Submission to the Senate Standing Committee on Legal and Constitutional Affairs regarding Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*

College of Physicians and Surgeons of Ontario

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The College of Physicians and Surgeons of Ontario (College) appreciates the opportunity to appear before the Senate Standing Committee on Legal and Constitutional Affairs regarding Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*.

As Canada's largest medical regulatory authority, the College has a legal mandate to serve and protect the public interest. All of our work, including that on medical assistance in dying (MAID), is undertaken with a view toward fulfilling our mandate. Core College responsibilities include:

- Issuing certificates of registration to physicians to allow them to practice medicine in Ontario;
- Monitoring and maintaining standards of practice through peer assessment and remediation;
- Investigating complaints about physicians on behalf of the public;
- Conducting discipline hearings when physicians may have committed an act of professional misconduct or may be incompetent;
- Articulating expectations for physician conduct on professionalism, medico-legal and other issues that are relevant to the practice of medicine through the Practice Guide and over fifty College policies.

With respect to the last listed core responsibility, the College has articulated expectations for physician conduct in relation to MAID in our *Interim Guidance on Physician-Assisted Death* . This document was finalized in January 2016 to guide the profession in the absence of a government framework.[1] This document has been used by physicians and judges of the Superior Court of Ontario and other provinces in managing requests for judicial authorization of MAID during the interim period from February to June 2016.

The College believes that it is essential that legislation on MAID be in place for June 6 2016. Bill C-14 represents an important step in establishing the framework necessary to implement the Supreme Court of Canada's decision in *Carter v. Canada (Attorney General)*[2] (*Carter*) and to legalize MAID in Canada. The College strongly supports many aspects of the Bill. This

[1] Policies relevant to MAID and cited in the *Interim Guidance* document include: *Planning for and Providing Quality End-of-Life Care*, *Consent to Treatment*, *Medical Records* and *Professional Obligations and Human Rights*.
[2] 2015 SCC 5.

submission will highlight those areas of support and articulate a few key concerns the College has with the Bill.

I. Areas of Support

The College agrees with the government's objective to ensure there is a consistent approach to MAID across Canada. We believe this is essential given the complexity of MAID, and the fact that the federal government together with the provincial/territorial governments and the professional regulatory colleges each have a role to play in implementing MAID in Canada. Professionals need clear and consistent direction and eligible patients need equitable access to MAID regardless of where in Canada they reside.

The College strongly supports the fact that nurse practitioners, along with physicians, will be authorized to provide MAID. Nurse practitioners currently play an important role in the provision of healthcare. In some communities, particularly those in remote or rural areas, nurse practitioners are the primary and at times, sole healthcare providers for the community. Enabling nurse practitioners to provide MAID is an important step toward ensuring patient access to MAID.

The College strongly supports subsections 241(3)(4) and (5) which serve to provide exemptions or liability protections to healthcare professionals and individuals who may aid the patient. The provisions relating to healthcare professionals recognize that healthcare is delivered through a collaborative team-based approach and that a range of professionals have an important role to play in providing MAID. The provisions relating to those aiding the patient serve to support patient choice by enabling patients who wish to pursue a self-administered approach to MAID to do so even if they have functional limitations or otherwise require assistance to achieve MAID.

The College strongly supports the government's intention, as evidenced by subsection 241.31(3) to ensure there is a data collection and monitoring system established regarding MAID. Data on MAID will be critical to enable government, regulatory colleges, healthcare professionals and indeed Canadian society as a whole to gain insight into our experience with MAID and to ensure that any future amendments to legislation, practice or policy can be evidence-based. The College encourages government to proceed with the development of regulations in a timely manner, and concurrently to develop a plan for collecting data in the interim, until the regulations are in force.

In addition to these specific provisions in the Bill, the College also strongly supports the government's stated commitment to increase funding for palliative and home care. Palliative care and home care are important elements of the overall healthcare system, and provide immeasurable assistance and support to Canadian citizens. In order to respect patient autonomy in healthcare decision-making, it is essential that all Canadians have access to a range of treatment options, including palliative options.

II. Key Concerns

In keeping with our mandate to protect and serve the public interest, the College supports respect for patient autonomy and patient access to care. The College's key concerns with Bill C-14 centre on those provisions that we believe may negatively impact patient access to MAID. They include the eligibility criteria for MAID; safeguards for MAID; and conscientious objections to MAID.

a) Eligibility Criteria for MAID

The College has key concerns with two elements relating to the eligibility criteria for MAID: subsection 241.2(1)(b), and subsection 241.2(2).

i) Subsection 241.2(1)(b): Age of Adult

The College notes that subsection 241.2(1)(b) specifies that patients must be eighteen (18) years of age and capable in order to access MAID. The inclusion of a specific age in the Bill enhances clarity of the language of 'adult' employed by the Supreme Court of Canada in *Carter.* We note, however, that connecting capacity to a specific age is at odds with the approach which underpins relevant Ontario legislation.

Under Ontario's *Health Care Consent Act, 1996,* patients, regardless of chronological age, are deemed to have capacity to consent to treatment if they are: able to understand the information that is relevant to making a decision about the treatment, and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.[3]

By linking capacity to the age of eighteen in the Bill, the consequential effect in Ontario is that patients under eighteen may be deemed capable of making healthcare decisions by virtue of Ontario legislation, (including decisions such as withdrawal of life-sustaining treatment) but

[3] Section 4(1) of the *Health Care Consent Act, 1996*, S.O. 1996, Sched. A.

may be ineligible to access MAID because of their age. For this reason, the College advocates that the government undertake its planned study of mature minors on a priority basis.

ii) Subsection 241.2(2): Grievous and Irremediable Medical Condition

Through the language employed in subsections 241.2(2)(a)(b) and (d), Bill C-14 appears to specify eligibility criteria that are more narrow than that established by the *Carter* decision.

- The use of the word 'incurable' in subsection 241.2(2)(a) suggests that patients must explore and undertake all treatment options or 'cures', (even those they do not find acceptable), prior to requesting MAID. It suggests MAID must be an option of last resort.

- The language in subsection 241.2(2)(b) which requires that patients be in an 'advanced state of irreversible decline in capability ', implies that only patients with conditions that progressively worsen over time will be eligible for MAID. This language would exclude conditions that may be 'serious and incurable' and cause 'enduring and intolerable suffering' but that do not advance in a progressive manner.

- Subsection 241.2(2)(b) together with subsection 241.2(2)(d) suggests that patients will only be eligible for MAID if their condition has progressed significantly and that death is, if not imminent, then certainly proximal to the request for MAID. Consequently, patients who may have non-terminal but 'serious, and incurable' conditions, for which they are experiencing 'enduring and intolerable suffering' would be disqualified from accessing MAID.

The College raises these points not to advance arguments regarding the Bill's concordance with the *Carter* decision or with the *Canadian Charter of Rights and Freedoms*[4]. We are aware of others who have expressed views on those points, and we will leave it to experts in constitutional law and legislative drafting to articulate those claims. We raise these points to illustrate that on this important issue of eligibility to MAID, the language employed in subsection 241.2(2) and the fact that it departs from the criteria established in *Carter* will cause confusion and lack of clarity amongst physicians and the public.

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[44] Part I of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982 (UK),* 1982, c.11.

b) Safeguards

Robust safeguards are a critically important element of the Bill and the College commends the government for its detailed and comprehensive approach. The safeguards align very closely with the Sample Process Map the College included in our *Interim Guidance* document.

These comments notwithstanding, the College has key concerns with two elements of the safeguards: provisions relating to the independence of witnesses and practitioners, and the provision relating to the reflection period.

i) Requirements for Independence

The College supports the principle that the process which governs the requests for and provision of MAID needs to be rigorous, and that patients should never be coerced or otherwise influenced in seeking or proceeding with MAID. However, the definitions of 'independence' as set out in subsections 241.2(5) and (6) are so stringent that they will effectively prevent many eligible patients from accessing MAID.

Regarding witnesses, some patients who would otherwise be eligible for MAID will not be able to find two individuals outside their family, caregivers or healthcare providers to act as independent witnesses, as required by subsection 241.2(5). For some patients, the very condition that has led them to seek access to MAID will have resulted in their isolation and loss of access to broader circles of support. Such patients would be forced to call upon virtual strangers to act as witnesses to a request that is intensely personal and private in order to comply with this element of the Bill. Many patients would find it very intrusive to do so and would not wish their personal health information and treatment decisions to be shared beyond their intimate circle of contacts. Indeed, the need for privacy with respect to requests for MAID is evidenced by the fact that in a number of applications for judicial authorization of MAID during the current interim period, patients have sought publication bans to protect their own privacy and that of their family members.

It is not clear what policy objective the requirement for witness 'independence' would satisfy that warrants imposing such a barrier to access. Witnesses in the context of Bill C-14 are not determining patient eligibility for MAID, and the voluntariness of a patient's request for MAID will be determined by the practitioners involved in assessing the patient, in accordance with the legal requirements for informed consent. Further, the College would note under Ontario legislation the very individuals who would be excluded from acting as a witness to MAID under Bill C-14 could in fact act as substitute decision makers for incapable patients in Ontario and in that capacity, make significant life and death decisions on a patient's behalf, such as

withdrawing life-sustaining treatment.[5] These individuals have legal duties with respect to how they must make decisions, and the validity of those decisions are assessed on a case-by-case basis and can be challenged when necessary using existing structures, such as the Consent and Capacity Board in Ontario.

Regarding practitioners, the College is supportive of subsection 241.2(6)(b), which would disqualify practitioners who have a financial interest in the patient proceeding with MAID. We are concerned, however, that the other two subsections in this provision (241.2(6)(a) and 241.2(6)(c)), pose significant challenges with respect to patient access to MAID.

The prohibition in subsection 241.2(6)(a) against physicians being in a 'business relationship' with one another does not reflect the realities of how healthcare is delivered in Ontario. The same is true for the requirement in subsection 241.2(6)(c) that physicians not be 'connected' to each other. Physicians typically practice medicine in a group setting: they work in practice groups in hospitals and other facilities. Further, in keeping with the Ontario Ministry of Health and Long-Term Care's comprehensive care model, family medicine in Ontario is delivered in the context of group practice models: family health groups, family health teams and family health organizations. The prohibition against being in a 'business relationship' or being 'connected' would disqualify all physicians who practice together in hospital or facility groups or in family medicine practice models from providing MAID.

The consequent impact of these provisions on patient access to MAID would be significant and would be felt in both urban and rural centres, as many or perhaps all physicians in a given centre would be part of the same practice group. For instance, in Barrie-North Simcoe, the vast majority of family physicians in the region are part of one family health team; they provide care to ninety-two percent (92 %) of the population. In Peterborough, ninety-eight percent (98%) of all family physicians are included in one family health team. In northern Ontario, fourteen municipalities are all covered by a Rural and Northern Physician Group Agreement. Under this agreement all fourteen municipalities are affiliated with a single family health team which provides all primary care services for that region.

The requirement in subsection 241.2(6)(c) poses an additional concern. The language requires that physicians not be 'connected' with the patient in 'any other way that would affect their

[5] See Ontario's *Health Care Consent Act, 1996* ,S.O. 1996, c. 2, Sched. A.

objectivity'. It is unclear how this will be interpreted in practice. The College is concerned that this subsection may prevent physicians from providing MAID to those patients with whom they have an existing treating relationship. We agree that objectivity is critical to providing quality health care. Objectivity, however, can be maintained even if there is an existing physician-patient relationship.

The College believes it is essential that the government clarify this subsection to ensure that physicians are not prevented from providing MAID to existing patients. We are concerned that otherwise, the subsection may be interpreted in a manner that would have negative consequences for patients. It may deprive patients of exploring MAID with the support of a trusted physician by their side. It may also require patients to seek out a new physician specifically for the purposes of MAID. Given the eligibility criteria for MAID set out in the Bill, many patients may not be well enough to do so.

ii) Reflection Period

The College supports the requirement in subsection 241.2(3)(g) for a period of reflection between the request for MAID and the provision of MAID. Further, the College supports the specific approach employed in the Bill: the specification of a time frame or duration for the reflection period, while allowing for deviation from this time period on a case-by-case basis. The College included a similar requirement, with comparable language in our *Interim Guidance* document.

We note, however, that physicians and nurse practitioners are only permitted to deviate from the fifteen day reflection period in two instances: when the patient's death is imminent, or when the patient's loss of capacity is imminent. The subsection as currently worded does not allow for the reflection period to be shortened in another equally pressing instance: when patient suffering has intensified as a result of the underlying condition. We believe that subsection 241.2(3)(g) should be amended to allow for the reflection period to be shortened for reasons related to patient suffering, in addition to when patient death or loss of capacity is imminent.

c) Conscientious Objections

The College supports recommendation ten (10) set out in the Report of the Special Joint Committee on Physician-Assisted Dying:

> That the Government of Canada work with the provinces and territories and their medical regulatory bodies to establish a process that respects a health care practitioner's freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient. (emphasis added)

Managing or accommodating the conscientious objections of practitioners is a key issue related to MAID that has direct implications for patient access to care. It is essential that government support patient access to care and take steps to ensure that patient access is facilitated. For these reasons, the College strongly advocates for the government to work together with provincial and territorial governments to ensure that objecting practitioners are required to provide an 'effective referral' and that this requirement is enshrined in provincial and territorial law.

The requirement to provide an effective referral aligns with the Supreme Court of Canada's comments in *Carter.* It mirrors professional expectations set out by the College in our *Interim Guidance* document and is consistent with the expectations the College of Nurses of Ontario[6] and the Ontario College of Pharmacists[7] have for their members on this topic.

An effective referral reconciles practitioner and patient rights, as directed by the Supreme Court of Canada in *Carter.* Practitioner rights are respected as they do not have to provide MAID contrary to their conscience or religious beliefs. Patient rights are respected as they are not deprived access to care (contrary to *Carter* and Bill C-14) due to the conscience or religious beliefs of practitioners.

We are aware that some stakeholders have advocated for a 'self-referral' model, where patients would be left to find willing practitioners with whom they can explore MAID. This model is contrary to the ethical and professional duties that physicians, nurses and other healthcare professionals owe to their patients. Specifically for physicians, it is contrary to the fiduciary duty to prioritize patient rights. Given the Bill requires patients to be in an advanced state of illness prior to receiving MAID, it is also unconscionable. Managing or accommodating the conscientious objections of practitioners should not impose a burden on patients.

An effective referral is not equivalent to providing MAID. In accordance with the requirements of Bill C-14, in order to obtain MAID two practitioners must agree that the patient meets the

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[6] College of Nurses of Ontario, *Medical Assistance in Dying: Interim Guidance for Nursing in Ontario,* May 3 2016, page 3.
[7] Ontario College of Pharmacists, *Physician-Assisted Death: Preliminary Guidance to Pharmacists and Pharmacy Technicians,* February 5 2016, page 4.

eligibility criteria and all of the safeguards set out in the Bill must be satisfied. Further, patients must provide informed consent to MAID. To claim that an effective referral is equivalent to providing MAID ignores or discounts the importance and rigour of the provisions included in Bill C-14, and the legal and ethical requirements regarding informed consent.

The College is concerned that if Canadian governments do not enshrine a requirement for an effective referral in legislation, the matter will be left to the regulatory authorities. This is an undesirable outcome as it may lead to a patchwork approach to conscientious objection that is contrary to the government's objective of ensuring consistency, and that importantly, will have distinct negative implications for patient access to MAID.

- Each regulatory authority would be left to determine how conscientious objections should be managed and accommodated. Depending on the position adopted by each regulatory authority, patient access to MAID could differ not only between provinces and territories but also within a given province or territory.

- It would also result in the management of conscientious objections being resolved through 'soft law' instruments like policies or codes of ethics whose enforceability can be more vulnerable to legal challenge than statute or regulation.

We trust our comments and suggestions are useful to the Committee as it continues its examination of Bill C-14 and would be happy to provide any further assistance that may be helpful.