Role of Professional Associations

Table 3. Key Professional Associations

Association	Description
CMA	Provides leadership to physicians and advocates for access to high quality care in Canada
	Represents physician and population concerns at the national level
	Membership is voluntary
PTMAs (such as the OMA)	Negotiates fee and benefit schedules with provincial governments
	Represents the economic and professional interests of physicians
	Membership is voluntary
	Provide physician health support
CMPA	Physician-run organization that protects the integrity of member physicians
	Provides legal defense against allegations of malpractice or negligence
	Provides risk management and educational programs
	Membership is voluntary but all physicians must have some form of liability insurance
RDoC and PHO	Upholds economic and professional interests of residents across Canada
	Facilitates discussion amongst PHOs regarding policy and advocacy items
CFMS and FMÉQ	Medical students are represented at their universities by student bodies, which collectively form the CFMS or FMÉQ
	FMÉQ membership includes that of francophone medical schools

Advocacy and Diversity
- Similar to how the FMEQ represents the interests of francophone medical schools and the CFMS represents those nation-wide, other professional associations serve and advocate on behalf of different communities
- These associations may serve traditionally underrepresented groups, underserved communities, communities facing structural barriers, and/or communities with unique health needs
- Some examples of professional associations that physicians or medical students may join are: Gay, Lesbian, Bisexual and Transgender (GLBT) Medical Students of Canada; the Black Medical Students Association of Canada; Black Physicians Association of Ontario (BPAO); Muslim Medical Association of Canada and the Indigenous Physicians Association of Canada (IPAC); Indigenous Medical/Dental Students Association (IMDSA, Alberta)

Ethical and Legal Issues in Canadian Medicine

Introduction to the Principles of Ethics

- ethics involves thinking about what the best course of action may be in a specific case, including:
  1. principles and values that help us consider what might be morally permissible and/or impermissible in specific circumstances
  2. rights, duties, and obligations of individuals and groups
- as a self-regulated profession, ethical and professional practice is guided by a shared code of conduct (the CMA code of ethics), and by our provincial licensing bodies (through policies)
- the physician-patient relationship significantly depends on trust, which is recognized in the concept of fiduciary duty/responsibility of physician towards patient
- a fiduciary duty is a legal duty to act in another party's interest. Profit from the fiduciary relationship must be strictly accounted for with any improper profit (monetary or otherwise) resulting in sanctions against the physician and potential compensation to the patient, even if no physical harm has befallen the patient

Autonomy vs. Competence vs. Capacity
Autonomy: the right that patients have to make decisions according to their values, beliefs, and preferences
Competence: the ability to make a specific decision for oneself as determined legally by the courts
Capacity: the ability to make a specific decision for oneself as determined by the clinicians proposing the specific treatment

Table 4. The Four Principles Approach to Medical Ethics

Principle	Definition
Autonomy	Recognizes an individual's right to make their own decisions in their own way(s) based on their wishes, beliefs, values, and preferences
	It may not be possible for a person to make a fully autonomous decision and/or to have an autonomous decision honoured in some circumstances. For instance, if an autonomous request for a medical intervention is deemed clinically inappropriate from the physician's perspective, then the physician need not offer it
	Autonomy is not synonymous with capacity
Beneficence	Obligation to provide benefit to the patient, based on what is considered to be their best interests. Consideration of best interests should consider the patient's values, beliefs, and preferences, so far as these are known. Best interests extend beyond solely medical considerations
	May be limited by the principle of Autonomy (such as when differences exist between patient and clinician's conception of best interests)
	Paramount in situations where consent/choice is not possible
Non-Maleficence	Obligation to avoid causing harm; primum non nocere ("First, do no harm")
	A limiting principle of the Beneficence principle
Justice	Fair distribution of benefits and harms within a community, regardless of geography, income, or other social factors
	Concept of fairness: Is the patient receiving what they deserve – their fair share? Are they treated the same as equally situated patients? (equity) How does one set of treatment decisions impact others? (equality)
	Equality and equity are different notions of justice. Equality involves providing the distribution of resources to all people irrespective of differing needs, and equity involves distributing resources in a way that considers differing needs (such as circumstance and social context). Both concepts raise different considerations
	Basic human rights, such as freedom from persecution and the right to have one's interests considered and respected

Note: The four principles approach (i.e. principlism) is just one approach to medical ethics. There exist many other ethical principles that are also relevant to medicine (e.g. transparency, trust, etc.).

4. gives parents the option to terminate a pregnancy or begin early treatment if/as applicable
   - ethical dilemmas may arise because of the sensitive nature of genetic information; important ethical complexities and considerations related to genetic testing may include:
     - the individual and familial implications (e.g. how will learning about information confirmed via genetic testing influence one's family dynamic?)
     - its pertinence to future disease
     - its ability to identify disorders for which there are no effective treatments or preventive steps (e.g. should a person know if they/their fetus is genetically predisposed to an incurable disease? Would the potential harms of knowing this information potentially outweigh the benefits?)
     - its ability to identify the sex of the fetus, which may or may not be desired and/or relevant information to one's decision-making
     - obtaining truly informed consent is difficult due to the complexity of genetic information and the inability to know precisely what will/will not occur as a result of such testing (e.g. people may receive unexpected and unwanted genetic information after consenting to the testing)
     - related to the above, consent to genetic testing and consent to disclosure of all genetic information that results from the test may be distinct
     - some patients may want to be informed of genetic test results in particular ways (e.g. with a support person present). In the case of delivering complex information, genetic counselling may be recommended
     - duty to maintain confidentiality vs. duty to warn family members (e.g. if a patient's sister is likely predisposed to the same genetic condition as your patient, what are your responsibilities to the sister, if any?)
     - risk of psychological harm
     - risk of experiencing unjust social discrimination if such genetic information is disclosed to certain parties

Legal Aspects
- as of 2017, the Genetic Non-Discrimination Act exists
- genetic testing requires informed consent
- physicians are obligated to inform patients that prenatal testing exists and is available
- in some specific circumstances, a physician may be able to breach confidentiality in order to warn family members about a condition if harm can possibly be prevented via treatment or prevention. In general, the patient's consent is required, unless the harm to be avoided is sufficiently serious to rise to the level of imminent risk of serious bodily harm or death (i.e. not a chronic condition, but an acute life-threatening condition). It is recommended to consult with legal counsel and bioethics if complexities arise in regard to breach of confidentiality/duty to warn

End-of-Life Care

Overview of Palliative and End-of-Life Care
- focus of care is comfort and respect for person nearing death and maximizing quality of life for patient, family, and loved ones
  - palliative care is an approach that improves the quality of life of patients facing life-threatening illness, through the prevention and relief of suffering, including treating pain, physical, psychosocial, and spiritual concerns
- appropriate for any patient at any stage of a serious or life-limiting illness
- may occur in a hospital, hospice, in the community, or at home
- often involves an interdisciplinary team of caregivers
- addresses the medical, psychosocial, and spiritual dimensions of care
- palliative sedation: the use of sedative medications for patients that are terminally ill to relieve suffering and manage symptoms
- withdrawing or withholding life sustaining interventions (e.g. artificial ventilation or nutrition) that are keeping the patient alive but no longer wanted or indicated

Palliative Care – Not the Same as Medical Assistance in Dying
Palliative care is an approach designed to improve symptoms and quality of life for the duration of a person's life, but unlike Medical Assistance in Dying, it does not aim directly at or intend to end the person's life. Many palliative care physicians are incorporating MAID into their practice, though some may conscientiously object

Medical Assistance in Dying
- medical assistance in dying: the administering or prescribing for self-administration, by a medical practitioner or nurse practitioner, of a substance, at the request of a person, that causes their death

Common Ethical Arguments/Opinions
- criminally prohibiting medical assistance in dying may influence some individuals to end their own lives and/or to endure intolerable suffering until their natural death occurs
- patient has the right to make autonomous choices about the time of their own death
- belief that there is no ethical difference between the acts of euthanasia/assisted suicide and forgoing life-sustaining treatments
- belief that these acts benefit terminally ill patients by relieving suffering
- belief that patient autonomy has limits and that one cannot and/or should not be allowed to make an autonomous request to end one's life
- death should be the consequence of the morally justified withdrawal of life-sustaining treatments only in cases where there is a fatal underlying condition, and it is the condition (not the withdrawal of treatment) that causes death

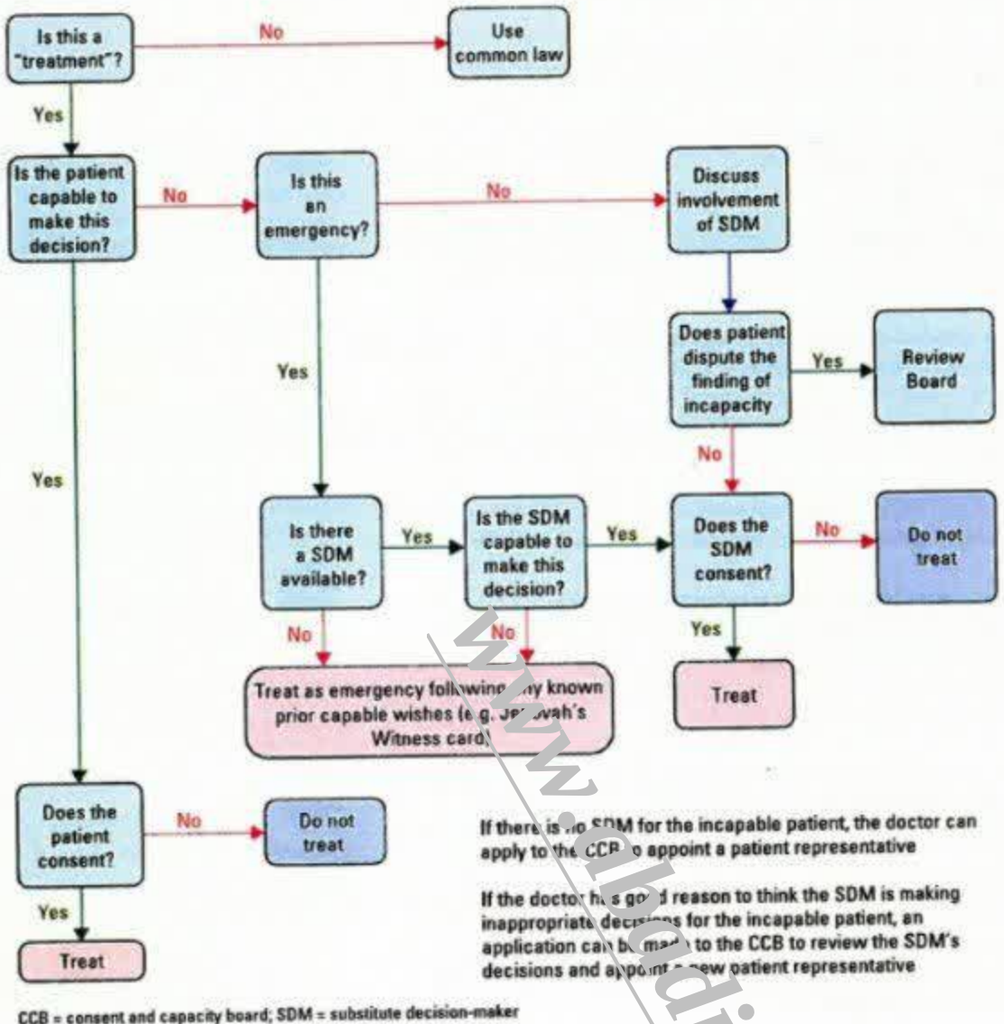

Figure 2. Ontario consent flowchart
Adapted by Hébert P from Sunnybrook Health Sciences Centre Consent Guidelines

Obtaining Legal Consent

- consent of the patient must be obtained before any medical intervention is provided; consent can be:
  - verbal or written, although written is usually preferred
  - a signed consent form is only evidence of consent – it does not replace the process for obtaining valid consent
  - most important component is what the patient understands and appreciates, not what the signed consent form states
  - implied (e.g. a patient holding out their arm for an immunization) or expressed
  - consent is an ongoing process and can be withdrawn or changed after it is given, unless stopping a procedure would put the patient at risk of serious harm, and the patient is not informed of and/or capable of considering these harms
  - if consent has been withdrawn during a procedure, the physician must stop treatment unless stopping the procedure would threaten the patient's life
  - in obtaining consent to continue the procedure, the physician need only re-explain the procedure and risks if there has been a material change in circumstances since obtaining consent originally. If there has been no material change in circumstances, simple assent to continue is sufficient (*Ciarlariello v. Schachter*)
- HCCA of Ontario (1996) covers consent to treatment, admission to a facility, and personal assistance services (e.g. home care)

Exceptions to Consent

1. Emergencies

- treatment can be provided without consent where a patient is experiencing severe suffering, or where a delay in treatment would lead to serious harm or death and consent cannot be obtained from the patient or their SDM
- emergency treatment should not violate a prior expressed wish of the patient (e.g. a signed Jehovah's Witness card)
- if patient is incapable, the physician must document reasons for incapacity and why situation is emergent
- patients have a right to challenge a finding of incapacity as it removes their decision-making ability
- if a SDM is not available, the physician can treat without consent until the SDM is available or the situation is no longer emergent

- it is the physician's responsibility to ensure appropriate security provisions with respect to electronic records and communications
  - with the advent of digital records, there have been increasing issues with healthcare providers that are not part of a patient's circle of care accessing medical records inappropriately (e.g. out of curiosity or for profit). All staff should be aware that most EMRs log which healthcare providers view records and automatically flag files for further review in certain cases (e.g. same surname, VIP patients, or audit of access to records)

Consent and Capacity

Ethical Principles Underlying Consent and Capacity

- consent is the autonomous authorization of a medical intervention by a patient
- usually the principle of respect for patient autonomy must be balanced with the principle of beneficence, since a physician need not offer an intervention that does not serve some benefit based on their clinical judgment
- informed consent is a process, not a transaction or a signature on a page
- informed refusal is equivalent in principle and approach
- if a patient is deemed incapable of consenting to a proposed medical intervention, then it is the duty of the SDM (or the physician in an emergency) to act on the patient's known prior wishes or, failing that, to act in the patient's best interests
- there is a duty to discover, if possible, what the patient would have wanted when capable
- central to determining best interests is understanding and taking into account the patient's values, beliefs, and preferences, including any relevant cultural and/or religious considerations and the patient's interpretation of those considerations
- more recently expressed wishes take priority over remote ones
- patient wishes may be expressed verbally or in written form
- patients found incapable of making a specific decision should still be involved in the decision-making process as much as possible. If a patient found incapable expresses a willingness to pursue the proposed treatment/intervention, then this is known as assent (rather than 'consent,' which requires capacity)
- agreement or disagreement with medical advice does not determine findings of capacity/incapacity
- however, patients opting for care that puts them at risk of serious harm that most people would want to avoid should have their capacity carefully assessed. Steer clear from the tendency to define what reasonable person standards may be. If appropriate, look to discern patterns of justification offered by patients and their individual values and beliefs, which may be influenced by social context, such as culture and/or religion
- laws pertaining to consent and capacity may vary by province/territory and readers are encouraged to consult provincial/territorial guidelines

Four Basic Requirements of Valid Consent

1. Voluntary

- consent must be given free of coercion or pressure (e.g. from family members who might exert 'undue influence,' from members of the clinical team)
- the physician must not deliberately mislead the patient about the proposed treatment
- the physician must engage in self-reflection prior to entering the conversation regarding their position of power and privilege as well as take measures to mitigate the power differential within the relationship

2. Capable

- the patient must be able to understand and appreciate the nature and effect of their condition as well as of the proposed treatment or decision

3. Specific

- the consent provided is specific to the procedure being proposed and to the provider who will carry out the procedure (e.g. the patient must be informed if students will be involved in providing the treatment)

4. Informed

- sufficient information and time must be provided to allow the patient to make choices in accordance with their wishes, including:
  - the nature of the treatment or investigation proposed and its expected effects
  - all significant risks and special or unusual risks
  - disclose common adverse events and all serious risks (e.g. death), even if remote
  - alternative treatments or investigations and their anticipated effects and significant risks
  - the consequences of declining treatment
  - answers to any questions the patient may have
- the reasonable person test – the physician must provide all information that would be needed "by a reasonable person in the patient's position" to be able to make a decision
- it is the physician's responsibility to make reasonable attempts to ensure that the patient understands the information, including overcoming language barriers, or communication challenges
- physicians have a duty to inform the patient of all legitimate therapeutic options and must not withhold information based on conscientious objections (e.g. not discussing the option of emergency contraception)

CPSO Policy Consent
Obtaining valid consent before carrying out medical, therapeutic, and diagnostic procedures has long been recognized as an elementary step in fulfilling the physician's obligations to the patient

PSO Policy on Capacity
Capacity is an essential component of valid consent, and obtaining valid consent is a policy of the CMA and other professional bodies

4 Basic Elements of Consent
- Voluntary
- Capable
- Specific
- Informed

Professional Considerations

Geriatric Patient
- Identify their goals of care and resuscitation options (CPR or DNR) (Note: we should aim to have goals of care discussions with all patients, regardless of age)
- Check for documentation of advance care planning (commonly referred to as "advance directives") and POA where applicable

Paediatric Patient
- Identify the primary decision-maker, if applicable (parents, guardian, wards-of-state, emancipated)
- Regarding capacity assessment (see *Paediatric Aspects of Capacity*, ELOM14)
- Be aware of custody issues, if applicable

Terminally Ill or Palliative Patient
- Consider the SPIKES approach to breaking bad news (see ELOM15)
- Identify the patient's goals of care (i.e. disease vs. symptom management)?
- Identify whether an advance care plan exists (See Palliative Medicine, PM5)
- Determine the patient's SDM according to the SDM hierarchy. If the patient has a POA then obtain a copy of the document
- Check for documentation of resuscitation options (CPR or DNR)

Incapable Patient
- Note: Capacity is treatment-specific and time-specific. An incapable patient is only incapable for the specific treatment at the specific time
- If not already present, perform a formal capacity assessment and thoroughly document
- Identify if the patient has an SDM or who has their POA and locate it, if applicable
- Check the patient's chart for any Mental Health Forms (e.g. Form 1) or any forms they may have on their person (e.g. Form 42)

- coercive relocation to isolated and sedentary communities away from ancestral lands, ending seasonally dynamic way of life
- sled dogs were killed, which discontinued the Inuit traditional way of life and forced them to rely on government supplies
- discs, to be worn around the neck, were issued with numbers in lieu of Inuit surnames and to ease bureaucratic workload

1965 *Royal Commission on Health Services* (Hall Commission) recommends federal leadership and financial support with provincial government operation

1966 *National Medical Care Insurance Act*
- federal government's first legislation with the goal of free access to healthcare
- federal government to pay half of medicare costs in any province with insurance plans that meet criteria of being universal, publicly administered, portable, and comprehensive
- Indian Health Services budget is reduced under the guise of equality and social and legal integration. Individuals can only receive support for healthcare services if they prove they are Indigenous, have been refused funds from their band, and can not obtain provincial health services. Financial limits are set to prevent "overuse" of services. This creates further barriers to accessing healthcare, while reducing barriers for non-Indigenous peoples

1984 *Canada Health Act* passed by federal government
- replaces *Medical Care Act* (1966) and *Hospital Insurance and Diagnostic Services Act* (1957)
- provides federal funds to provinces with universal hospital insurance
- maintains federal government contribution at 50% on average, with poorer provinces receiving more funds
- medical insurance must be "comprehensive, portable, universal, and publicly administered"
- bans extra-billing by new fifth criterion: accessibility

1985 *Bill C-31*
- the *Indian Act* forced Indigenous women who married non-Indigenous men to lose their Indian status
- *Bill C-31* attempted to stop the involuntary enfranchisement of Indigenous women (and their children) who married non-Indigenous men
- *Bill C-3* in 2011 and later cases ensured that eligible grandchildren of women who lost status could regain it

1990 Oka Crisis
- land dispute over ancestral Kanienkehaka (Mohawk) territory
- brought about the Royal Commission on Aboriginal Peoples (1996)

1996 *Canada Health and Social Transfer Act* passed by federal government
- federal government gives provinces a single grant for healthcare, social programs, and post-secondary education; division of resources at provinces' discretion

1996 Royal Commission on Aboriginal Peoples
- established in the wake of the Oka Crisis. The Commission's Report, the product of extensive research and community consultation, was a broad survey of historical and contemporary relations between Aboriginal and non-Aboriginal peoples in Canada
- recommendations made on how to repair the relationship between Indigenous peoples and Canada

2001 *Kirby and Romanow Commissions* appointed
- *Kirby Commission* (final report, October 2002)
- examines history of the healthcare system in Canada, pressures and constraints of current healthcare system, role of federal government, and healthcare systems in foreign jurisdictions

Romanow Commission (final report, November 2002)
- dialogue with Canadians on the future of Canada's public healthcare system

2004 *First Ministers' Meeting on the Future of Health Care* produces a 10 year plan
- priorities include reductions in waiting times, development of a national pharmacare plan, and primary care reform

2005 *Chaoulli v. Québec*, Supreme Court of Canada decision
- rules that Québec's banning of private insurance is unconstitutional under the Québec Charter of Rights since patients cannot access the relevant services under the public system in a timely manner