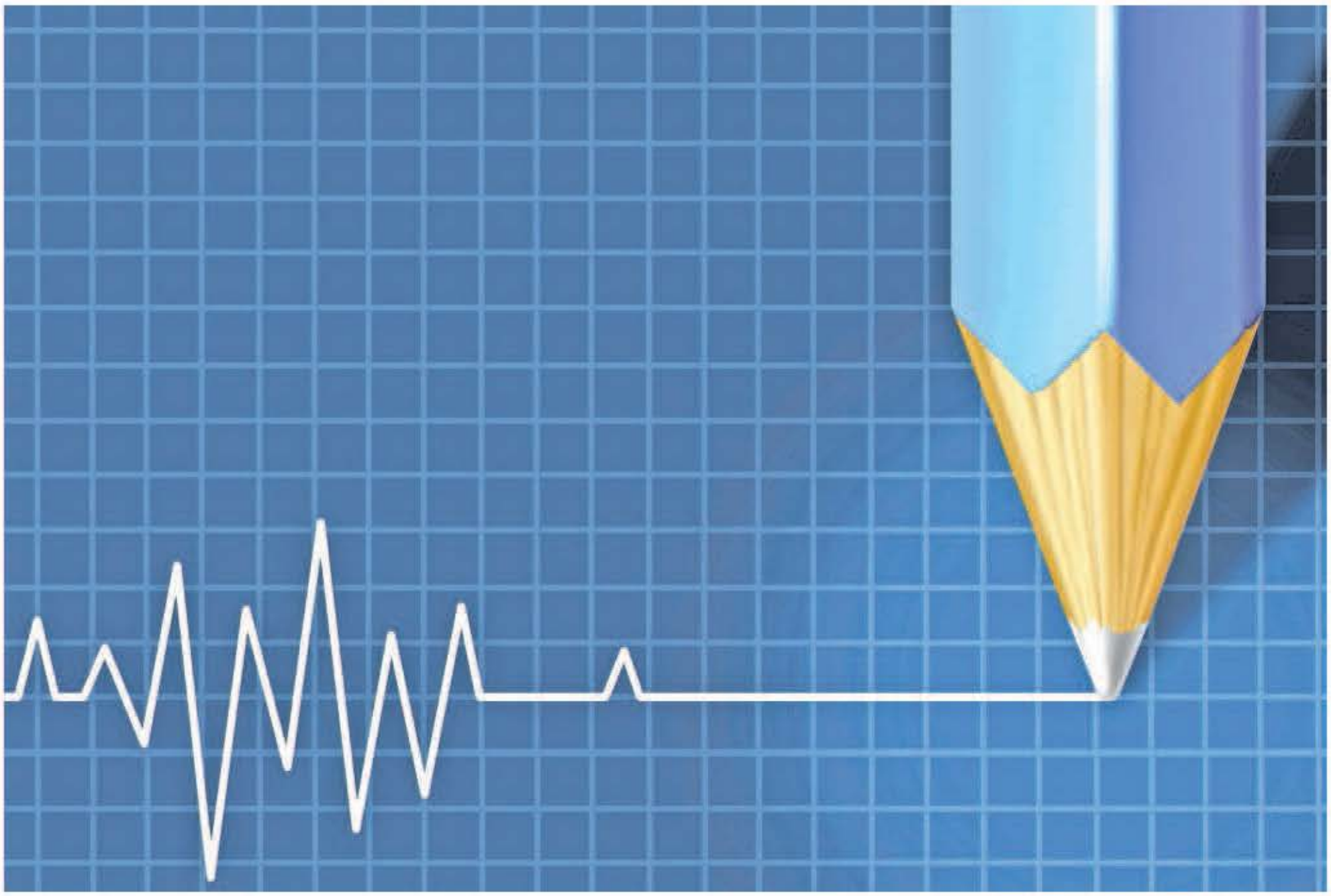
Focus HEALTH LAW



The rules for dying

With legislation affecting physician assisted death coming soon, the medical profession awaits direction

Kimberly Jakeman
Dionne Liu

It has been roughly ten months since the Supreme Court of Canada held that sections 14 and 241(b) of the *Criminal Code* are unconstitutional, to the extent that they prohibit physician-assisted dying for persons who clearly consent to the termination of their life because they have a grievous and irremediable medical condition that causes intolerable suffering.

Less than three months before the February 2016 deadline for legislative reform, we are still waiting for legislation from all the provincial and territorial governments with the exception of Quebec, and the federal government. The Canadian public and regulatory bodies of health professionals, who will also need to enact standards of practice, are waiting with bated breath for some direction.

In Alberta, Donna DeLorme could not continue waiting. She was a competent patient suffering from progressive multiple sclerosis who quietly died in her Calgary home in September. DeLorme did not make public the details of how she ended her life, but according to the media she could not continue waiting as the lacuna of legislation leading up to February 2016 puts physician-assisted dying in a legal purgatory.

As a reminder, the eligibility requirements for physician-assisted dying set out by the Supreme Court of Canada in *Carter v. Canada (Attorney General)* [2015] S.C.J. No. 5 are that the patient: 1) be a competent adult; 2) provide informed consent to the termination of their life; 3) have a grievous and irremediable medical condition (including an illness, disease or disability); and 4) consider the suffering caused by their medical condition intolerable.

Trying to get ahead of the game, the Colleges of Physicians and Surgeons of Saskatchewan, Alberta, and Manitoba, and the Canadian Medical Association have each taken a proactive approach. Quebec has taken a giant leap forward passing Bill 52, set to come into force next month.

The College of Physicians and Surgeons of Alberta (CPSA) has released a draft "advice to the profession" document regulating both physician assisted suicide and voluntary euthanasia. Physician-assisted suicide is when a doctor provides the means of dying but the patient ultimately administers his or her own death. Voluntary euthanasia involves the physician administering the medical aid required for the patient's death.

Uncertainty, Page 13

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Focus HEALTH LAW

Mental health comes out of shadows

Mary Jane Dykeman

Mental health is an area of law that has changed significantly over the years, creating many opportunities for advocacy and diversity in the practice of law.

For many years, mental health has played out in the shadows of society, sheltered from public discourse. That has changed dramatically as new government initiatives relating to youth mental health have been given priority and rolled out in the school system. Longstanding members of the bar have blazed a path from the earliest days, and a new generation of lawyers is also embracing the opportunity to improve the system.

Ontario's *Mental Health Act* (and similar legislation in other jurisdictions) applies primarily to patients in psychiatric facilities, notwithstanding the closure of many in-patient beds over the past decades and an influx of patients into community settings. The Ontario act was amended in 2000, including broadening detention and admission options, and the creation of a community treatment order regime.

The amendments arose in part from mental health inquests. For example, an inquest was held in the late 1990s into the death of Zachary Antidormi, a Hamilton boy killed by a neighbour with a serious mental illness who, according to the evidence, had trouble accessing mental health resources.

The inquest demonstrated that the powers of police under the *Mental Health Act* at that time were a barrier for law enforcement to take action when faced with a person with an apparent mental disorder, given that they had to personally witness the behaviours. The tragedy led to many changes, and the work of mental health services providers in this part of the province is ongoing in outreach to those with mental illness. As much as inquests are sometimes criticized for having little practical effect, this is one example where legislative policy change has made a difference.

Another effective measure is legislative change accompanied by the practical tools to de-escalate such situations in the first place.

In June last year, Justice Frank Iacobucci was commissioned by then-Toronto police chief William Blair to prepare a landmark report. Justice Iacobucci's *Police Encounters with People in Crisis* report examined how mental health services are delivered and the training of police. It followed a number of police shootings of individuals termed "persons in crisis," including those with a mental illness or in an emotional crisis. Among them was the July 2013 death on a Toronto streetcar of Sammy Yatim, shot by a police officer. For many, the situation echoed the death of Edmond Yu, shot by police on a streetcar in 1997 after brandishing what turned out to be small hammer. More recently, in February of last year, Sylvia Klibingaitis, Michael Eligon and Reyal Jardine-Douglas each had mental health diagnoses and were fatally shot by police while holding a small object, whether knives or scissors. Mental health lawyers continue to advocate for change, and the training of police and health-care providers to recognize and respond to persons in crisis.

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The Consent and Capacity Board's mandate has also been broadened over the years, its panels hearing appeals of particular changes of legal status under multiple statutes (i.e., the *Mental Health Act*, *Health Care Consent Act* and *Personal Health Information Protection Act*). These include involuntary detention, treatment incapacity, incapacity to manage property and incapacity to consent to certain information-sharing. It is an independent, expert tribunal. Hearings before panels of the board are generally initiated within seven days, which means lawyers must be swift in their preparation and advocacy.

Although the *Mental Health Act* has rarely been amended over the years, Bill 122, the *Mental Health Statute Law Amendment Act, 2015* was in second reading before the Legislature as of this writing. If enacted, it will introduce a new concept of "certificates of continuation," such that after three certificates of renewal have expired, an involuntary patient can only be detained at a psychiatric facility where a certificate of continuation has been issued.

The proposed changes arise in part from a December 2014 decision of the Court of Appeal for Ontario in *P.S. v. Ontario* [2014] O.J. No. 6151. The constitutionality of the community treatment order regime under the *Mental Health Act* was challenged and upheld in the lower court in *Thompson v. Ontario (Attorney General)* [2011] O.J. No. 1469, but the decision is under appeal.

All said, mental health law is an evolving field which is bringing opportunities for lawyers, and for important social change.

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Uncertainty: Intolerable suffering can be difficult to determine

Continued from page 12

The CPSA proposal includes an onerous procedure which requires more than one consultation, detailed discussion with the patient, including discussion of alternatives, a second physician to attest to the patient's competency and consent, and a waiting period. The proposal also makes room for conscientious objectors since it says physicians may decline to provide physician-assisted dying.

Others are following Alberta, with some guidance from Quebec. Does this consensus mean that we are making good progress towards meeting the deadline? Not really, as in fact there remains much uncertainty. The federal government will need to set down the fundamental legislative scheme on which provincial governments and professional regulators can build. The federal framework would be the ideal platform to combat interprovincial inconsistencies. Particularly, someone will need to provide clarity on the broad eligibility requirements the Supreme Court has given us.

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Kimberly Jakeman and Dionne Liu
Harper Grey

How do we determine what constitutes a grievous and irremediable medical condition? Will there be parameters as to the types of treatments patients can find objectionable? How do we determine what constitutes intolerable suffering? In fact, who is to determine what constitutes intolerable suffering? On this point, the proposals differ. In Saskatchewan and Manitoba, the physician is to make that determination. In Alberta, the patient decides.

On top of the eligibility requirements set out by the Supreme Court, let us not forget about the physician's overarching duty to act in the best interests of the patient. Given that the court has already acknowledged that a physician and patient may disagree, who gets to make the decision of what will be in the best interests of the patient? A delicate balance needs to be struck. We are long past the days when physicians occupied a paternalistic role. However, physicians are in the unique position to determine the prognosis and treatment options for patients.

Additionally, the court's decision was narrowly focused on patients who are mentally capable but physically incapable. The colleges' proposals requiring that the patient have capacity at the time of physician-assisted dying preclude requests by advanced directives. This excludes a large number of patients who are not cognitively intact because of their medical conditions. Patients who face a decline in mental capacity are faced with the choice of ending their life while still mentally capable or enduring the mental decline. Could this mean further litigation to define, more broadly, or clarify the parameters?

So where do we go from here? With the federal government recently suggesting they will request more time to review this overwhelmingly important issue, we must simply wait and see.

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