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# CONFLICT RESOLUTION PROCESSES IN END-OF-LIFE CARE DISPUTES BETWEEN FAMILIES AND HEALTHCARE PROVIDERS IN CANADA

Matthew P. Ponsford\*

## ABSTRACT

Conflict at the end-of-life, particularly between families and health-care providers, involves many complex factors; differing opinions surrounding a patient's prognosis, cultural differences, moral values, and religious beliefs, associated costs, internal family dynamics, and of course, legal ramifications. Legislative reform at both the provincial and federal levels with respect to assisted dying has had far-reaching implications for healthcare decision-making for families, healthcare providers, religious groups, and others. These reforms provide the backdrop for this paper, which examines the conflict resolution processes that can provide a solution amidst an often stressful, costly, and time-consuming ordeal. This paper reviews several processes, but focuses on the Ontario Consent and Capacity Board. In addition, this paper discusses the importance of empathy and cultural understanding in the face of cross-cultural conflict in end-of-life decision-making processes.

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## INTRODUCTION

Conflict at the end-of-life, particularly between families and healthcare providers in Canada, involves many complex factors: differing opinions surrounding a patient's prognosis, cultural differences, moral values and religious beliefs, associated costs, internal family dynamics and, of course, legal ramifications.<sup>1</sup> In June 2013, Véronique Hivon, then-Minister for Social Services and Youth Protection for the governing Parti Québécois in Québec, Canada, introduced Bill 52: *An Act Respecting End-of-Life Care* ["Bill C-52"]. The Bill provides:

### PURPOSE OF THE ACT

The purpose of this Act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.<sup>2</sup>

Scholars have grappled with the sensitive topic of end-of-life care for decades.<sup>3</sup> National Assembly legislators and Québec civil society engaged in a polarizing debate before Québec became the first province to legalize euthanasia on June 5, 2014,<sup>4</sup> with a vote of 94 to 22.<sup>5</sup>

Bill 52 has had far-reaching implications for healthcare decision-making for families, healthcare providers, religious groups, and others. In this article, I use

<sup>1</sup> Ian Anderson, *Conflict at the End of Life: Ian Anderson Continuing Education Program in End-of-Life Care*, online: University of Toronto <<http://www.cme.utoronto.ca/endoflife/Slides/PPT%20Conflict.pdf>> [Anderson].

<sup>2</sup> Bill 52, *An Act Respecting End-of-Life Care*, 1st Sess, 40th Leg, Québec, 2013 [Bill 52].

<sup>3</sup> Margaret Somerville, *Death Talk: the Case Against Euthanasia and Physician-Assisted Suicide* (Montréal: McGill-Queen's University Press, 2001).

<sup>4</sup> Graeme Hamilton, "Québec could become destination for 'euthanasia tourists' from other provinces if Bill 52 passes, legislators say" *National Post* (5 December 2013), online: National Post <<http://news.nationalpost.com/2013/12/05/quebec-could-become-destination-for-euthanasia-tourists-from-other-provinces-if-bill-52-passes-legislators-say>>.

<sup>5</sup> CBC News, "Quebec passes landmark end-of-life-care bill" *CBC News: Montreal* (5 June 2014) <<http://www.cbc.ca/news/canada/montreal/quebec-passes-landmark-end-of-life-care-bill-1.2665834>>.

Bill 52 as the backdrop to examine the often neglected stories of disputes arising between families and healthcare providers, and the communication strategies, negotiation and mediation processes which result amidst an often stressful, costly, and time-consuming ordeal. I review a number of conflict resolution processes, but my analysis focuses on Ontario's Consent and Capacity Board. I also highlight the importance of empathy and cultural understanding, as well as the challenges of cross-cultural conflict, including sensitivities toward Canada's Aboriginal peoples.

### **Background: Euthanasia, Assisted Suicide, and Physician-Assisted Suicide in Canada**

It is important to recognize the fundamental distinctions between euthanasia, assisted suicide, and physician-assisted suicide. Euthanasia is defined as “the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person’s suffering where the act is the cause of death”.<sup>6</sup> Physician-assisted suicide is closely related to assisted suicide, and both of these terms refer to “intentionally, knowingly, and directly providing the means of death to another person so that the person can use that means to commit suicide.”<sup>7</sup> An example of physician-assisted suicide would be a prescription for an intentional drug overdose. With assisted suicide, patients themselves perform the last act before death, whereas the last act rests with the patient’s physician in the case of euthanasia.<sup>8</sup>

The category of “natural death” has historically caused confusion. In this scenario, physicians and healthcare providers withdraw or withhold treatment where it would be ineffective or death is deemed inevitable. A Library of Parliament research publication entitled *Euthanasia and Assisted Suicide in Canada*<sup>9</sup>

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<sup>6</sup> Institute of Marriage and Family Canada, “Euthanasia and Assisted Suicide Terminology” online: Institute of Marriage and Family Canada <<http://www.imfcanada.org/fact-sheet/euthanasia-and-assisted-suicide-terminology>> [Marriage and Family Canada].

<sup>7</sup> Marriage and Family Canada, *supra* note 6.

<sup>8</sup> *Ibid.*

<sup>9</sup> Martha Butler & Marlisa Tiedemann, “Background Paper: Euthanasia and Assisted Suicide in Canada” online: Library of Parliament <<http://www.parl.gc.ca/Content/LOP/ResearchPublications/2010-68-e.pdf>> at 11 [Butler].

spoke to this issue in discussing the 1992 case of Nancy B.<sup>10</sup> The Québec Superior Court ruled that a patient had the right to instruct a doctor to remove a respirator if they were a “competent, adult patient suffering from an incurable disease.”<sup>11</sup> In this case, Justice Dufour concurred, noting the patient’s disease was seen to have taken its “natural course,” and thus the case fell outside the scope of euthanasia or physician-assisted suicide.<sup>12</sup>

Although euthanasia is sometimes referred to as “medical aid in dying” (MAID) or “death with dignity”, until recently in Canada criminal liability rested on physicians or other healthcare providers who administered legal injections or assisted in a patient’s death through similar means, even at the patient’s request. Suicide itself is not a *Criminal Code*<sup>13</sup> offence in Canada.<sup>14</sup> However, other sections of the *Criminal Code* criminalized euthanasia. Section 14 of the *Criminal Code* stated: “No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given”. Section 241 prohibited counseling or aiding suicide, and stated: “Every one who: (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.”

In Canada, prior to *Carter*, numerous high profile, landmark cases challenged Canada’s end-of-life care restrictions and criminalization. One of the most seminal decisions involved Ms. Sue Rodriguez,<sup>17</sup> a woman who suffered from amyotrophic lateral sclerosis (ALS) and, in 1992-93, challenged the validity of Section 241(b) of the *Criminal Code*. At both the British Columbia Court of Appeal and British Columbia Supreme Court<sup>19</sup> Rodriguez claimed this provision violated Sections 7 (the right to “life, liberty and security of the person”), 12 (protection

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<sup>10</sup> *Nancy B v Hôtel-Dieu de Québec* (1992), 86 DLR (4th) 385, 69 CCC (3d) 450 (CanLII) [*Nancy B*].

<sup>11</sup> Butler, *supra* note 9.

<sup>12</sup> *Nancy B*, *supra* note 10.

<sup>13</sup> *Criminal Code*, RSC 1985, c C-34 [*Criminal Code*].

<sup>14</sup> This provision was struck from the *Criminal Code* in 1972.

<sup>17</sup> *Rodriguez v British Columbia (AG)*, (1993) 79 CCC (3d) 1, 14 CRR (2d) 34, [1993] 3 WWR 553 [BCCA]; *Rodriguez v British Columbia (AG)*, (1992) 18 WCB (2d) 279, [1993] BCWLD 347 [BCSC].

<sup>19</sup> *Rodriguez v British Columbia (AG)*, *supra* note 15.

from “cruel and unusual punishment”) and 15 (equality rights) of the *Charter*.<sup>20</sup> The case made its way to the Supreme Court of Canada.<sup>21</sup> The Supreme Court rendered a 5-4 decision on September 30, 1993, dismissing Rodriguez’ appeal, and upheld the status quo by prohibiting physician-assisted suicide. In 1994, Ms. Rodriguez ended her own life with the assistance of an unknown physician.<sup>22</sup> The high-profile case raised many ethical and constitutional dilemmas, which were not unique to Ms. Rodriguez’s case or Bill 52 which passed the Québec National Assembly, but the issue has certainly received renewed national attention.<sup>23</sup>

The Supreme Court of Canada released the historic decision in *Carter v Canada*<sup>24</sup> on February 6, 2015. A British Columbia couple’s lawsuit originally was filed in 2011 with the assistance of the BC Civil Liberties Association (BCCLA). The original plaintiffs, Lee Carter and Hollis Johnson, sued the government on behalf of their relative, Kay Carter, who travelled to a Switzerland clinic in 2010 to die by choice, after she was denied physician-assisted suicide in Canada. Gloria Taylor, a woman with ALS who later joined the plaintiffs in their case, died in 2012.

The British Columbia Supreme Court overturned the assisted-suicide law, a decision later challenged by the Canadian government.<sup>26</sup> The British Columbia Court of Appeal allowed the appeal in a 2-1 decision.<sup>27</sup> The Supreme Court of Canada granted leave to appeal in the case on January 16, 2014.<sup>28</sup> At the time,

<sup>20</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, ss 7, 12, 15 [*Charter*].

<sup>21</sup> *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519, 107 DLR (4th) 342.

<sup>22</sup> Sandra Martin, “The heart of dying: A personal journey” *Special to The Globe and Mail* (16 April 2016), online: The Globe and Mail <<http://www.theglobeandmail.com/news/national/the-heart-of-dying-a-personaljourney/article29652781>>.

<sup>23</sup> James Keller, “B.C. ruling to thrust assisted-suicide debate back onto Supreme Court agenda” *The Globe and Mail* (9 October 2013), online: The Globe and Mail <<http://www.theglobeandmail.com/news/british-columbia/bc-ruling-to-thrust-assisted-suicide-debate-back-onto-supreme-court-agenda/article14775230>>.

<sup>24</sup> *Carter v Canada (AG)*, 2015 SCC 5, 1 SCR 331 [*Carter*].

<sup>26</sup> *Carter v Canada (AG)*, 2012 BCSC 886, 287 CCC (3d) 1 (reasons for judgment); *Carter v Canada (AG)*, 2012 BCSC 1587, [2012] BCJ No 2259 (QL) (costs).

<sup>27</sup> *Carter v Canada (AG)*, 2013 BCCA 435 (CanLII), 365 DLR (4th) 351 (BCCA) with dissent from the Honourable Chief Justice Finch.

<sup>28</sup> Supreme Court of Canada, “Judgments to be Rendered in Leave Applications” *News Releases* (12 January 2014), online: <<http://scc-csc.lexum.com/scc-csc/news/en/item/4487/index.do?r=AAAAAQASQkMgQ2l2aWwWgTGliZXJ0aWVzAQ>>. See also CBC News, “Assisted suicide appeal to be heard by

Grace Pastine, litigation director with the BCCLA, stated: “There are few rights more fundamental, or more deeply personal, than the right to determine how much suffering to endure and whether to seek a doctor's assistance to hasten death if living becomes unbearable.”<sup>29</sup>

The country's highest court ruled that Sections 14 and 241(b) of the *Criminal Code* unjustifiably infringed Section 7 of the *Canadian Charter of Rights and Freedoms*,<sup>30</sup> protecting life, liberty, and security of the person. The court declared the provisions were of “no force or effect.”<sup>31</sup> The declaration of invalidity was suspended for 12 months, expiring on February 6, 2016, to allow the Parliament of Canada to respond. A new Canadian majority government, the Liberal Party of Canada, was elected on October 19, 2015. Shortly thereafter, on November 4, 2015, the Prime Minister appointed the Honourable Dr. Jane Philpott as Minister of Health, and the Honourable Jody Wilson-Raybould as Minister of Justice and Attorney General of Canada.<sup>32</sup>

Ministers Philpott and Wilson-Raybould provided a new mandate to an external panel, which considered options for legislative response to *Carter v Canada*. The external panel was originally formed in July 2015 at the direction of the previously governing Conservative Party of Canada.<sup>33</sup> The Ministers tasked the Panel to produce a comprehensive recommendations report following an extensive consultation process involving thousands of stakeholders, including individuals, medical experts, and organizations.<sup>34</sup> A new mandate letter from both

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Supreme Court” *CBC News: British Columbia* (16 January 2014): <<http://www.cbc.ca/news/canada/british-columbia/assisted-suicide-appeal-to-be-heard-by-supreme-court-1.2498892>>.

<sup>29</sup> *Ibid.*

<sup>30</sup> *Charter*, *supra* note 20, which states: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”.

<sup>31</sup> *Ibid.*

<sup>32</sup> CBC News, “Meet Justin Trudeau’s new Liberal cabinet” *CBC News: Politics* (4 November 2015), online: CBC News <<http://www.cbc.ca/news/politics/trudea-cabinet-ministers-profile-1.3304176>>.

<sup>33</sup> Department of Justice, Expert Panel on Options for a Legislative Response to *Carter v Canada*. *Consultations on Physician-Assisted Dying – Summary of Results and Key Findings – Final Report* (15 December 2015), online: <<http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/pad.pdf>>.

<sup>34</sup> Government of Canada, “Ministers Wilson-Raybould and Philpott provide a new mandate to the External Panel on Options for a Legislative Response to *Carter v. Canada*” (14 November 2015), online: Government of Canada <<http://news.gc.ca/web/article-en.do?nid=1020829&tp=1>>. The Quick Facts section stated: “The Panel consulted directly with 66 experts through 51 meetings in five countries, and 95 representatives from 48 Canadian organizations. The Panel received over 300 document submissions from stakeholders and over 11,000 responses to its online consultation.”

Ministers extended the final report deadline by one month, to December 15, 2015.<sup>35</sup> The new mandate adapted the focus of the report to emphasize results stemming from consultations rather than the original focus of proposing legislative options, in an effort to expeditiously complete the Panel's work.<sup>36</sup>

The new Liberal government was provided a four-month extension in a subsequent 5-4 decision of the Supreme Court of Canada.<sup>37</sup> The government then introduced Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* on April 14, 2016.<sup>38</sup> The Bill received Royal Assent on June 17, 2016.<sup>39</sup>

In addition to Québec, euthanasia is currently legal in Belgium, the Netherlands, and Luxembourg. Physician-assisted suicide is legal in Switzerland, Canada (post-*Carter*), and, in some form, in five U.S. states: Oregon (1997), Washington (2008), Montana (2009), Vermont (2013), and—most recently—California (2015).<sup>40</sup> California enacted assisted suicide legislation after the motion was passed in the State Assembly in September 2015, and later, the Senate.

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<sup>35</sup> Government of Canada, "Letter from Minister Wilson-Raybould and Minister Philpott to the External Panel on Options for a Legislative Response to *Carter v. Canada*" (November 2015), online: Government of Canada <<http://news.gc.ca/web/article-en.do?nid=1020779>>. The Panel's original report deadline was November 15, 2015.

<sup>36</sup> *Ibid.* "Rather than providing legislative options as per your original mandate, we would ask that instead you prepare a report summarizing the results and key findings of your consultations. This modified mandate should allow you to complete a comprehensive report by mid-December, in time to inform the next stages of work leading to the Government's response to the Supreme Court of Canada's decision in *Carter v. Canada*. Your report will provide invaluable insight into the views of Canadians, stakeholders and experts as we move forward with a response."

<sup>37</sup> CBC News, "Supreme court gives federal government 4-month extension to pass assisted dying law" *CBC News* (15 January 2016), online: CBC News Politics <<http://www.cbc.ca/news/politics/assisted-dying-supreme-court-federal-1.3406009>>.

<sup>38</sup> Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (first reading 14 April 2016).

<sup>39</sup> Catherine Tunney, "Liberals' assisted dying bill is now law after clearing final hurdles" *CBC News* (17 June 2016), online: <<http://www.cbc.ca/news/politics/assisted-dying-bill-senate-approval-1.3640195>>.

<sup>40</sup> Ian Lovett, "California Legislature Approves Assisted Suicide" *The New York Times* (11 September 2015), online: *The New York Times* <[http://www.nytimes.com/2015/09/12/us/california-legislature-approves-assisted-suicide.html?\\_r=0](http://www.nytimes.com/2015/09/12/us/california-legislature-approves-assisted-suicide.html?_r=0)>.



Governor Jerry Brown ultimately signed the *End of Life Option Act*<sup>41</sup> despite tremendous religious opposition.<sup>42</sup>

### **End-of-Life Care in Canada: Demographics and Social Attitudes**

Canadians today are living longer; in fact, between 1997 and 2007, the average life expectancy of Canadians rose 2.3 years, to 85 years at birth.<sup>43</sup> Those 65 years and older make up the fastest growing part of the Canadian population.<sup>44</sup> Dying from chronic diseases tends to occur more often in healthcare and institutional facilities, although Canadians prefer to die at home if given the option.<sup>45</sup> According to Statistics Canada, 69% of Canadians die in a hospital, and 31% die elsewhere.<sup>46</sup> These figures emphasize the importance of healthcare providers in assisting patients and their families in important end-of-life decision-making. A 2010 Angus Reid poll conducted with 1,003 Canadians yielded 67% respondents in favour of legalizing voluntary euthanasia and 76% believed legalization would improve guidelines for physicians involved in end-of-life decisions.<sup>47</sup> The legal status of (a) withholding and withdrawing potentially life-sustaining treatment is understood, as is the legal status of (b) voluntary euthanasia and (c) assisted suicide. However, the ethics of these practices, particularly options (b) and (c), are less certain and notoriously controversial.<sup>48</sup>

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<sup>41</sup> *End of Life Option Act*, 2015:

<[https://leginfo.ca.gov/faces/billNavClient.xhtml?bill\\_id=201520160SB128](https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB128)>.

<sup>42</sup> Associated Press, "California to become fifth state to legalize assisted dying" *The Guardian* (5 October 2015), online: *The Guardian* <<http://www.theguardian.com/us-news/2015/oct/05/california-assisted-dying-legal-fifth-state>>.

<sup>43</sup> Udo Schuklenk et al, "End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making" (2011) 25 *Bioethics* S1 at 8 [Schuklenk et al].

<sup>44</sup> *Ibid* at 4(a) ("Demographic Transition in Canada: a. Aging").

<sup>45</sup> *Ibid* at 2(b) ("Canadian Experience at the End of Life: Location of Death").

<sup>46</sup> *Ibid*.

<sup>47</sup> *Ibid* at 17.

<sup>48</sup> *Ibid* at 28-29.

## End-of-Life Care Disputes between Families and Healthcare Providers

It is clear the legislative, legal, ethical, and public policy debates surrounding euthanasia and physician-assisted suicide will continue in the province of Québec, the rest of Canada, and beyond, but the focus of this paper will now shift to the conflicts arising between (a) patients and physicians, and (b) families and healthcare providers, with an emphasis on the latter. As stated earlier, end-of-life decisions unleash “inevitable conflict,” given the complex family dynamics, cultural differences, and varying beliefs involved in these discussions.<sup>49</sup> The rest of this paper considers issues that may arise in these circumstances and potential models for dispute resolution.

It is estimated that serious conflicts arise in 2-5% of end-of-life encounters, but even these relatively few situations pose significant challenges for patients, their families, and the healthcare system.<sup>50</sup> Conflicts can be time-consuming and stressful, can be financially burdensome to families, can impact hospital and other medical resources, and can result in either lack of treatment or overtreatment for patients.<sup>51</sup> The Ian Anderson Continuing Education Program in End-of-Life Care outlines the main causes of end-of-life conflict, including: differences in meaning and quality of life; conflicting perspectives on choices, including social class, education, and culture; as well as confusion about individual and healthcare providers’ rights to make decisions.<sup>52</sup> Additionally, end-of-life decisions may not allow the opportunity for reflection, as decisions may be made hastily and involve high stakes for patients and their families. Finding common ground, or a shared purpose, can often be an effective strategy, as it enables each disputant to establish shared goals and create open dialogue.

One potential area for conflict, as noted above, involves the decision-making philosophies and values of the involved parties. Rights-based decision-making is a Western-centric philosophy, compared to the more communal and

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<sup>49</sup> Anderson, *supra* note 1 at 10, 14.

<sup>50</sup> *Ibid* at 3.

<sup>51</sup> *Ibid* at 3, 8.

<sup>52</sup> *Ibid* at 6.

consensus-based decision-making found in other cultures.<sup>53</sup> Patients' rights include discussions with physicians about the termination of treatment in situations where life improvement may be unlikely or impossible.<sup>54</sup> If a patient decides to stop treatment, after reflecting upon the medical advice or prognosis, healthcare professionals must accept the patient's wishes.<sup>55</sup> This decision is more straightforward, and seemingly less controversial, than the debate surrounding euthanasia and physician-assisted suicide, which poses more stringent limitations on physicians' professional autonomy. However, conflicts could arise from physicians' conscientious objections to certain procedures, placing frontline healthcare providers in direct opposition to patient demands. In Canada, assistance could be transferred to another healthcare professional to respect physicians' freedom of conscience and religion.<sup>56</sup>

The Preamble of Bill C-14 briefly mentions conscientious objection rights for physicians involved in cases of physician-assisted death, noting "the Government of Canada has committed to develop non-legislative measures that would support the improvement of a full range of options for end-of-life care, **respect the personal convictions of health care providers** [...] [emphasis added]. *Carter* also emphasized that "*Charter* rights of patients and physicians will need to be reconciled," and further, that "a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief"<sup>57</sup> in reference to similar physician rights articulated in the context of abortion in the *Morgentaler*<sup>58</sup> decision.

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<sup>53</sup> *Ibid* at 30.

<sup>54</sup> Schuklenk et al, *supra* note 39 at 46.

<sup>55</sup> *Ibid*.

<sup>56</sup> *Ibid*.

<sup>57</sup> *Carter*, *supra* note 24 at para 132.

<sup>58</sup> *R v Morgentaler*, [1988] 1 SCR 30, 63 OR (2d) 281.

## Inability to Consent: Vulnerable Populations and Substitute Decision-Making

Another potential area of conflict in end-of-life care arises where patients lack capacity to consent. The government's new assisted dying legislation does not apply where the patient is unwilling to provide consent (s 241.2(1)(e)) or lacks the capacity to consent. Individuals must be at least 18 years of age and "capable of making decisions with respect to their health" as stipulated in s 241.2(1)(b), while simultaneously fulfilling all other criteria prescribed under the eligibility for medical assistance in dying.<sup>59</sup> Determining capacity and ability to consent often relies on provincial and territorial medical body guidelines. As these guidelines and policies are more fully developed it will improve decision-making with respect to MAID for vulnerable persons, such as those suffering advanced Alzheimer's, dementia, and other cognitive-impairing medical conditions influencing patient capacity.

In circumstances other than MAID, the legislature in some provinces provides guidance for situations where patients are unable to consent. For example, in Ontario, the *Health Care Consent Act (HCCA)*<sup>60</sup> provides rules for treatment to ensure consistency in all healthcare settings with respect to consent issues. Section 1(e) is particularly relevant to disputes between families and healthcare practitioners. The Act's purpose is to "ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service."<sup>61</sup>

In October 2013, a 5-2 decision of the Supreme Court of Canada ruled that doctors could not unilaterally end life support services for Mr. Hassan Rasouli,<sup>62</sup> an Ontario patient residing at Sunnybrook Hospital in Toronto, who had been in a comatose state since 2010.<sup>63</sup> There is much disagreement surrounding unilateral

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<sup>59</sup> Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (first reading 14 April 2016).

<sup>60</sup> *Health Care Consent Act*, SO 1996, c 2 [HCCA].

<sup>61</sup> *Ibid*, s 1(e).

<sup>62</sup> *Cuthbertson v Rasouli*, 2013 SCC 53, [2013] 3 SCR 341 [Rasouli].

<sup>63</sup> Jessica Barrett, "Doctors can't end Hassan Rasouli's life support without consent, Supreme Court rules" *National Post* (18 October 2013), online: National Post <<http://news.nationalpost.com/2013/10/18/supreme-court-upholds-right-to-demand-life-support-against-advice-doctors-cant-end-aid-without-consent>>.

decision-making in academic literature.<sup>64</sup> The top court instructed physicians to seek permission from the man's family, or permission from the Ontario Consent and Capacity Board,<sup>65</sup> regulated by Part V (sections 70-81) of Ontario's *HCCA*.

Justices Andromache Karakatsanis (writing for the minority) expressed strong, dissenting opinions in *Rasouli*, noting:

[168] In my view, the common law does not entitle a patient to insist upon continuation of treatment; it does not require a patient's consent to the withholding or withdrawal of treatment that the physician considers has no chance of being medically effective and that is no longer consistent with the professional standard of care. For the reasons that follow, I conclude that such consent is not required at common law, even in the context of withholding or withdrawal of life support. I note that rights pursuant to the *Canadian Charter of Rights and Freedoms* have not been raised or argued in this appeal.<sup>66</sup>

Karakatsanis J argues that a physician cannot be "required to act outside of his standard of care and contrary to his professional duties."<sup>67</sup> The dissenting opinion emphasizes the sometimes deep divide between family or substitute decision-makers' wishes and a physicians' claim to providing professional standards of care. Karakatsanis J highlights that physicians' rights to refuse treatment are well documented in the common law, but the same cannot be said for the insistence of medical treatment by patients or substitute decision-makers.<sup>68</sup> The rights of substitute decision-makers exist by virtue of legislation and are limited by the scope of these enactments.

### **Ontario's Consent and Capacity Board: A Dispute Resolution Model**

It is important to note that the Supreme Court's decision in *Rasouli* only applied to cases in Ontario and left the debate surrounding final decision-making

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<sup>64</sup> Thaddeus Mason Pope & Ellen A Waldman, "Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure" (2007) 23:1 Ohio State Journal on Dispute Resolution 143.

<sup>65</sup> *HCCA*, *supra* note 60, ss 70-81.

<sup>66</sup> *Rasouli*, *supra* note 62, at para 168.

<sup>67</sup> *Ibid* at para 169.

<sup>68</sup> *Ibid* at para 173.

authority between families and physicians in other jurisdictions unanswered. Chief Justice MacLachlin, writing for the majority, stated:

[3] The appellant physicians in this case take the position that the *HCCA* does not apply because consent is *not required for withdrawal of life support that does not provide any medical benefit to the patient*. The courts below rejected that contention, as would I. It follows that the appeal should be dismissed. Where a substitute decision-maker does not consent to the withdrawal of life support, the physicians' remedy is an application to the Board [emphasis added].<sup>69</sup>

The Consent and Capacity Board MacLachlin CJ references is one example of a dispute resolution process available to families and healthcare professionals. However, the Board's decision is not final and can be reviewed in court.<sup>70</sup> In other provincial and territorial jurisdictions, in the absence of statutes such as the *HCCA*, it is unclear who has the authority to withdraw life-sustaining treatment or support. As well, although Québec, British Columbia, Manitoba, Prince Edward Island, and the Yukon have legislation similar to the *HCCA*, they have no Consent and Capacity Board. One consequence of these differing regimes is that Ontario's specialized Board may lessen the likelihood these cases reach court, which is the only avenue for medical intervention decision-making in other Canadian jurisdictions.

The Consent and Capacity Board in Ontario is an excellent example of a dispute resolution process that assists in cases of contention between families and healthcare providers. The process moves quickly: within seven days of receiving written application, the Board's hearing begins (s 75(2)), unless the application is submitted under Section 39(2) of the *Mental Health Act*,<sup>71</sup> which requires a hearing to begin within 30 days.<sup>72</sup> One day following the end of the hearing, a decision is released (s 75(3)). Reasons for the decision can be requested by the parties within 30 days, to which a reply will be granted within four business days (s 75(4)(a)(b)). A transparency measure is built into the Board's dispute resolution process to

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<sup>69</sup> *Rasouli*, *supra* note 62 at para 3.

<sup>70</sup> *HCCA*, *supra* note 60, s 80(1): "A party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both."

<sup>71</sup> *Mental Health Act*, RSO 1990, c M-7, s 39(1).

<sup>72</sup> *HCCA*, *supra* note 60, s 75(2).

ensure the parties are given notice of their right to request reasons (s 75(5)). Section 18(1) of the *Statutory Powers and Procedure Act* enables the tribunal to enact its own rules, such as the Board's decision to widen the methods permitted to send decisions and reasons to parties of the dispute (s 75(6)(c)).<sup>73</sup>

The advantages of the Board are significant: the process moves quickly, the Board's members are appointed by the Lieutenant Governor in Council (s 70(2)) on the basis of specialized expertise, the chair of the Board may require specific qualifications for a member to examine an application on his or her own (s 71(3)), and reasons can be made available to both parties upon request (s 75(4)). There is also a built-in appeals mechanism (s 80(1)) where a party can appeal the Board's decision to Ontario's Superior Court of Justice "on a question of law or fact or both."<sup>74</sup> The appeal must be made within seven days of the Board's decision (s 80(2)). On appeal, the court holds significant power, including the right to "substitute its opinion for that of a health practitioner, an evaluator, a *substitute decision-maker*, or the Board" (s 10(b)) [emphasis added].

Overall, physicians and families appear to be pleased with the accessibility of applications ("Form G") to the Consent and Capacity Board. Timely decisions minimized patient harm.<sup>75</sup> The process was described as "patient centered, process oriented, orderly and efficient."<sup>76</sup> The most common reasons for applications to the Board included impasse with family, aggressive treatment not in the best interest of the patient (or treatment which would result in further harm to the patient), moral distress, or substitute decision-makers acting in their own interests (Table 1).<sup>77</sup>

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<sup>73</sup> *Statutory Powers and Procedure Act*, RSO 1990, c S-22, s 18(1).

<sup>74</sup> *HCCA*, *supra* note 60, s 80(1).

<sup>75</sup> Paula Chidwick & Robert Sibbald, "Physician Perspectives on Legal Processes for Resolving End-of-Life Disputes" (2011) 14: 2 *Healthcare Quarterly* 69 at 69 [Chidwick].

<sup>76</sup> *Ibid* at 73.

<sup>77</sup> *Ibid* at 71.

Over 33% of the 12 physician respondent cases surveyed<sup>78</sup> involved appeals following the Board's decision, and although the process exhausted much "moral energy," all but one physician would recommend the Board's process to colleagues.<sup>79</sup> Delays due to the appeal process (s 80(2)) raised concerns of the appeal option's ineffective response to intensive-care unit (ICU) patients; nevertheless, physicians acknowledged numerous advantages, including: the authoritative decision of the Board; the perception of the Board as a neutral third party and a forum for diverse interests to be heard; and the addition of a voice, or advocate, for the patient (Table 3).<sup>80</sup>

### **Alternative Dispute Resolution Processes in End-of-Life Care**

Now that I have reviewed the operation of Ontario's Consent and Capacity Board, I will move to a discussion of other ADR processes facilitating end-of-life disputes between families and healthcare providers, many of which are less formal than the Ontario model. These processes are often included, in some form, in the Ontario model, but they can also operate effectively on their own. This section of the paper briefly introduces the variety of strategies that can be used before resorting to more formal processes, such as Ontario's Board model or the courts. A search for alternatives can lead to better decision-making in end-of-life care overall, as the process becomes less adversarial. Generally, the legal system is moving toward more ADR (e.g., in family law) in an effort to expedite files, reduce administrative burden and court backlogs, and alleviate costs. For instance, a 1996 Ontario Civil Justice Review Report recommended province-wide, mandatory case management, proposed early mandatory ADR and, shortly thereafter, initiated pilot projects in Toronto, Ottawa, and Essex. These recommendations and the proliferation of ADR methods have important implications for other areas of the law, including MAID, the topic explored in this article.

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<sup>78</sup> *Ibid* at 74. For example, physician interview questions included: "Was this your first application? How did you learn about the process? What challenges did you find in the process? What were the benefits of this process [(a) for you and your colleagues, (b) for the patient]?"

<sup>79</sup> *Ibid* at 71-72.

<sup>80</sup> *Ibid* at 72.



## Negotiation

Negotiation in any context is complicated, yet it is important to build alternative dispute resolution processes into clinical practice, including end-of-life care. Effective patient advocacy begins with acknowledging others and reflecting upon one's ethical principles. Sensitive medical situations require acute self-awareness from medical personnel, and an ability to speak with others at multiple levels.<sup>81</sup> Bohm and Edwards write: "fragmentation consists of false division, making a division where there is a tight connection and seeing separateness where there is wholeness. Fragmentation is the hidden source of the social, political, and environmental crises facing the world."<sup>82</sup> This statement reveals a fundamental principle of negotiation in a legal setting: finding common ground is an important starting point. Legal intervention is a likely reaction or result where patients, their families, and their caregivers fail to acknowledge common ground and shared goals. Debra Gerardi, an expert in the field of healthcare collaboration and conflict resolution, emphasizes that collaboration requires time and commitment: "in return for that investment we gain understanding, build trust, discover common purpose, and expand possibility."<sup>83</sup>

Interest-based negotiation is the most practical negotiation approach in end-of-life care disputes. Rights-based negotiation is possible through legal channels if negotiations between two parties fail (e.g., family members and healthcare providers), but an interest-based approach shifts the focus from positions to interests.<sup>84</sup> Creative options are made possible by embracing dialogue, which prevents deadlock.<sup>85</sup> Too often, in contentious end-of-life disputes between substitute decision-makers and physicians, the involved parties use rights-based and power-based discourses. These latter tactics commonly result in litigation.

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<sup>81</sup> Debra Gerardi, "Team Disputes at End-of-Life: Toward an Ethic of Collaboration" (2006) 10:3 The Permanente Journal 43 at 43 [Gerardi].

<sup>82</sup> David Bohm & Mark Edwards, *Changing Consciousness: Exploring the Hidden Source of the Social, Political and Environmental Crises Facing our World* (San Francisco: Harper, 1991) [*Changing Consciousness*] as cited in Gerardi, *supra* note 81 at 43.

<sup>83</sup> Gerardi, *supra* note 81 at 43.

<sup>84</sup> Yona Shamir, *Alternative Dispute Resolution Approaches and Their Application*, online: Israel Center for Negotiation and Mediation <<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.468.2176&rep=rep1&type=pdf>>.

<sup>85</sup> *Ibid* at 32.

Assertive demands, even threats, are the primary forms of communication. Experts advise against this approach given the need to engage in joint problem solving and cooperative decision-making that will benefit patient needs.<sup>86</sup> Negotiation also involves speaking clearly and precisely, ensuring what is conveyed to another party is perceived accurately, continuously reframing positions as interests, and separating the people from the problem. Effective negotiation is challenging, requiring patience and practice.

### Mediation

Mediation is similar to negotiation except that the parties involved in the dispute are assisted or facilitated by a third party. The mediation is voluntary, conducted in private, and the mediator normally does not have power to render a decision nor should they have an interest in the decision being made. The mediator contributes actively by designing the process, reframing interests, asking open-ended questions, and encouraging the parties to think innovatively and creatively, while allowing the two sides to be the ultimate “architects of the solution.”<sup>87</sup> At least one U.S. state currently allows ethics committees to adjudicate medical disputes between families and physicians, but the vast majority of cases in the U.S. and Canada are resolved through more traditional alternative dispute resolution processes.<sup>88</sup>

In today’s healthcare context, the main challenge, even in cases of medical malpractice, is the lack of physician participation. Although medical errors are reduced and litigation costs curbed through mediation, a 2010 study of 31 mediation cases from 11 nonprofit hospitals in New York City reported zero participation by physicians in the medical disputes studied.<sup>89</sup> The absence of physicians meant missed opportunities to “repair the relationship between human

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<sup>86</sup> *Ibid* at 6-8.

<sup>87</sup> *Ibid* at 23-25.

<sup>88</sup> JM Luce, “A history of resolving conflicts over end-of-life care in intensive care units in the United States” (2010) 38:8 *Critical Care Medicine* 1623 at 1623.

<sup>89</sup> CS Hyman et al, “Interest-based mediation of medical malpractice lawsuits: a route to improved patient safety?” (2010) 35:5 *Journal of Health Politics, Policy and Law* 797 at 798, 816-18.

beings” (the patient, or their family, and the physician).<sup>90</sup> The most powerful theme from the study is the potential for mediation to improve patient safety “in a way litigation cannot.”<sup>91</sup> Most mediations between families and physicians in Canada do not involve legal counsel, making the involvement of physicians easier to facilitate than it would be in the distinct culture of hyper-litigious medical practice in the United States.

In fact, a policy statement published by the College of Physicians and Surgeons of Ontario (the College) entitled *Decision-making for the End of Life* encourages physicians to offer consenting patients or substitute decision-makers access to mediation, as well as arbitration or adjudication processes, if available in the physician’s facility.<sup>92</sup> The document’s purpose is to assist physicians providing care to patients at the end-of-life and to “lessen conflict and distress.”<sup>93</sup> Patients or their families are often offered other support services, including onsite social workers, pastoral services, and palliative care resources.<sup>94</sup> Professionals note these discussions in the patient’s health file for accountability. Following mediation, or a similar process, it is possible the patient or family will insist on a particular treatment; in this case, a physician who feels treatment would not be in the best interest of the patient is permitted to transfer care to another healthcare provider or facility, so long as the physician complies with the College’s policy on “Ending the Physician-Patient Relationship”.<sup>95</sup> Other complex mediation scenarios include situations involving minors or children suffering incurable disease, although these discussions are complex and unique, and are outside the scope of the current analysis.

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<sup>90</sup> Katherine Hobson, “Big Challenge for Mediation in Medical Malpractice: Doctor Participation” *The Wall Street Journal* (14 December 2010), online: The Wall Street Journal <<http://blogs.wsj.com/health/2010/12/14/big-challenge-for-mediation-in-medical-malpractice-doctor-participation>>.

<sup>91</sup> *Ibid.*

<sup>92</sup> College of Physicians and Surgeons of Ontario, *Policy Statement #1-06: Decision-making for the End of Life*, online: The College of Physicians and Surgeons of Ontario <<http://www.cpso.on.ca/cpso/media/uploadedfiles/policies/policies/policyitems/end-of-life.pdf>>.

<sup>93</sup> *Ibid.*

<sup>94</sup> *Ibid* at 6.

<sup>95</sup> *Ibid* at 7.

### The Potential of Alternative Dispute Resolution Mechanisms in the Canadian End-of-Life Care Context

Canadian courts are already inundated with a backlog of litigation in a variety of areas, including family law and medico-legal issues. Provincial and territorial implementation of formal ADR mechanisms in the context of MAID may prove effective in avoiding lengthy and costly court battles for end-of-life patient requests. As stated earlier in the article, Ontario remains the only province or territory with a formal adjudicating process for medical matters involving a patient's lack of capacity to consent. Adopting this type of model, along with other ADR processes, will prove helpful in other jurisdictions. Providing mediation, negotiation, and other services to patients and their families will not reduce the need to reference *Carter* entirely, but it will sharply reduce the system's reliance on court-adjudicated disputes. In the future, the current law on MAID could be amended to include emphasis on efforts to engage patients and families in ADR practices, and to encourage provincial and territorial medical bodies to develop comprehensive policies and strategies relating to same.

### **Cultural Complexity and Alternative Dispute Resolution Mechanisms**

Canada is an increasingly heterogeneous society, embracing people of diverse ethnicities, languages, health practices, socio-economic statuses, beliefs and spiritualities. Between November 4, 2015 and July 17, 2016, for instance, 29,207 Syrian refugees arrived to Canada.<sup>96</sup> According to Statistics Canada, by 2031, 25-28%—almost one-third of the Canadian population—could be foreign-born.<sup>97</sup> This brings a new aspect to the debate about end-of-life care. Other countries, such as the United Kingdom, are having similar cross-cultural discussions.<sup>99</sup> Cultural sensitivity considerations are paramount in end-of-life

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<sup>96</sup> Government of Canada, “#WelcomeRefugees: Key figures” online: Government of Canada <<http://www.cic.gc.ca/english/refugees/welcome/milestones.asp>>.

<sup>97</sup> Schuklenk et al, *supra* note 43 at 12-13.

<sup>99</sup> SM Carey & JF Cosgrove, “Cultural issues surrounding end-of-life care” (2006) 17 *Current Anaesthesia & Critical Care* 263.

considerations, regardless of the dispute resolution process employed in end-of-life care disputes between families and healthcare providers.

Different cultures have different views on discussing death. For instance, in Chinese culture, studies have shown that discussions about death and dying are more frequently avoided, as many claim it is “unwise to make predictions about one’s future.”<sup>100</sup> Another example stems from a Health Canada-sponsored study of South-Asian Canadians, where many respondents felt their terminal illness was “God’s wish.”<sup>101</sup> Of course, these studies are not necessarily entirely representative of this culture’s beliefs, but they exemplify the diverse cultural considerations at play.

In a Western-dominant cultural landscape, it is an ongoing challenge for Canadian healthcare systems to implement cross-cultural understandings of end-of-life in discussions of death and dying with patients and their families.<sup>102</sup> For example, Aboriginal people in Canada hold different cultural beliefs about life and death than other Canadians. In addition, many Aboriginal people have been historically disadvantaged and marginalized, both in society at large and by the medical system itself. Truth-telling about one’s health is sometimes viewed as bad for one’s well-being, and many Aboriginal peoples would prefer to die on reserve to inner-city hospital facilities.<sup>103</sup> One study interviewed 44 Aboriginal residents, community elders and religious leaders, physicians and nurses in Manitoba; nearly all would prefer to die on reserve, at their homes, with family.<sup>104</sup> Another study identified a lack of palliative care services in remote communities as a serious problem in northern Manitoba and other jurisdictions outside Canada.<sup>105</sup> Interestingly, the background paper on *Euthanasia and Assisted Suicide* authored by the Library of Parliament makes no mention of cultural differences in legally

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<sup>100</sup> Schuklenk et al, *supra* note 43 at 13.

<sup>101</sup> *Ibid.*

<sup>102</sup> *Ibid.*

<sup>103</sup> *Ibid.*

<sup>104</sup> KE Hotson, SM Macdonald & BD Martin, “Understanding death and dying in select First Nations Communities in northern Manitoba: issues of culture and remote service delivery in palliative care” (2004) 63 *International Journal of Circumpolar Health* 25 at 25, 35.

<sup>105</sup> Roger Thomas et al, “A Literature Review of Preferences for End-of-Life Care in Developed Countries by Individuals With Different Cultural Affiliations and Ethnicity” (2008) 10:3 *Journal of Hospice & Palliative Nursing* 162.

disputed medical decision-making.<sup>106</sup> This omission is problematic and must be addressed going forward.

There is ample literature on the importance of developing ADR mechanisms in a culturally sensitive manner, particularly with respect to Aboriginal peoples. A 2007 report prepared for the Canadian Human Rights Commission, entitled “Alternative Dispute Resolution (ADR) in Aboriginal Contexts: A Critical Review”<sup>107</sup> highlighted the contrast between Western modes of ADR (such as negotiation, mediation, arbitration, and conciliation) and Indigenous modes of ADR (including the “rejuvenation and reclamation of ways in which disputes may be resolved according to the culture and custom of the Indigenous party involved”).<sup>108</sup>

The report notes that ADR methods in the Indigenous context must include understandings of colonialism and its effects. The indigenous ADR processes themselves are also not easily categorized as those of the Western paradigm. However, a combination of both modes can be, and is often, utilized.<sup>109</sup> Challenges with ADR processes in the Aboriginal context include language barriers, cultural difference, and power imbalances.<sup>110</sup> On the issue of power imbalances, the author notes that “as long as Aboriginal forums are restrained by laws not of their own, or are given jurisdiction by an authority other than their own, or are seen as being delegated by or ‘alternative’ to, then these forums are simply another way of maintaining Aboriginal dependence and power imbalances firmly rooted in colonial legacy.”<sup>111</sup> Thus, any discussion which aims to promote reconciliation with Aboriginal peoples must recognize and adapt to these dynamics.

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<sup>106</sup> Butler, *supra* note 9.

<sup>107</sup> Wenona Victor, *Alternative Dispute Resolution (ADR) in Aboriginal Contexts: A Critical Review* (Canadian Human Rights Commission, 2007), online: <[http://www.chrc-ccdp.ca/sites/default/files/adrred\\_en\\_1.pdf](http://www.chrc-ccdp.ca/sites/default/files/adrred_en_1.pdf)>.

<sup>108</sup> *Ibid* at 3.

<sup>109</sup> *Ibid*.

<sup>110</sup> *Ibid* at 8.

<sup>111</sup> *Ibid* at 10.

## Moving Forward: Alternative Dispute Resolution Processes at the End-of-Life

End-of-life decision-making between families and healthcare providers is difficult in any circumstances, and increasingly complex when discussing euthanasia and physician-assisted suicide more broadly. Incapacitated individuals who rely on substitute decision-makers to make life-and-death decisions in their best interest further complicate the decision to withdraw treatment from patients, thus enabling “natural death.” An examination of the Consent and Capacity Board of Ontario shows that some systemic challenges remain; for example, ICU patients may suffer from long delays in decision-making due to ongoing litigation through the internal appeals mechanism within the *HCCA*.<sup>112</sup> However, the overall reaction to the Board has been positive. In reflecting on the Board’s usefulness, doctors have stated “from an ethical or professional point of view, it would have been wrong to take no action”<sup>113</sup> and noted fewer family arguments resulted because the process gave a “voice to the patient’s needs; advocating for their welfare so they can die peacefully and comfortably rather than slowly and with suffering.”<sup>114</sup> Negotiation and mediation dispute mechanisms are also available to families and physicians outside the Board process. In all cases, differences in culture, ethnicity, religion, spiritual beliefs and understanding place enormous strain on all parties, highlighting the sensitive nature of end-of-life decision-making in a diverse cultural environment such as Canada.

Moving forward, all levels of government in Canada must place an increased emphasis on ensuring that hospitals and healthcare facilities have mediation and negotiation staff expertise, with the capacity and responsibility to effectively provide legal, ethical, and medical advice to healthcare providers and patient’s families. Too often the social service needs of the most vulnerable members of our communities, including those at the end of their lives, do not accompany the standard medical services provided to patients. Shortfalls place enormous burdens on patients’ families, causing undue hardship in an already agonizing and sometimes debilitating process. These shortcomings also have significant moral

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<sup>112</sup> *HCCA*, *supra* note 60.

<sup>113</sup> Chidwick, *supra* note 75 at 71.

<sup>114</sup> *Ibid* at 72.

and ethical implications. The gap between social and legal services and top quality medical care must be narrowed if the Canadian healthcare system is to thrive and operate efficiently in contemporary society. In fact, the highest standard of medical care for twenty-first century aging Canadians may be impossible without accessible social and medical conflict resolution strategies and resources. We must ensure there is nothing contentious about that.