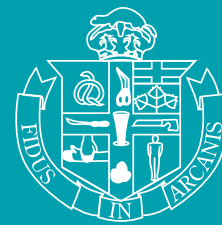


Medical Assistance in Dying Policy: Frequently Asked Questions



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Medical Assistance in Dying : Frequently Asked Questions

1. Why did the federal government introduce legislation on medical assistance in dying?

The legislation on medical assistance in dying is the federal government's response to the Supreme Court of Canada's (SCC's) decision in the case of *Carter v. Canada*. In that case, the SCC considered the constitutional validity of existing criminal laws that prohibited medical assistance in dying (referred to as 'physician-assisted death' by the SCC). The SCC ruled that these laws violated the *Charter* rights of competent adults, who are suffering intolerably from grievous and irremediable medical conditions, and seek a physician's assistance in dying.

The SCC suspended its decision to allow the federal and/or provincial governments to design, should they so choose, a framework to govern the provision of medical assistance in dying. In response, on June 17th 2016, the federal government passed legislation to allow eligible adults to request medical assistance in dying. The legislation includes rules on who is eligible for medical assistance in dying and outlines safeguards that must be followed to ensure public protection.

2. What is the meaning of 'medical assistance in dying' and what does the term encompass?

In accordance with the federal legislation, medical assistance in dying refers to an individual seeking and obtaining the assistance of a physician or nurse practitioner to end his/her life. This assistance encompasses two potential scenarios:

- i. The physician or nurse practitioner provides the patient with the means to end his/her own life (e.g. a prescription for a fatal dose of medication); or
- ii. The physician or nurse practitioner is directly involved in administering an agent to end the patient's life. This is often referred to as voluntary euthanasia.

3. What criteria must be met in order for an individual to access medical assistance in dying?

In accordance with federal law, for an individual to access medical assistance in dying, he/she must:

- i. Be eligible for publicly funded health services in Canada;
- ii. Be at least 18 years of age and capable of making decisions with respect to their health;
- iii. Have a grievous and irremediable medical condition (including an illness, disease or disability);
- iv. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and

- v. Provide informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

4. What is a grievous and irremediable medical condition?

An individual must have a grievous and irremediable medical condition to access medical assistance in dying. Under federal law, an individual has a grievous and irremediable medical condition if:

- a. They have a serious and incurable illness, disease or disability;
- b. They are in an advanced state of irreversible decline in capability;
- c. That illness, disease or disability, or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the individual has to live.

The federal government has stated that the patient need not have a terminal condition to be eligible for medical assistance in dying. Rather, there must be a real possibility of death, evidenced by the patient's irreversible decline, within a period of time that is foreseeable in the not too distant future. The federal government advises that the nature of the illness causing the patient intolerable and enduring suffering, and any other medical conditions or health-related factors such as age and/or frailty, are to be considered in assessing a patient's trajectory towards death.

5. In order access medical assistance in dying, the patient must be capable of making decisions with respect to their health. Does this mean the patient has to be capable when they request medical assistance in dying, when they receive medical assistance in dying, or both?

The federal legislation specifies that medical assistance in dying is available only to individuals who are capable of making decisions with respect to their health. This means that patients who are eligible for medical assistance in dying must maintain decision-making capacity from the time the request for medical assistance in dying is made, right up to the time at which medical assistance in dying is provided. This safeguard protects the



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patient's right to rescind a request for medical assistance in dying at any time. Further, it allows the physician to confirm that the patient wishes to proceed, and respects the patient's wishes if he/she decides not to proceed immediately prior to receiving medical assistance in dying.

6. Can requests for medical assistance in dying be made through an advance directive, or the patient's substitute decision-maker?

Requests for medical assistance in dying must be made by the patient, and not through an advance directive or the patient's substitute decision-maker. As described above, the federal legislation specifies that medical assistance in dying is available only to individuals who are capable of making decisions with respect to their health.

In accordance with Ontario's *Health Care Consent Act, 1996*, a substitute decision-maker would only make decisions for a patient in circumstances where the patient no longer has capacity. Similarly, advance directives only take effect if the patient loses capacity. With respect to medical assistance in dying, therefore, substitute decision makers do not have a role to play, and advance directives are not applicable.

The legislation requires that the federal government conduct further studies to examine the legal, medical and ethical questions surrounding advance requests for medical assistance in dying. The College will keep members abreast of any developments in this regard.

7. Your policy and the federal legislation requires a 10-day reflection period after a request for medical assistance in dying. Is this period flexible?

Yes, a period of at least 10 days must pass between the day on which the request for medical assistance in dying is signed by or on behalf of the patient, and the day on which medical assistance in dying is provided. In accordance with the federal legislation, this timeframe may be shortened if both the physician(s) and/or nurse practitioner(s) agree that death or loss of capacity to provide consent is imminent.

8. A patient's request for medical assistance in dying must be signed and dated before two independent witnesses. What is meant by "independent" in this context?

In accordance with the federal legislation, an independent witness is someone who is at least 18 years of age, and who understands the nature of the request for medical assistance in

dying. An independent witness cannot be a beneficiary under the patient's will; a recipient in any other way of a financial or other material benefit resulting from the patient's death; own or operate the health care facility at which the patient making the request is being treated; nor be directly involved in providing the patient's healthcare and/or personal care.

9. According to the policy, a second independent physician or nurse practitioner must confirm, in writing, whether the patient meets the eligibility criteria for medical assistance in dying. The first and second physician must be independent of each other. What does this mean?

In accordance with the federal legislation and as set out in the policy, the first and second physician or nurse practitioner assessing a patient's eligibility for medical assistance in dying must be independent of each other. This means that they must not:

- Be a mentor to, or be responsible for supervising the work of the first physician or nurse practitioner;
- Know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
- Know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

10. What should I do if I come to the conclusion that the patient does not meet the criteria for medical assistance in dying, and the patient disagrees?

Such situations will be challenging and emotionally charged. Where the attending or consulting physician and patient do not agree on whether the criteria for medical assistance in dying has been met, the physician must tell the patient that he/she is entitled to a second opinion from another physician. That physician would then again assess the patient against the criteria for physician-assisted death.

11. Are physicians permitted to use telemedicine to assess a patient's request for medical assistance in dying?

The practice of telemedicine is the practice of medicine. The College's *Telemedicine* policy indicates that any care provided through telemedicine must meet all of the standards and



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expectations that apply to care provided in person. The policy also specifies that before providing care through telemedicine, physicians must use their professional judgment to determine whether telemedicine is appropriate in a particular circumstance. In doing so, physicians must consider whether practising telemedicine will enable them to satisfy all relevant and applicable legal and professional obligations and meet the standard of care.

In relation to medical assistance in dying, there is nothing in the *Telemedicine* policy that would prevent or preclude physicians from using telemedicine. Physicians would need to be satisfied that they can assess the patient in keeping with the criteria set out in the federal legislation. Using telemedicine, the physician must be able to reach a clinically sound, comprehensive and defensible conclusion regarding whether the patient meets the criteria for medical assistance in dying.

If the physician believes that an in-person appointment is needed in order to assess any element of the patient's request and/or the criteria for medical assistance in dying set out in the federal legislation, medical assistance in dying, the physician must then meet with the patient in person. In such circumstances, exclusive use of telemedicine would not be appropriate.

As with care provided in-person, the physician would need to document the assessment in the medical record in keeping with the College's *Medical Assistance in Dying* and *Medical Records* policy.

12. Could an individual with a mental illness potentially meet the criteria for medical assistance in dying?

Individuals with mental illness are not precluded from accessing medical assistance in dying, as long as they meet the criteria for medical assistance in dying, as set out in the federal legislation. This includes the requirement that the individual who is seeking medical assistance in dying has decision-making capacity.

The federal government has stated that where an individual is suffering only from a mental illness, the criteria for medical assistance in dying would not be satisfied. The federal government has committed to conducting further studies to examine the legal, medical and ethical questions that arise where individuals, who suffer from mental illness only, are seeking a medically assisted death.

13. I have a religious objection to providing medical assistance in dying. (a) Am I compelled to participate? (b) What are my professional obligations to my patients?

The policy directs physicians to comply with the College's general position on conscientious objection, as set out in the *Professional Obligations and Human Rights* policy. Consistent with that policy, physicians do not have to provide services that conflict with their conscience or religious beliefs. This means that physicians, who object to providing medical assistance in dying for reasons of conscience or religion, are not required to provide medical assistance in dying. Further, objecting physicians are not responsible for assessing whether a patient is eligible for medical assistance in dying.

Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, an effective referral must be provided to the patient in a timely manner. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The *Medical Assistance in Dying* policy reinforces that Ontario physicians have a continuing positive obligation to their patients. Physicians must not abandon their patients or impede access to care. For more information on and examples of what constitutes an 'effective referral', please see document titled '*Fact Sheet: Effective Referral*', available on the College's website.

14. At this stage, it is unclear which physicians will be willing to provide physician-assisted death. How can I make an effective referral?

The College acknowledges that the number of physicians and/or agencies to which a referral would be directed may be limited, particularly at the outset of the provision of medical assistance in dying in Ontario, and that this is relevant to any consideration of whether a physician has complied with the requirement to provide an effective referral.

In light of these circumstances, the College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape. As with making referrals in other contexts, physicians are advised to utilize their professional networks to gain information about which physicians are willing to assess a patient for medical assistance in dying and/or provide medical assistance in dying.

The Ministry of Health and Long-Term Care has established a toll-free referral support line to help Ontario physicians to arrange referrals for patients requesting medical assistance in



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dying. Clinicians seeking assistance in making a referral can call toll-free: 1-844-243-5880. If physicians have general questions about the referral support line, or if they want to register as a potentially willing provider, please contact the Ministry of Health and Long-Term Care at MAIDregistration@ontario.ca.

15. The College's *Professional Obligations and Human Rights* policy requires physicians to provide care in emergencies, even where that care conflicts with physicians' conscience or religious beliefs. Does this requirement apply to medical assistance in dying? Will the College require physicians to provide medical assistance in dying, even if it is contrary to their conscience or religion?

No, physicians who have a religious or conscientious objection to providing medical assistance in dying are not required to provide medical assistance in dying, in any circumstance. A request for medical assistance in dying is not considered an emergency. That is why the expectation set out in the *Professional Obligations and Human Rights* policy, that physicians provide care in an emergency even where that care conflicts with their conscience or religious beliefs, has not been included in the College's *Medical Assistance in Dying* policy.

Objecting physicians are, however, required to provide an 'effective referral' in accordance with College policy. The College does not consider providing an effective referral to be 'providing' medical assistance in dying.

16. Once medical assistance in dying is provided, what are my obligations under the *Coroners Act*?

As directed by the Coroner, in accordance with the *Coroners Act, 1990*, coroners are required to complete the Medical Certificate of Death in all cases where medical assistance in dying is provided. All medically assisted deaths, therefore, will require notification to the Office of the Chief Coroner.

Physicians must disclose to their patients that the Office of the Chief Coroner will investigate all medically assisted deaths. The extent of a coroner's investigation cannot be determined in advance, and may or may not include an autopsy.