seems implicit in the agreement.

V.4.3 In the case of a failed physician-assisted suicide that incapacitates a patient, it is likely that the responsible physician will be expected to fulfil his commitment to help bring about the death of the patient by providing a lethal injection or finding someone willing to do so. The expectation would be stronger if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt.

V.4.4 Here the issue of physicians willing to assist in suicide but unwilling to provide euthanasia becomes acute. Those willing to assist with suicide but not euthanasia may be reluctant or unwilling to ask another colleague to kill the patient. Moreover, the *Carter* ruling limits the provision of euthanasia to competent patients. Thus, to ask physicians to kill a patient who has been rendered incompetent by a colleague's failed attempt would seem to expose them to prosecution for first degree murder or, at least, assisted suicide.

V5. Urgent situations

V.5.1 Some authorities have stated that a physician's obligation to provide treatment urgently needed to prevent imminent harm to patients does not extend to providing assisted suicide or euthanasia.[7] This presumes that, since the procedures require extensive preliminary consultation and preparation before they can be authorized, they can never be urgently required.

V.5.2 That presumption is challenged by testimony taken by the Quebec legislative committee studying what later became the province's euthanasia law (*An Act Respecting End of Life Care*). Representatives of the College of Pharmacists of Quebec agreed that the provision of euthanasia would not seem to involve "the same urgency" as other kinds of procedures, and that arrangements could normally be made to accommodate conscientious objection by pharmacists because the decision could be anticipated.[8] However, they also stated that situations may evolve more quickly than expected, and that (for example) palliative sedation might be urgently requested as a result of respiratory distress precipitated by sudden bleeding.[9]

V.5.3 The pharmacist representatives distinguished between making a decision that euthanasia or assisted suicide should be provided - a decision which might take days or weeks - and

a decision that a drug should be urgently provided to deal with an unanticipated and critical development in a patient's condition.[10]

V.5.4 Under the terms of the *Carter* ruling and the *Draft Guideline Document*, it is possible that a responsible physician might agree to provide euthanasia or assisted suicide on a given date and time, to accommodate (for example) the desire of geographically distant family members to be present at the patient's death. Between the time that decision is made and the appointed time, however, a sudden deterioration of the patient's condition may cause him to ask for immediate relief from pain or suffering by euthanasia or assisted suicide.

V.5.5 No problem will arise if the responsible physician is immediately available to fulfil the request. However, there is likely to be a problem if the responsible physician is absent or unavailable, and other physicians willing to kill the patient or assist in suicide cannot be conveniently found. This situation is more likely to arise if the originally appointed time for euthanasia/assisted suicide is some days later than the decision to provide the procedure.

V.6 Recommendations

V.6.1 In order to avoid conflicts of conscience occurring in particularly difficult circumstances, and to avoid conflicts of conscience among health care workers who may be involved in other aspects of the care or treatment of a patient:

1) Physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.

2) In all cases, the responsible physician should, immediately prior to administering or providing the lethal medication, obtain written direction from the patient as to what action should be taken if the prescribed or administered drugs fail to cause death. (NB. In the case of patients incapacitated by failed euthanasia/assisted suicide, it is not known if this would be legally sufficient to invoke the exemption from prosecution provided by *Carter*.)

3) The responsible physician should personally administer the lethal drug or be personally present when it is ingested, and remain with the patient until death ensues.

4) A responsible physician who has agreed to provide euthanasia or assisted suicide must be continuously available to do so from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request.

5) A responsible physician who has agreed to provide euthanasia or assisted suicide must also arrange for a second responsible physician to provide the procedure in the event that he is unable to be continuously present or is unable to act.

6) The second responsible physician must be continuously available to act in the place of the primary responsible physician.

VI. Suggested policy on physician exercise of freedom of conscience

VI.1 Appendix "A" provides a policy concerning the exercise of freedom of conscience by physicians that, in the Project's experience, would be acceptable to most objecting physicians, even with respect to euthanasia and assisted suicide. It is consistent with

- the *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999);
- the Canadian Medical Association *Code of Ethics* (2004);
- the Canadian Medical Protective Association publication, *Consent: A guide for Canadian physicians* (2006);
- the Canadian Medical Association's *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015)

VI.2 The policy provides seven alternative responses for objecting physicians, reflecting the fact that different ethical, moral or religious traditions may take different approaches to the issue of complicity in morally contested acts. Further, within some traditions, the facts of a particular case may influence the moral judgement of a physician.

VI.3 CMA guidance noted in VI.1 does not preclude the other alternatives in the suggested policy for reasons given by the Association to the Supreme Court of Canada:

> The CMA's purpose, in developing and setting policy, is not to override individual judgment or to mandate a standard of care.[11]
>
> The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience.[12]

VI.4 None of the responses obstruct patient access to euthanasia or assisted suicide. Some responses involve deliberate of facilitation of the services. It is up to the physician to decide which response to choose in each case.

Appendix "A"

Physician Exercise of Freedom of Conscience and Religion

AI. Introduction

AI.1 To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of Parts AII and AIII for services they are unwilling to provide for reasons of conscience or religion.

AII. Providing information to patients

AII.1 This Part highlights points of particular interest within the context of the exercise of freedom of conscience. It is not an exhaustive treatment of the subject of informed consent.

AII.2 In exercising freedom of conscience and religion, physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21[14]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Disclosure of information; Standard of disclosure.[15]
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 1.2, 5.2[16]

AII.3 Sufficient information is that which a reasonable patient in the place of the patient would want to have, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21[14]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (1), (2).

(4), (5)[15]

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 1.2, 5.2[16]

AII.4 Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

AII.5 Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician.

- Canadian Medical Association *Code of Ethics* (2004) para. 23[17]

AII.6 Physicians whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.

- Canadian Medical Association *Code of Ethics* (2004) para.45[18]

AII.7 The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21,[14] 22[19]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (3)[15]
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Foundational Principle (6), (10)[20]

AII.8 Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

AIII. Exercising freedom of conscience or religion

AIII.1 In exercising freedom of conscience and religion, physicians must adhere to the requirements of Part AII (Providing information to patients).

AIII.2 In general, and when providing information to facilitate informed decision making, physicians must give reasonable notice to patients of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 12,[21] 21[14]

AIII.3 Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted.

AIII.4 In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

AIII.5 Physicians who decline to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere, and provide information about how to find other service providers. Should the patient do so, physicians must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient.

- (CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21[14]
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 5.2[22]

AIII.6 Alternatively, in response to a patient request, physicians may respond in one of the following ways, consistent with their moral, ethical or religious convictions:

a) by arranging for a transfer of care to another physician able to provide the service; or

b) by providing a formal referral to someone able to provide the service; or

c) by providing contact information for someone able to provide the service; or

d) by providing contact information for an agency or organization that will refer the patient to a service provider; or

e) by providing contact information for an agency or organization that provides information the patient may use to contact a service provider; or

f) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, heath care workers or sources of information about the services being sought by the patient.

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 5.2[22]

AIII.7 A physician's response under AIII.5 or AIII.6 must be timely. Timely responses will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

AIII.8 In acting pursuant to AIII.5 or AIII.6, physicians must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16, II.11[13]

- Canadian Medical Association *Code of Ethics* (2004) para. 19,[23] 21[14]

AIII.9 Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

AIII.10 Physicians who provide medical services in a health care facility must give reasonable notice to a medical administrator of the facility if religious, ethical or other conscientious convictions prevent them from providing certain procedures or services, and those procedures or services are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility.

AIV. Reminder: treatments in emergencies

AIV.1 Physicians must provide medical treatment that is within their competence when a patient is likely to die or suffer grave injury if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment.

- Canadian Medical Association *Code of Ethics* (2004) para. 18[24]

AIV.2 Physicians who fail to provide or arrange for medical treatment in such circumstances may be liable for negligence or malpractice.

Notes

1. Groenewoud JH, van der Heide A. Onwuteaka-Philipsen BD Willems DL van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *N Engl J Med* 2000; 342:551-556 February 24, 2000

2. Ubelacker S. "Quebec MDs to get euthanasia guide to prepare for legalized assisted death: Unclear whether other provinces and territories will adopt a similar practice."*The Canadian Press*, 1 September, 2015 (http://www.cbc.ca/news/canada/montreal/quebec-mds-to-get-euthanasia-guide-to-prepare-for-legalized-assisted-death-1.3212081) Accessed 2015-09-03.

3. Moore E. "Doctor is hoping feds will guide on assisted suicide legislation." *Edson Leader*, 12 February, 2015. (http://www.edsonleader.com/2015/02/12/doctor-is-hoping-feds-will-guide-on-assisted-suicide-legislation) Accessed 2015-07-16.

4. Rich, P. "Physician perspective on end-of-life issues fully aired." *Canadian Medical Association*, 19 August, 2014 (https://www.cma.ca/En/Pages/Physician-perspective-on-end-of-life-issues-fully-aired.aspx) Accessed 2015-06-22

5. Ubelacker S. "Medical professionals try to answer burning questions on doctor-assisted death." *Associated Press*, 13 February, 2015 (http://www.1310news.com/2015/02/13/medical-professionals-try-to-answer-burning-questions-on-doctor-assisted-death/) Accessed 2015-07-04

6. Kirkey S. "How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling." *National Post*, 23 February, 2015 (http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling) 2015-07-04

7. "A request for physician assisted death will not be considered an emergency in the context of this policy, and is therefore not a service or intervention that physicians will be required to provide, contrary to their conscience or religion." College of Physicians and Surgeons of Ontario, *Professional Obligations and Human Rights: Frequently Asked Questions*. (http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights-FAQ.pdf?ext=.pdf) Accessed 2015-10-17

8. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#49, T#58 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#049; http://www.consciencelaws.org/background/procedures/assist009-005.aspx#058)

9. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#33 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#033)

10. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#76, T#87, T#88 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#076) (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#087) (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#088)

11. In the Supreme Court of Canada (On Appeal from the Court of Appeal of British Columbia) *Affidavit of Dr. Chris Simpson, Motion for Leave to Intervene by the Canadian Medical Association* (5 June, 2014), para. 17 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/Supreme-Court-Affidavit-Carter-Case.pdf) Accessed 2015-06-22.

12. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association* (27 August, 2014), para. 9 (http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf)

13. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada) (http://www.consciencelaws.org/background/policy/associations-001.aspx)

14. Canadian Medical Association *Code of Ethics* (2004): "21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

15. Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006) (https://www.cmpa-acpm.ca/-/consent-a-guide-for-canadian-physicians#disclosure) Accessed 2015-09-15

16. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) "Section 1.2: 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." "Section 5.2: . . . 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."

17. Canadian Medical Association *Code of Ethics* (2004): "23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. . ." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

18. Canadian Medical Association *Code of Ethics* (2004): "45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

19. Canadian Medical Association *Code of Ethics* (2004): "22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

20. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) "Foundational Principle (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." "Foundational Principle (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."

21. Canadian Medical Association *Code of Ethics* (2004): "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

22. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) "Section 5.2: . . . 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."

23. Canadian Medical Association *Code of Ethics* (2004): "19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

24. Canadian Medical Association *Code of Ethics* (2004): "18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care. "

(http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22