Anticipated Impact of Carter on Hospitals and Physicians

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Both hospitals and physicians will need to be prepared by February 6, 2016, to provide access to medical aid in dying to patients, even if patient referrals or patient transfers are required (i.e., for physicians or hospitals that conscientiously object to providing medical aid in dying). Until and unless appropriate guidance is provided, however, hospitals and physicians will be operating in a regulatory vacuum that could create indeterminate liability for negligent or wrongful death, etc. For example, hospitals and physicians can anticipate difficult cases where medical aid in dying is requested, where the criteria in Carter will need to be clinically applied, including:

- By patients who are “mature minors” (“adult” as used in Carter must be interpreted under provincial health care consent legislation, and does not necessarily mean age of majority)
- By patients who have recently experienced, but not yet adapted or come to terms with, significant traumatic injury (paralysis, amputation, blindness etc.)
- By patients with capacity who have significant emotional or mental health issues (bipolarity, depression etc.), or who only have capacity when heavily medicated
- By patients who lose capacity, or have fluctuating capacity, before medical aid in dying is carried out (raising questions as to whether a substitute decision-maker could consent)

Additionally, in providing access to medical aid in dying, even in cases that clearly fall within the Carter criteria, hospitals in particular will need to answer some very difficult questions, including:

- Is the hospital required to provide access to medical aid in dying at all, or can institutions “conscientiously object”?
- Does the hospital need to ensure it has a minimum number of physicians on staff who agree to provide medical aid in dying, and to recruit and retain physicians accordingly?
- Does the hospital need to identify specialized “care teams”, to provide medical aid in dying, or identify frontline allied health professionals who agree to take part?
- In the absence of a legislative or regulatory framework, what policies and procedures will the hospital need to have in place to regulate the provision of medical aid in dying?
- Should the hospital notify the coroner when medical aid in dying is provided?
- What cause of death should be listed on the death certificate? (for the patient in Carter, it was the underlying disease, so as not to compromise her life insurance policy).
- How will hospitals handle ethical issues around organ donation in medical aid in dying?
- How will hospitals ensure access to a supply of lethal dosages to provide medical aid in dying, and how will they determine the appropriate drug formula to be prescribed?

Importantly, while Carter may shield physicians from criminal prosecution for providing medical aid in dying, it will not prevent civil suits for negligent or wrongful deaths (although it may raise a defence). Consider, for example, recent disturbing experiences in the U.S. penal system with botched executions, where condemned convicts have, by many accounts, suffered excruciatingly painful deaths, or have suffered through failed attempts to carry out their execution. Although medical schools already include end-of-life care in their curricula in Canada, how to provide or administer medical aid in dying is not (yet) a specific competency that is included.

**STAKEHOLDER RESPONSES TO CARTER**

As part of its response to Carter, the former federal Conservative government established the External Panel on Options for a Legislative Response to Carter v. Canada (the Federal Panel). The mandate of the Federal Panel was to engage Canadians and key stakeholders on issues the federal government needs to consider in its response to the Carter ruling. On December 15, 2015, the Federal Panel submitted its report summarizing the results and key findings of its consultations to the federal Minister of Justice and Attorney General of Canada, and the federal Minister of Health. The report will be carefully reviewed by the Ministers and will be one source on which the federal government will draw to respond to Carter. It is anticipated that the report will be made public early in the new year, once the government has had a chance to consider it.

All provinces and territories (except Quebec) also joined together to form a Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying (the Advisory Group) in response to Carter, to provide advice and inform the development of policies, practices and safeguards required when physician-assisted dying is legalized in their jurisdictions. This work was in addition to the Federal Panel. The provincial-territorial expert advisory group sought advice from stakeholders, and those with expertise in this area, and considered key policy questions related to how the provinces and territories implement Carter, since their jurisdictions are responsible for delivering health care and regulating health care professions.

On December 14, 2015, the Advisory Group released its Final Report on physician-assisted dying, covering issues including eligibility criteria, protection of vulnerable people and the role of conscientiously objecting health care providers. The Final Report contains a list of 43 recommendations including, in particular, that all provincial, territorial and federal governments should work together to develop a pan-Canadian strategy for palliative and end-of-life care (i.e., as opposed to Quebec’s “go-it-alone” approach). The recommendations further include that:

- All provinces and territories should ensure access to both physician-administered (i.e., euthanasia) and
self-administered physician-assisted dying through provincial/territorial legislation (and should publicly fund physician-assisted dying).
- Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party (substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying).
- Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits, but should be based on competence.
- “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient (specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation).
- Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services (i.e., to prevent medical aid in dying “tourism”).
- Two physicians must assess the patient to ensure that all criteria are met.
- There should be no requirement that a physician be present at a self-administered assisted death.
- Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. (This review will ensure transparency and confirm compliance with existing policies and procedures).
- Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories, and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.
- Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.
- Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider, or to contact a third party and transfer the patient’s records through the system.
- Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.
- Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying.
- Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service, to ensure compliance with relevant federal/provincial/territorial legislation and health-professional regulatory standards, transparency and accountability.
- Provincal and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-Life Care to provide system oversight and to report to the public.

These recommendations, while not binding, will be an important touchstone for provincial and territorial governments as they craft responses to Carter. The degree to which legislation will be harmonized, however, remains to be seen, as many of the recommendations already depart from provisions of the Quebec Act (discussed below). While the Quebec Act is likely to be amended in response to Carter, it has set the precedent for other provinces and territories.

Non-governmental stakeholders have also begun developing draft frameworks, principles, guidelines and recommendations. In early December, the College of Physicians and Surgeons of Ontario (CPSO) released
draft Interim Guidance on Physician-Assisted Death as part of any open consultation on the issue it is running until January 13, 2016. The draft Interim Guidance is only intended to operate in the absence of a framework to govern the provision of physician-assisted death, and would be superseded by the development of any such framework in Ontario. The draft recommends that physicians should only provide physician-assisted death in accordance with the criteria set out in Carter and existing CPSO policies, such as those regarding Consent to Treatment, Planning for and Providing Quality End-of-Life Care, Professional Obligations and Human Rights, and Medical Records. Additionally, the draft recommends that physicians should only provide physician-assisted death to residents of Ontario who are insured under the Ontario Health Insurance Plan (OHIP), as an insured service, and not by advance directive or the consent of a substitute decision-maker. The draft attaches a “Sample Process Map for Physician-Assisted Death” that includes provisions for a waiting period of 15 days, a second opinion, self-administration or physician-administration of a fatal dose, and reporting and data collection.

The Canadian Medical Association (CMA) has also developed a comprehensive draft framework through its Principles-Based Approach to Assisted Dying in Canada. The framework, which predates the Advisory Group’s Final Report as well as the CPSO’s draft Interim Guidance, includes detailed recommendations for potential statutory and regulatory responses similar to those now being advanced by the CPSO, and also provides detailed clinical criteria and procedures for medical aid in dying. The framework will be a valuable resource for provincial and territorial governments across Canada because it represents the physicians’ perspective.

**BALANCING RIGHT OF ACCESS WITH CONSCIENTIOUS OBJECTION**

In developing any legislative or regulatory response, stakeholders should heed the statement of the Supreme Court in Carter that its decision is not intended to compel physicians to provide medical aid in dying, but that the final determination of that issue, and other related issues, would require further guidance from the governments and regulatory colleges. In doing so, the Supreme Court acknowledged that the Charter rights of patients and physicians need to be reconciled.

Perhaps the most significant issue to be resolved post-Carter then will be balancing patients’ rights to access medical aid in dying with physicians’ rights to conscientiously object to providing it, particularly in small community hospitals and rural areas. Consider the following poll taken by the CMA of its members in response to Carter:

> Following the Supreme Court of Canada decision regarding medical aid in dying, would you consider providing medical aid in dying if it was requested by a patient?

63% - NO  
29% - YES  
8% - DON’T KNOW

(Source: “Making headway with assisted dying”, The Medical Post (13 October 2015) at 27).

Statistically, these poll numbers suggest that in some small community hospitals and rural areas, there may be no immediately available physicians who are willing and able to provide medical aid in dying. The
CMA, for its part, supports both sides of the debate and, as noted above, has issued draft recommendations, as noted above, that address moral opposition to medical aid in dying.

On the one hand, the CMA advocates that hospitals and health authorities that oppose medical aid in dying should not prohibit physicians from providing these services in other locations, and there should be no discrimination against physicians who elect to provide medical aid in dying. On the other hand, the CMA also advocates that physicians should not be obligated to fulfill requests for medical aid in dying, and that there should be no discrimination against a physician for refusing to participate in medical aid in dying.

In order to reconcile physicians’ conscientious objection with patient access to medical aid in dying, the CMA advocates that a system should be developed whereby referral (or perhaps, more accurately, “notification”) occurs by the physician to a third party that will provide assistance and information to the patient who has requested medical aid in dying. Where a physician objects to making a physician-to-physician “referral” for a consultation on medical aid in dying, the third party may need to be a hospital administrator. Hospitals, therefore, need to be prepared to designate a hospital administrator for this purpose (i.e., someone who is prepared to do so).