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January 13, 2016

**VIA EMAIL [interimguidance@cpsso.on.ca](mailto:interimguidance@cpsso.on.ca)**

College of Physicians and Surgeons of Ontario  
80 College Street  
Toronto, ON M5G 2E2

ATTENTION: POLICY DEPARTMENT

Dear Sir/Madam:

**Re: Comments on Draft Interim Guidance on Physician-Assisted Death**

The following are the Advocacy Centre for the Elderly's comments on the Interim Guidance on Physician-Assisted Death for your consideration.

**The Advocacy Centre for the Elderly (ACE)**

ACE is a specialty community legal clinic that provides range of legal services to low-income older adults in Ontario. Established in 1984, ACE is the first and oldest legal clinic in Canada with a specific mandate to provide a range of legal services to low income older adults in Ontario. ACE's legal services include individual and group client advice and representation, public legal education, community development and law reform activities.

ACE staff have extensive experience in issues related to health care consent, and have been involved in many of the law, policy, and education initiatives relating to these issues in Ontario over the last 30 years. These have included:

- Participating as a member of the Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992*, and subsequently the *Health Care Consent Act, 1996*;<sup>1</sup>
- Acting as one of the principal authors of the training materials for health care professionals produced as part of two of the Alzheimer Society of

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<sup>1</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (*HCCA*)

Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;

- Participating on the Ontario Medical Association President's Advisory Committee on Palliative Care and Advance Care Planning;
- Participating currently on the Advisory Committee for the Law Commission of Ontario Project on Legal Capacity, Decision-making and Guardianship;
- Engaging presently, and for the past two years, in a number of educational initiatives for health care practitioners on health care consent and advance care planning. These include, but are not limited to, initiatives in the Erie-St Clair LHIN, Central East LHIN, Hamilton Niagara Haldimand Brant (HNHB) LHIN, and Northwest LHIN. These initiatives have involved interactive, detailed training sessions as well as the production of an online training course on health care consent and advance care planning. This course has become a requirement for licensees signing Long-Term Care Home Service Accountability Agreements in the HNHB LHIN;
- Co-authoring, with the law firm of Dykeman Dewhirst O'Brien LLP, a major research paper for the Law Commission of Ontario entitled *Health Care Consent and Advance Care Planning in Ontario*;<sup>2</sup> and,
- Providing comments on previous College of Physicians and Surgeons of Ontario (CPSO) policies.

Our comments are based on extensive experience conducting educational seminars for lawyers and physicians on health care consent and end-of-life decision-making. Through these experiences, ACE has observed that many physicians inadvertently fall afoul of Ontario law on health care consent generally, and around end-of-life decision-making issues, in particular.

Given our years of working on health law and policy issues that impact older adults in Ontario and across Canada, we trust that our comments on the Draft Interim Guidance on Physician-Assisted Death will be of assistance.

### **Commentary on the Draft Interim Guidance on Physician-Assisted Death**

Overall, this version of the Draft Interim Guidance on Physician-Assisted Death (the Draft Policy) accurately reflects the law as set out in *Carter v. Canada (Attorney General)*

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<sup>2</sup> Judith Wahl, Mary Jane Dykeman and Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario: Legal Capacity, Decision-Making in Guardianship*, Law Commission of Ontario: January 2014, available at: <http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf>

(*Carter*).<sup>3</sup> ACE advocates for scrupulous safeguards in order to ensure that physician-assisted death is entered into voluntarily and is not abused.

ACE applauds the efforts of the CPSO in providing guidance to physicians in this time of uncertainty in the area of end-of-life decision-making. As indicated in the Draft Policy, much of this document may have to be revised when the Federal and Provincial Governments determine their legislative response to the *Carter* decision.

Our comments will address the following aspects of the Draft Policy:

1. Ascertaining voluntary and informed consent to physician-assisted death;
2. Reviewing the sample process map; and,
3. Informing patients about the option of physician-assisted death.

### **1. Ascertaining Voluntary and Informed Consent to Physician-Assisted Death**

As the Draft Policy correctly states at lines 107 to 110, the *Health Care Consent Act, 1996*, provides that the following elements of consent must be met for consent to be considered valid:

1. The consent must relate to the treatment;
2. The consent must be informed;
3. The consent must be given voluntarily; and
4. The consent must not be obtained through misrepresentation or fraud.<sup>4</sup>

These elements relate to consent to treatment. Nevertheless, given the irremediable consequences of physician-assisted dying, these elements are to be strictly complied with in order to ensure the protection of those involved.

ACE wholeheartedly agrees that a patient must understand all of the palliative care options available to them. Understanding alternatives to physician-assisted dying is an important aspect of informed consent. At no point should a patient's choice to terminate life be made because they are unaware of other ways to alleviate the suffering or pain caused by their condition.

ACE is concerned, however, that the Draft Policy does not provide sufficient guidance to physicians who are assessing the voluntariness of their patients' consent to physician-

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<sup>3</sup> 2015 SCC 5

<sup>4</sup> *Supra*, note 1, s. 11 (1).

assisted death. In our experience, persons who experience multiple disadvantages may be susceptible to undue influence and pressure. Persons who have grievous or irremediable medical conditions and who are also experiencing discrimination due to age may be particularly vulnerable. They may feel that they are a burden on others as they lose their independence; they may be socially isolated; or they may fear not having adequate social supports to meet their needs, all of which may be inducements toward physician-assisted death. They may be making their decisions, not based on their illness, but rather on fears about the availability of care at their end of life.

The attending and consulting physicians must spend significant time with the patient searching out these vulnerabilities, in order to assess whether the patient's decision-making is truly voluntary. ACE questions whether this burden should be placed on physicians or should be the responsibility of another, specialized body. In ACE's experience, there is also some misunderstanding among physicians about the law of consent as it relates to treatment. Nevertheless, at this time, physicians are being placed in the role of having to assess the voluntariness of a patient's consent to physician-assisted death. Physicians will require additional guidance and education in the law of consent and in identifying possible undue influence in order to fulfil this role.

Furthermore, ACE is concerned that the Draft Policy misstates the role of "advance directives" in end-of-life decision-making. At line 119, the Draft Policy correctly indicates that requests for and/consent to physician-assisted death cannot be made through a substitute decision-maker, only by a capable patient. The Draft Policy also states on the same line that the physician must decline requests made through an advance directive. This statement may cause unnecessary confusion. In Ontario, consent to treatment cannot be obtained vis-a-vis an advance directive. If a patient expressed a capable wish with regard to a particular treatment in future, not with respect to their present health-condition, and subsequently became incapable, the wish is to be interpreted by the substitute decision-maker and conveyed to the health care provider. The statement at line 119 is misleading and should be clarified by adding, "As with treatment decisions" when discussing requests made through advance directives.

Additionally, physicians should avail themselves of appropriate translation services in order to ensure that patient consent is informed and voluntary. Physicians often rely on family members for translation, which is generally not recommended. Given the nature of physician-assisted death and the potential for faulty translation by family members who are not professional translators and may have conflicting interests, it is vital to use independent translation services. Similarly, persons with alternate communication requirements (i.e. pocket talkers, bliss boards, etc.) must be accommodated with translators or assistive devices to ensure that they do not face barriers to accessing physician-assisted death, nor to understanding its consequences and any alternative treatments.

## **2. The Sample Process Map**

On lines 210 to 222, the Draft Policy contains a sample process map. Such a process map offers useful guidance to physicians who will be assisting patients in dying.

ACE submits that it is vital that the initial discussion between patient and physician regarding physician-assisted death be held outside the presence of others, including family members, excepting impartial communication assistance. Given the possibility of influence by third parties, as earlier discussed, it will be important to ensure that the patient is free of any undue influence. Meeting with the patient (except as indicated above) will provide the physician with the opportunity to assess the voluntariness of the patient's consent to physician-assisted death, and will allow a proper flow of communication between the patient and the physician.

ACE questions the utility of the declaration requirement in the first request stage. ACE believes that a signed declaration is insufficient to ensure that consent to physician-assisted death is informed and voluntary. ACE hopes that the legislation will offer additional protections in this regard. As it stands, the proposed document is intended to be witnessed by two persons, only one of whom is not a relative or entitled to a portion of the estate. Given the potential for abuse in these cases, ACE strongly recommends that neither witness be a relative or potential beneficiary of the patient's estate.

At stage two, the process map lacks clarity on the issue of timelines for the reassessment of capacity. While the process map indicates that both the attending and consulting physicians must agree that the patient has capacity to consent to physician-assisted death and that the patient's consent is free from undue influence, it does not indicate whether the patient must be capable of consent at the time of the administration of the "fatal dose". This issue becomes more problematic where a person is self-administering the fatal dose at home and the physician is not present. There is also not much clarity regarding how much time can pass between the stage-two capacity assessment and the administration of the fatal dose.

## **3. Informing Patients about the Option of Physician-Assisted Death**

While the Draft Policy provides some guidance to physicians on how they should discuss patient requests for physician-assisted death, it is silent on how physicians should themselves broach the option of physician-assisted death when discussing a patient's treatment options.

The *Health Care Consent Act, 1996*, provides that consent to treatment must be informed, which requires that the patient be provided with information regarding the

nature, expected benefits, material risks and material side effects of the treatment.<sup>5</sup> Informed consent also requires that the health practitioner provide information about alternative courses of action.<sup>6</sup> One of the alternative courses of action in some instances will be physician-assisted death.

The Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying<sup>7</sup> recommends that physicians be required to inform patients of all end-of-life options, including physician-assisted dying.<sup>8</sup> While this recommendation was provided in the context of a discussion of the duties of conscientiously objecting health care providers, the “duty to inform,” as described in the Final Report, applies equally to all physicians. All reasonable options at the end of life should be discussed with patients.

However, it is vital that this discussion take place with an acknowledgement of the significant potential for harm. Physicians must be aware of their biases with regard to quality of life when discussing this option with patients, even as an alternative. ACE perceives a real risk that older patients will be provided with the option of physician-assisted death at a relative rate that is much higher than younger patients with similar illnesses.

When this option is being canvassed with patients as an alternative to other forms of treatment, the patient should not take it as a suggestion, rather as a discussion of **all** possible options. The patient should not be left with the belief that this option is being proposed instead of palliative or hospice care, for example. As noted above, persons with specific vulnerabilities may be affected by these discussions and see them as encouragement by the physician to take this option because of pre-existing fears of being burdensome or a drain on the resources of their family members or the particular health care facility that they are in. ACE recommends that significant guidance be provided to all physicians to ensure that patients are not made to feel devalued by the discussion of physician-assisted death and that pre-conceived notions about the quality of life of older adults do not taint the discussion between physician and patient.

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<sup>5</sup> *Ibid.*, ss. 11(2) and (3)

<sup>6</sup> *Ibid.*, s. 11(3)

<sup>7</sup> Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, November 30, 2015, available at: [http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport\\_20151214\\_en.pdf](http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf)

<sup>8</sup> *Ibid.*, p. 9

## Conclusion

The introduction of physician-assisted death into the Canadian health care system presents profound challenges for all involved. Appropriate safeguards must be put in place at all levels to ensure that a balance is struck between access to the option of physician-assisted death and protection of vulnerable persons from pressures to take this option. While this Draft Policy is a positive step in this direction, the Federal and Provincial legislatures must move to ensure this balance.

ACE recommends that the Draft Policy:

- Include a statement that physicians should use independent translation services or other appropriate accommodations to facilitate communication when obtaining informed consent to physician-assessed death;
- Provide more guidance on how physicians should assess for patients' vulnerabilities in order to ensure that requests for physician-assisted death are voluntary;
- Be amended at lines 119 to 121 to read "as with treatment decisions, requests for physician-assisted death cannot be made through an advance directive"; and,
- Provide more guidance regarding when, and how, physicians should advise patients of the option of physician-assisted dying when discussing treatment options.

ACE also recommends that the process map:

- Be amended to stipulate that the initial discussion with the patient is held with the patient alone, with appropriate accommodation to prevent any linguistic or other communication barriers;
- Be amended so that neither witness to a patient's written request for physician-assisted death may be that patient's relative, or anyone else entitled to any portion of the patient's estate; and,
- Provide clarity as to whether a patient must be capable of consenting to the administration of the "fatal dose" of medication and how much time can pass between the capacity assessment and the administration of the medication, especially in cases of self-administration.

We would like to thank the CPSO for this opportunity to provide feedback on the Draft Interim Guidance on Physician-Assisted Death, and would be pleased to clarify or discuss any aspect of this commentary going forward.

Yours truly,

**ADVOCACY CENTRE FOR THE ELDERLY**

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