



POLICY STATEMENT #4-16

# Medical Assistance in Dying

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<b>REFERENCE MATERIALS:</b>	<i>Carter v. Canada (Attorney General)</i> , 2015 SCC 5.
<b>OTHER RESOURCES:</b>	Fact Sheet: Ensuring Access to Care – Effective Referral
<b>COLLEGE CONTACTS:</b>	Public and Physician Advisory Service

# Medical Assistance in Dying

## INTRODUCTION

Historically, it has been a crime in Canada to assist another person in ending his/her own life. This criminal prohibition has applied to circumstances where a physician provides or administers medication that intentionally brings about a patient's death, at the request of the patient.

In the case of *Carter v. Canada*,<sup>1</sup> the Supreme Court of Canada (SCC) considered whether the criminal prohibition on medical assistance in dying (referred to as 'physician-assisted death' by the SCC), violates the *Charter* rights of competent adults, who are suffering intolerably from grievous and irremediable medical conditions, and seek assistance in dying. The SCC unanimously determined that an absolute prohibition on medical assistance in dying does violate the *Charter* rights of these individuals, and is unconstitutional.

The SCC suspended its decision to allow the federal and/or provincial<sup>2</sup> governments to design, should they so choose, a framework to govern the provision of medical assistance in dying. In response, the federal government enacted legislation, through amendments to the *Criminal Code*<sup>3</sup>, to establish a federal framework for medical assistance in dying in Canada.

## DEFINITIONS

**Medical Assistance in Dying:** In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes a substance for an individual to self-administer to cause their own death.

**Medical Practitioner:** A physician who is entitled to practise medicine in Ontario.

**Nurse Practitioner:** A registered nurse who, under the laws of Ontario, is entitled to practise as a nurse practitioner, and autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances, and treat patients.

## PURPOSE OF DOCUMENT

This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in federal legislation, provincial legislation, and relevant College policies.<sup>4</sup> The policy includes the eligibility criteria for medical assistance in dying and provides a process map for managing requests for medical assistance in dying.

## PRINCIPLES

The key values of medical professionalism, as articulated in the College's *Practice Guide*, are compassion, service, altruism, and trustworthiness. The fiduciary nature of the physician-patient relationship requires that physicians prioritize patient interests. In doing so, physicians must strive to create and foster an environment in which the rights, dignity, and autonomy of all patients are respected.

Physicians embody the key values of medical professionalism and uphold the reputation of the profession by, among other things:

- Respecting patient autonomy with respect to healthcare goals and treatment decisions;
- Acting in the best interests of their patients, and ensuring that all patients receive equitable access to care;
- Communicating sensitively and effectively with patients in a manner that supports patients' autonomy in decision-

1. *Carter v. Canada (Attorney General)*, 2015 SCC 5 [Carter].

2. Physicians are advised to consult the Ontario Ministry of Health and Long-Term Care (MOHLTC) website for additional information and resources on medical assistance in dying: <https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions>.

3. *Criminal Code*, R.S.C., 1985, c. C-46.

4. This policy will refer to nurse practitioners and pharmacists, where relevant, in order to reflect the language of the federal law. The policy does not set professional responsibilities and accountabilities for members of the College of Nurses of Ontario, or members of the Ontario College of Pharmacists. For information on the professional accountabilities of nurse practitioners and other members of the College of Nurses of Ontario, please see the College of Nurses of Ontario document titled: *Guidance on Nurses' Roles in Medical Assistance in Dying*. For information on the professional accountabilities for members of the Ontario College of Pharmacists, please see the Ontario College of Pharmacists document titled: *Medical Assistance in Dying: Guidance to Pharmacists and Pharmacy Technicians*.



making, and ensures they are informed about their medical care; and

- Demonstrating professional competence, which includes meeting the standard of care, and acting in accordance with all relevant and applicable legal and professional obligations.

## POLICY

Physicians are expected to manage all requests for medical assistance in dying in accordance with the expectations set out in this policy.

### Criteria for Medical Assistance in Dying

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

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. 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.

Physicians must use their professional judgement to assess an individual's suitability for medical assistance in dying against the above criteria. The content that follows elaborates upon each element of the criteria for medical assistance in dying.

#### 1. Eligible for publicly funded health-care services in Canada

In accordance with federal legislation, medical assistance in dying must only be provided to patients who are eligible for publicly-funded health services in Canada. The activities involved in both assessing whether a patient

meets the criteria for medical assistance in dying, and providing medical assistance in dying, are insured services. These activities may include, for instance, counselling and prescribing. Accordingly, physicians must not charge patients directly for medical assistance in dying or associated activities. Physicians are advised to refer to the OHIP Schedule of Benefits for further information.

#### 2. Capable adult of at least 18 years of age

##### (i) Age Requirement

The federal legislation specifies that medical assistance in dying is available only to individuals who are at least 18 years of age and capable of making decisions with respect to their health.

Physicians will note that the requirement that patients be at least 18 years of age and capable departs from Ontario's *Health Care Consent Act, 1996*,<sup>5</sup> which does not specify an 'age of consent'.

##### (ii) Capacity

Under Ontario's *Health Care Consent Act, 1996*, a patient has capacity to consent to treatment if they are able to understand the information that is relevant to making the decision, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.<sup>6</sup> The patient must be able to understand and appreciate the history and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

In the context of medical assistance in dying, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of medication. A patient's capacity is fluid and may change over time. Therefore, physicians must be alert to potential changes in the patient's capacity.

When assessing capacity in the context of a request for medical assistance in dying, physicians are advised to rely on existing practices and procedures for capacity assessments.

5. *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. (hereinafter *HCCA*).

6. Section 4(1) of the *HCCA*.

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## 3. Grievous and Irremediable Medical Condition

Under federal legislation, 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 College acknowledges that the above definition of a ‘grievous and irremediable medical condition’ does not follow terminology typically used in a clinical context. In determining whether a patient has a grievous and irremediable medical condition, physicians must use their professional judgement to assess the patient.<sup>7</sup> Physicians may also wish to obtain independent legal advice.<sup>8</sup>

## 4. Voluntary Request for Medical Assistance in Dying

In accordance with federal legislation and the requirements for consent under the *Health Care Consent Act, 1996*, requests for medical assistance in dying must be voluntary and not made as a result of external pressure or coercion.

The physician must be satisfied that the patient’s decision to undergo medical assistance in dying has been made freely, without undue influence from family members, healthcare providers, or others. The patient must have requested medical assistance in dying him/herself, thoughtfully and in a free and informed manner.

## 5. Informed Consent

In order to receive medical assistance in dying, a patient must provide their informed consent. The process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to medical assistance in dying.

The College’s *Consent to Treatment* policy outlines the legal requirements of valid consent as set out in the Health Care Consent Act, 1996. In order for consent to be valid it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.<sup>9</sup>

As part of obtaining informed consent, physicians must discuss all treatment options with the patient. With respect to medical assistance in dying specifically, federal legislation requires that the patient be informed of the means that are available to relieve their suffering, including palliative care. The College’s *Planning for and Providing Quality End-of-Life Care* policy sets out the College’s expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

As noted above, a patient must be capable of making decisions with respect to their health to meet the criteria for medical assistance in dying. Therefore, consent to medical assistance in dying must be provided by a capable patient and not by a substitute decision maker.

## Conscientious Objection

The federal legislation does not address how conscientious objections of physicians, nurse practitioners, or other healthcare providers are to be managed. In the *Carter* case, the Supreme Court of Canada noted that the *Charter* rights of patients and physicians would have to be reconciled. Physicians who have a conscientious objection to providing medical assistance in dying are directed to comply with the College’s

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7. Further details on interpreting the statutory definition of a grievous and irremediable medical condition can be found in companion resources authored by the federal government, which are available on the Government of Canada website: <http://healthycanadians.gc.ca/health-system-systeme-sante/services/palliative-palliatifs/medical-assistance-dying-aide-medecale-mourir-eng.php>.

8. Physicians may wish to consult their own lawyer or the Canadian Medical Protective Association (CMPA) for independent legal advice.

9. Section 11(1) of the *HCCA*.



expectations for conscientious objections in general, set out in the *Professional Obligations and Human Rights* policy.<sup>10</sup>

These expectations are as follows:

- Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must do so in a manner that respects patient dignity. Physicians must not impede access to medical assistance in dying, even if it conflicts with their conscience or religious beliefs.
- The physician must communicate his/her objection to medical assistance in dying to the patient directly and with sensitivity. The physician must inform the patient that the objection is due to personal and not clinical reasons. In the course of communicating an objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.
- In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient's clinical needs, concerns, and/or wishes. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.
- Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician

must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.<sup>11,12</sup>

The federal legislation does not compel physicians to provide or assist in providing medical assistance in dying. For clarity, the College does not consider providing the patient with an 'effective referral' as 'assisting' in providing medical assistance in dying.

### Reporting Obligations

Physicians who provide medical assistance in dying must report the medically assisted death to the Office of the Chief Coroner (the "Coroner").<sup>13</sup> While the Coroner must be notified of all medically assisted deaths, an investigation is not required unless the Coroner deems one to be necessary.<sup>14</sup>

Physicians must provide the Coroner with any information about the facts and circumstances relating to the medically assisted death that the Coroner considers necessary to form an opinion as to whether the death ought to be investigated.<sup>15</sup> In practice, the College understands that physicians would typically fulfill this reporting obligation by contacting the Coroner and submitting the section(s) of the patient's medical record that pertains to the medically assisted death.<sup>16</sup> Details on medical record keeping requirements in the medical assistance in dying context are set out below.

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10. 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.

11. For more information on and examples of what constitutes an 'effective referral', please see document titled, 'Fact Sheet: Ensuring Access to Care: Effective Referral', available on the College's website: <http://www.cpso.on.ca/CPSTO/media/documents/Policies/Policy-Items/PAD-Effective-Referral-FactSheet.pdf>.

12. The College acknowledges that the number of physicians, health-care providers, and/or agencies to which an effective 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. The Ministry of Health and Long-Term Care has established the Care Coordination Service (CCS) to allow clinicians, patients, and caregivers to access information about medical assistance in dying and end-of-life care options, and to request referrals for medical assistance in dying. Clinicians seeking assistance in making a referral can call the CCS toll-free: 1-866-286-4023. If physicians have general questions about the CCS, or wish to register for the CCS as a willing provider, please contact the Ministry of Health and Long-Term Care at [MAIDregistration@ontario.ca](mailto:MAIDregistration@ontario.ca). The College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

13. Section 10.1(1) of the *Coroners Act*, R.S.O. 1990, c. C.3 (hereinafter "*Coroners Act*").

14. Section 10.1(1) of the *Coroners Act*.

15. Section 10.1(2) of the *Coroners Act*.

16. Following the provision of medical assistance in dying, the physician must notify the Coroner by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the Coroner's MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

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## Medical Record Keeping

The College's *Medical Records* policy sets out physicians' professional and legal obligations with respect to medical records. The policy requires that physicians document each physician-patient encounter in the medical record. This would include encounters concerning medical assistance in dying. The medical record must be legible, and the information in the medical record must be understood by other healthcare professionals. Where there is more than one healthcare professional making entries in a record, each professional's entry must be identifiable.

Each record of a physician-patient encounter, regardless of where the patient is seen, must include a focused relevant history, documentation of an assessment and an appropriately focused physical exam (when indicated), including a provisional diagnosis (where indicated), and a management plan.

Where a patient has requested medical assistance in dying, the physician must document each element of the patient's assessment in accordance with the criteria outlined above, and include a copy of their written opinion in the medical record. Further, all oral and written requests for medical assistance in dying, as well as the dates of these requests, must be documented in the medical record. A copy of the patient's written request must also be included.<sup>17</sup>

Where medical assistance in dying is provided, physicians must also document additional information in the patient's medical record. Such information will assist physicians in fulfilling their reporting obligation to the Coroner, as detailed above. The information to be recorded in the medical record includes, but is not limited to:

- The start and end-date of the required 10-day reflection period between the patient's signed request for medical assistance in dying and the date on which medical assistance

in dying is provided;

- The rationale for shortening the 10-day reflection period, if applicable (i.e., both clinicians and/or nurse practitioners are of the opinion that the patient's death or loss of capacity is imminent);
- The time of the patient's death; and
- The medication protocol utilized (i.e., drug type(s) and dosages).

In circumstances where a physician declines to provide medical assistance in dying, the physician must document that an effective referral was provided to the patient. This includes documenting, in the medical record, the date on which the effective referral was made and the physician, nurse practitioner and/or agency to which the referral was directed.

## Completion of Death Certificate

Upon receipt of a report regarding a medically assisted death, the Coroner will determine whether the death ought to be investigated.<sup>18</sup> If the Coroner determines that an investigation is not required, the attending physician or nurse practitioner who provided medical assistance in dying must complete the medical certificate of death.<sup>19</sup> However, if the Coroner is of the opinion that the death ought to be investigated, the medical certificate of death must be completed by the Coroner.

As directed by the province, when completing the death certificate for a medically assisted death, the illness, disease, or disability leading to the request for medical assistance in dying must be recorded as the underlying cause of death. Physicians are to make no reference to medical assistance in dying, or the drugs administered to achieve medical assistance in dying, on the death certificate.<sup>20</sup>

## Data Collection

The federal legislation authorizes the Federal Minister of Health to make regulations to establish a monitoring regime

17. The Ministry of Health and Long-Term Care (MOHLTC) has developed clinician aids to support the provision of medical assistance in dying. These include forms to: (a) assist patients who request medical assistance in dying (<http://bit.ly/29Sovs0>); (b) assist physicians who provide medical assistance in dying (<http://bit.ly/2a9M8Pf>); and (c) assist physicians who provide a written opinion confirming that the patient meets the eligibility criteria to receive medical assistance in dying (<http://bit.ly/29Spk3Y>).

18. Section 10.1(2) of the *Coroners Act*.

19. Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.

20. Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.



for medical assistance in dying in Canada. According to the federal government, these regulations could, for instance, stipulate the types of data to be provided and to whom; the body that would collect and analyze the data; and how often reports would be published. The federal regulations remain under development, and the College will keep its members abreast of any developments in this regard.

## PROCESS MAP FOR MEDICAL ASSISTANCE IN DYING

The process map that follows details the steps that physicians must undertake in relation to medical assistance in dying. It complies with federal legislation and outlines safeguards that must be adhered to, by law, prior to the provision of medical assistance in dying. Nurse practitioners and other professionals are noted in the Process Map only to the extent necessary to reflect relevant provisions of the federal legislation. Expectations for the responsibilities and accountabilities of nurse practitioners, pharmacists and other health care providers are set by their respective regulatory bodies.

Physicians and nurse practitioners, along with those who support them, are protected from liability if acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.<sup>21</sup>

### STEP 1: Patient makes initial inquiry for medical assistance in dying to a physician or a nurse practitioner.

Physicians who have a conscientious objection to medical assistance in dying are not obliged to proceed further through the process map and evaluate a patient's inquiry for medical assistance in dying. As described above, objecting physicians must provide the patient with an effective referral to a non-objecting physician, nurse practitioner, or agency. The objecting physician must document, in the medical record, the date on which the effective referral was made, and the physician, nurse practitioner and/or agency to which the referral was directed.

### STEP 2: Physician or nurse practitioner assesses the patient against eligibility criteria for medical assistance in dying.

The physician or nurse practitioner must ensure that the patient meets the criteria for medical assistance in dying. As described above, the patient must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. 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.

Where the patient's capacity or voluntariness is in question, the attending physician must refer the patient for a specialized capacity assessment.

With respect to the third element of the above criteria, a patient has a grievous and irremediable medical condition if:

- They have a serious and incurable illness, disease or disability;
- They are in an advanced state of irreversible decline in capability;
- 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
- 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.

If the physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to make a request for medical assistance

21. Liability protections extend to pharmacists, any individuals supporting physicians or nurse practitioners (not limited to regulated health professionals), and individuals who aid a patient to self-administer the fatal dose of medication, when acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.

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in dying to another physician who would again assess the patient using the above criteria.

The physician must document the outcome of the patient's assessment in the medical record.

## **STEP 3:** Patient makes written request for medical assistance in dying before two independent witnesses.

The patient's request for medical assistance in dying must be made in writing. The written request must be signed and dated by the patient requesting medical assistance in dying on a date after the patient has been informed that they have a grievous and irremediable medical condition.

If the patient requesting medical assistance in dying is unable to sign and date the request, another person who is at least 18 years of age, who understands the nature of the request for medical assistance in dying, and who does not 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 material benefit resulting from the patient's death, may do so in the patient's presence, on the patient's behalf, and under the patient's express direction.

The patient's request for medical assistance in dying must be signed and dated before two independent witnesses, who then must also sign and date the request. 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 individual may not act as an independent witness if they are a beneficiary under the patient's will, or are 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; or are directly involved in providing the patient's healthcare and/or personal care.

The physician must document the date of the patient's request for medical assistance in dying in the medical record. A copy of the physician's written opinion regarding whether the patient meets the eligibility criteria must also be included in the medical record.

## **STEP 4:** The physician or nurse practitioner must remind the patient of his/her ability to rescind the request at any time.

The physician or nurse practitioner must remind the patient that they may, at any time and in any manner, withdraw their request.

## **STEP 5:** An independent second physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for medical assistance in dying.

A second physician or nurse practitioner must assess the patient in accordance with the criteria provided above, and provide their written opinion confirming that the requisite criteria for medical assistance in dying have been met.

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 other 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.

If the second physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to have another physician assess them against the criteria.





### **STEP 6:** A 10-day period of reflection from date of request to provision of medical assistance in dying.

A period of at least 10 clear days<sup>22</sup> 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 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.

Physicians must document the start and end-date of the 10-day reflection period in the medical record, and their rationale for shortening the 10-day reflection period if applicable.

### **STEP 7:** Physician or nurse practitioner informs dispensing pharmacist that prescribed substance is intended for medical assistance in dying.

Medical assistance in dying includes both situations where the physician or nurse practitioner writes a prescription for medication that the patient takes him/herself, and situations where the physician or nurse practitioner is directly involved in administering an agent to end the patient's life.

Physician(s) and/or nurse practitioner(s) must inform the pharmacist of the purpose for which the substance is intended before the pharmacist dispenses the substance.

Physicians are advised to notify the pharmacist as early as possible (e.g. at the commencement of the reflection period) that medications for medical assistance in dying will likely be required. This will provide the pharmacist with sufficient time to obtain the required medications.

Physicians must exercise their professional judgement in determining the appropriate drug protocol to follow to achieve

medical assistance in dying. The goals of any drug protocol for medical assistance in dying include ensuring the patient is comfortable, and that pain and anxiety are controlled.

Physicians must document the medication protocol utilized (i.e., drug type(s) and dosages) in the medical record.

College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the College's website.

### **STEP 8:** Provision of Medical Assistance in Dying

The patient must be capable not only at the time the request for medical assistance in dying is made, but also at the time they receive medical assistance in dying.

Immediately before providing medical assistance in dying, the physician(s) and/or nurse practitioner(s) involved must provide the patient with an opportunity to withdraw the request and if the patient wishes to proceed, confirm that the patient has provided express consent. This must occur either immediately before the medication is administered or immediately before the prescription is provided.

Where medical assistance in dying is provided, physicians must document the patient's time of death in the medical record.

Physicians and nurse practitioners who provide medical assistance in dying, and those who assist them throughout the process, are protected from liability if they are acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules. These protections would extend, for example, to pharmacists, any individual who supports a physician or nurse practitioner (not limited to regulated health professionals), or individuals who aid a patient to self-administer the fatal dose of medication.

22. The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day. Therefore, in the context of medical assistance in dying, the 10-day reflection period would commence on the day following the day on which the patient's request is made, and would end the day following the tenth day.

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Where the patient plans to self-administer the fatal dose of medication at home, physicians must help patients and caregivers assess whether this is a manageable option. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.

Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.

## STEP 9: Mandatory Report to Coroner and Certification of Death

Physicians who provide medical assistance in dying must report the medically assisted death to the Office of the Chief Coroner (the "Coroner").<sup>23,24</sup> Upon notification, the Coroner will determine whether the death ought to be investigated. If the Coroner determines that an investigation is not required, the physician or nurse practitioner who provided medical assistance in dying must complete the medical certificate of death. If the Coroner is of the opinion that an investigation is required, the Coroner would complete the death certificate.<sup>25</sup>

When completing the death certificate for a medically assisted death, the illness, disease, or disability leading to the request for medical assistance in dying must be recorded as the underlying cause of death. The death certificate must not make reference to medical assistance in dying, or the drugs administered to achieve medical assistance in dying.<sup>26</sup>

23. Section 10.1(2) of the *Coroners Act*.

24. Physicians notify the Coroner of a medically assisted death by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the Coroner's MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

25. Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.

26. Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

