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January 13, 2016


To Whom it May Concern:

Re: Response to Request for Stakeholder Feedback on Physician-Assisted Dying

In response to your recent request for public input, the Ontario Hospital Association (OHA) appreciates this opportunity to provide feedback, on behalf of its members, on the College of Physicians and Surgeons’ (CPSO) Interim Guidance Document on Physician-Assisted Death (“Interim Guidance Document”).

The OHA represents 147 public hospital corporations in Ontario, who serve patients across a wide spectrum of care needs, including end of life care. The OHA’s comments are based on collective views, gained from member input provided to us, and from feedback through a number of OHA groups and committees. The comments reflect the views of senior administrative and health professional leaders and ethicists, from hospitals of various types (academic, community, small, mental health, complex continuing care and rehabilitation) and geographic locations across the province. Given the diversity of our members’ views on end of life care, the comments provided in this letter should be construed as general feedback, rather than an endorsement of any particular perspective.

We commend the important work of the CPSO in providing guidance on the issue of physician-assisted death (PAD), particularly in the absence of a legislative framework. We would also like to affirm our commitment to working with the CPSO with respect to the implications of this issue for the provincial hospital sector. As the OHA continues to engage with our members on this issue, we would like to foster an ongoing dialogue with the CPSO, to ensure that the guidance provided is attentive to the unique role of hospitals and other providers in the health system.

The OHA recognizes that patients and their caregivers or families may face sensitivities and challenges around end of life care treatment decisions, especially with respect to PAD. At the same time, hospitals and healthcare providers, including physicians, will have to navigate many clinical and operational complexities to continue to maintain quality, safe, and patient-centered care. Based on member feedback received on the Interim Guidance Document, the OHA would like to offer the following comments for consideration.
Overall Purpose and Guiding Principles of the Document

The Interim Guidance Document provides clear information regarding the implications of the Supreme Court of Canada’s decision in *Carter v. Canada (Attorney General)* – in particular, with respect to the criteria for access to PAD outlined in that case, and the legal effects of the Court’s decision on the availability of PAD.

The OHA supports the CPSO’s guidance that physicians uphold the key values of medical professionalism, as articulated in the College’s *Practice Guide*, and that physicians should strive to “create and foster an environment in which the rights, dignity and autonomy of all patients are respected.” The OHA also agrees with the CPSO’s expectation that physicians communicate sensitively and effectively with their patients, ensuring informed decision-making; and that physicians demonstrate professional competence, which includes meeting all relevant legal and professional obligations.

However, with respect to the characterization of the physician-patient relationship, the CPSO may wish to consider the following factors:

- Physicians provide care for patients in varying geographic locations, and in a wide range of treatment settings (including hospitals of various sizes and types). The OHA suggests that the CPSO consider how to account for context-sensitive application of physician and patient expectations in unique situations – especially where access to care may be beyond the physician’s immediate control;

- Depending on the particular method of administration of PAD (patient self-administered or physician-administered), the physician may have to rely on other healthcare providers (including nurses, pharmacists or others) to fulfill the patient’s request. As such, it may be helpful for the CPSO to clarify its expectations of physicians in these circumstances; and

- Various interests and values may be involved in a request for PAD, and it is necessary to strike a meaningful balance between these perspectives. It is also important to consider the potential need for an ongoing therapeutic relationship between the patient and the physician. Given potential emotional sensitivities during this time, further guidance from the CPSO on appropriate dispute resolution mechanisms, particularly within existing legislative frameworks, may be of assistance.

The CPSO may also wish to clarify its expectations for the use of the Interim Guidance Document and its direction to the profession generally should a legislative framework to govern PAD not be in place in the near future.

Part IV – A – Criteria for PAD

The Interim Guidance Document clearly and comprehensively elaborates upon each element of the criteria for PAD set out by the Supreme Court. The OHA supports the CPSO’s expectation that “physicians must use their knowledge, skill and judgment to assess an individual’s suitability for PAD” against the relevant criteria.

Recognizing that some of the key terms used by the Supreme Court to establish patient eligibility criteria may be subjective and give rise to uncertainty, the OHA would like to
suggest the following considerations for further clarification of the Interim Guidance Document:

1. Definition of “adult” – while the Supreme Court did not expressly define the term “adult” in the Carter decision, other pieces of legislation affecting Ontario’s hospitals set out age-related requirements. For example, the Child and Family Services Act defines “child” as “a person under the age of eighteen years” and provides that those under the age of twelve years may consent to counselling services in some circumstances. Clarity around how any potential uncertainties around age-related eligibility should be resolved would be beneficial;

2. “Clear consent to the termination of life” – in the context of a request for PAD, the voluntariness of a patient’s consent could be directly affected by underlying mental health conditions, or by broader social or environmental factors. The CPSO may wish to recommend that physicians be attentive to these issues, as part of a comprehensive assessment to ensure a patient’s true and informed consent to PAD; and

3. Definition of “grievous and irremediable medical condition” – the meaning of these terms may fluctuate, depending on factors such as the patient’s age, health condition (physical or mental health impairment), health prognosis and co-morbid conditions, and treatment options at any given point. As such, it may be helpful for the CPSO to highlight the need to conduct a fulsome clinical assessment of the patient’s health needs over time, and provide referrals as appropriate.

Overall, in assessing eligibility for PAD, the OHA agrees that a patient-centered perspective should be applied. We support the CPSO’s expectation that the perception of “intolerable suffering” be assessed from the patient’s own understanding of his or her illness. We also encourage the CPSO to highlight the importance of clear communication and an ongoing dialogue regarding the patient’s experience in managing his or her condition.

**Part IV – C – Conscientious Objection**

As the Supreme Court indicated in Carter, it is necessary to reconcile the rights of physicians, who might object to participating in assisted dying processes, with the need to ensure equitable patient access to clinical services. The OHA recognizes that in some geographic areas and smaller communities, it may be challenging for patients to identify physicians who are both willing and able to provide medical aid in dying. However, given the Court’s findings in the Carter case on the various interests at stake, it is important to consider how best to strike a balance that is mindful both of constitutional Charter rights and of patient needs.

The OHA supports the CPSO’s expectation that physicians must communicate their perspectives in a manner that respects patient dignity, with sensitivity and without expressing personal moral judgment. We also agree with the CPSO’s guidance that physicians should uphold patient autonomy and facilitate the decision-making process, particularly by providing patients with “information about all options for care that may be available or appropriate to meet the patient’s clinical needs, concerns and/or wishes.”

The Interim Guidance Document indicates that where a physician declines to participate in PAD for reasons of conscience or religion, “an effective referral to another health care

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The CPSO may wish to consider whether the definition of “effective referral”, in the context of PAD, could be expanded or modified to account for a number of complexities.

For example, in a clinical sense, the term “referral” is used to indicate that an attending physician is directing the patient to another healthcare provider, in order to appropriately meet the patient’s care needs. In situations where an attending physician declines to participate in PAD for reasons of conscience, he or she may not be in a position to direct whether PAD might be appropriate care for that patient. With the aim of maintaining an ongoing therapeutic relationship with the patient, a physician may instead wish to provide further information about PAD, rather than a direct referral.

Additionally, the CPSO may wish to highlight the importance of maintaining ongoing trust and respect between the patient and the physician, especially in sensitive circumstances. Some healthcare facilities may operate under a specific mission, vision and/or set of values, particularly within the overall context of end of life care. In particular, it would be helpful to provide clarity on the relationship between patients and physicians working in faith-based health facilities (including hospices and hospitals).

Part IV – D – Documentation Requirements

The OHA agrees with the CPSO’s direction regarding the importance of clear and comprehensive documentation in the medical record for each physician-patient encounter. The CPSO could also consider addressing the following issues arising from documentation processes within the context of PAD:

- The need for particular documentation to be made in the patient’s medical record and on the patient’s death certificate regarding the medical cause of death (including immediate and antecedent causes, if any) when PAD is administered; and
- Whether or how the death should be reported to the Office of the Chief Coroner of Ontario under the Coroner’s Act.
- To provide further clarity, the CPSO may also wish to consider the potential medico-legal implications of documentation in this context – for example, whether and for how long the physician should retain copies of the patient’s formal signed and witnessed request for PAD and other relevant documentation.

Part IV - Sample Process Map for PAD

The OHA commends the CPSO for its evidence-based approach to providing a sample process map for PAD, including the comparative work undertaken to assess the guidance on PAD provided in jurisdictions outside of Ontario. We understand this sample process map to be an elective process – i.e. a proposed approach that physicians may choose to follow if they decide to provide PAD.

While recognizing the challenge of setting out a process map for PAD in the absence of legislative direction, the OHA would like to highlight the following issues for the CPSO’s consideration:

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2 According to the Interim Guidance Document, an “effective referral” means a referral made in good faith, to a non-objecting, available and accessible physician or agency.
At the first stage, the formal documentation requirements around the patient’s second request for PAD may present a number of difficulties in the clinical setting. For example, it may place undue stress on the patient to find an individual who meets the requirements for independence to witness the request. Moreover, requiring that witnesses attest to the capacity and voluntariness of the patient would, in some circumstances, require them to make assessments that are beyond their knowledge or expertise. In addition to addressing these potential complexities, the CPSO may also wish to clarify the role of the attending or consulting physician as a witness to the second request.

At the second stage, with respect to requirements around capacity assessment, the CPSO’s guidance would be welcome around the role, if any, of the Ontario Consent and Capacity Board in addressing disputes regarding a patient’s capacity.

At the third stage, regarding self-administration or physician-administration of the fatal dose, it is important to emphasize the need for patient and public safety. The CPSO may wish to highlight that in providing PAD as an option for their patients, physicians ought to be guided by self-assessment of their professional competence. The CPSO has also provided direction regarding the appropriate drug protocol to follow when providing PAD. With respect to the peer-reviewed journal references noted in the Interim Guidance Document, the CPSO may wish to provide direction on how the drug protocols outlined should be applied in local (Canadian and/or Ontario) clinical environments, and consider providing additional resources with current leading best practices, as necessary.

Part V - Reporting and Data Collection

With respect to the CPSO’s recommendations for the “establishment of a formal oversight and reporting mechanism that would collect data on PAD,” it is important to note that two distinct functions may be involved, namely:

- Oversight, referring to the need to ensure compliance with specific requirements related to PAD; and
- Reporting, referring to the need to collect data on PAD for statistical or other purposes.

The CPSO could clarify its perspective on the relationship between these functions, and the obligations that would be incumbent on physicians under each function. In addition, to avoid undue administrative burden, if information regarding PAD is required for formal oversight and/or reporting purposes, documentation requirements should be aligned with existing processes and legislation governing hospitals in Ontario.

Additional Comments

Inter-Professional Care

PAD will be a complex and sensitive process, and many health care providers may be involved in the patient’s care during this time. It is essential to consider not only the responsibilities of physicians (including appropriate specialists), but also that of nurses, pharmacists, social workers, spiritual care workers and other members of the patient’s healthcare team. The Interim Guidance Document could further highlight the importance of ongoing collaborative and inter-professional care, with a patient-centered perspective.
Palliative Care

Palliative care is an integral part of a patient’s quality of care at the end of life. The OHA supports the CPSO’s guidance that treatment options discussed with the patient include all reasonable and available palliative care interventions. We also agree with the CPSO’s expectation that physicians meet their professional and legal obligations, as set out in College policy,3 in planning for and providing quality end of life care. This includes “proposing and/or providing palliative care where appropriate.”

Resources and Training to Support the Delivery of PAD

Ontario’s hospitals and healthcare providers, including physicians, will need ongoing guidance and support as they navigate many new complexities with the legal availability of PAD. Should the CPSO develop further resources and training to support the delivery of PAD, the OHA recommends broad inter-professional and inter-disciplinary stakeholder engagement, to ensure that healthcare sector needs are reflected. The OHA would be pleased to further collaborate with the CPSO and other stakeholders on such initiatives.

Conclusion

Thank you again for the opportunity to provide input on the issue of physician-assisted dying. The OHA looks forward to further occasions to engage with the CPSO and other stakeholders on this important issue, and we would like to reaffirm our commitment to participating in an ongoing dialogue.

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3 College of Physicians and Surgeons, Policy Number 4-15, Planning for and Providing Quality End of Life Care (2015).