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Policy on Medical Assistance in Dying

This "*Policy on Medical Assistance in Dying*" has been developed by the College of Physicians and Surgeons of Prince Edward Island (the College) as a guidance document for physicians following the Supreme Court Decision Carter v. Canada (Attorney General 2015) and the newly amended criminal Code. The Canadian Parliament passed Bill C-14 entitled "An Act to Amend the Criminal Code and to make related amendments to other Acts (Medical Assistance in Dying)". This new legislation received Royal Assent thereby passing into law on June17, 2016. The new law specifically amends the Criminal Code of Canada to create exemptions from the offenses of culpable homicide, of aiding suicide and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying. The new law also prescribes the eligibility requirements and the legal procedure to be followed for medical assistance in dying.

This Policy document was initially developed from the recommendations of the Federation of Medical Regulatory Authorities' (FMRAC) Advisory Group on Physician-Assisted Dying, which was struck in response to the Supreme Court decision, Carter v. Canada. These recommendations were developed from the Canadian Medical Association's (CMA) draft framework. This Policy was also developed with the assistance of documents prepared by the College of Physicians and Surgeons of Alberta, the College of Physicians and Surgeons of Saskatchewan, and the College of Physicians and Surgeons of Manitoba.

This document was previously revised in 2017 to align with the newly amended Criminal Code. In December, 2018 it was revised again to include new federal reporting requirements for medical assistance in dying that became effective November 1st, 2018. As new federal and provincial legislation is developed over time, this Policy will be reviewed, revised and amended.

Legal Background:

On February 6, 2015, the Supreme Court of Canada struck down the law prohibiting physician-assisted dying.[1] The Court initially suspended that decision for 12 months. The effect of that decision was that, after February 6, 2016 and in the absence of new Federal legislation changing the Criminal Code, it would not be illegal for a physician to assist a competent adult patient to die if they met the Carter criteria:

1) the patient clearly consents to the termination of life, and
2) the patient has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition;

[1] Carter v. Canada (Attorney General), 2015 SCC5https://www.canlii,org/en/ca/scc/doc/2015/2015Ssvv5.htm;?resultindex=1

In the same decision, the Supreme Court also found that:

1) Nothing in its declaration compels physicians to provide assistance in dying.
2) The Charter rights of patients and physicians need to be reconciled in any legislative or regulatory regime in which medical assistance in dying is permitted.
3) Physicians are capable of reliably assessing patient competence and it is possible to detect vulnerability and coercion, and undue influence.
4) The principles of informed consent can apply.

On January 15, 2016 (before the February 6, 2016 date on which the original suspension would end) the Supreme Court of Canada gave the federal government an additional 4 month extension, or until June 6, 2016, to further consider the necessary amendments to the law and to respond. During that time, or until new legislation was passed, those who wished to seek physician-assisted dying could apply to the court in their jurisdiction for an exemption from the then current law prohibiting physician-assisted dying. During that time and without such an exemption, it remained illegal for anyone, including physicians, to counsel, aid, or abet a person to commit suicide. However, after the suspension ended on June 6, 2016 and until new federal legislation was passed, it was no longer illegal for physician- assisted dying. Bill C-14, an Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) was first introduced in parliament and to the public on April 14, 2016. After much debate, on June 17, 2016, parliament passed and gave Royal Assent to Bill C-14.

Eligibility for medical assistance in dying under the amended Criminal Code reads:
A person may receive medical assistance in dying only if they meet all of the following criteria:

1) they are eligible-or, but for any applicable minimum period of residence or waiting period, would be eligible-for health services funded by a government in Canada;
2) they are at least 18 years of age and capable of making decisions with respect to their health;
3) they have a grievous and irremediable medical condition;
4) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
5) they give 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.

A person has a **grievous and irremediable medical condition** only if they meet all of the following criteria:

1) they have a serious and incurable illness, disease or disability;
2) they are in an advanced state of irreversible decline in capability;
3) 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
4) 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 they have remaining.

New federal **reporting requirements for medical assistance in dying** became effective November 1, 2018. As of this date, the Regulations for the Monitoring of Medical Assistance in Dying require physicians, nurse practitioners, and pharmacists to provide information related to written requests for, and the provision of, medical assistance in dying. A written request can be in the form of hand-written, typed, emailed or text messaged. There are six scenarios in the Regulations where reporting is required; two when medical assistance in dying was provided and four when medical assistance in dying was not provided. Reporting time frames vary depending on the scenario and range from 30 to120 days. The

Regulations require practitioners to report based on where the written request was received. For PEI, reporting on medical assistance in dying is submitted online to Health Canada, through the Canadian MAID Data Collection Portal. If the portal cannot be accessed, a report can be submitted by fax or mail. To do this a PDF version of the reporting form must first be requested from Health Canada. A practitioner who knowingly fails to comply with the reporting requirements could face a maximum term of imprisonment of two years.
The new Regulations for the Monitoring of MAID can be found at http://www.gazette.gc.ca/rp-pr/p2/2018/2018-08-08/html/sor-dors166-eng.html
The federal government has developed a document 'Guidance for reporting on medical assistance in dying' which details the new reporting requirements and is meant to support physicians, nurse practitioners and pharmacists in fulfilling their responsibilities under the Regulations. It also has checklists of information required for reporting for use by physicians, nurse practitioners and pharmacists. The Guidance document can be found at https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary/document.html#7.1

Ethical Background

Relevant excerpts from the…

CMA Code of Ethics and Professionalism, December, 2018 (Adopted by Council 2019)

Fundamental Commitments of the Medical Profession:

Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.

Provide appropriate care and management across the care continuum.

Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.

Always respect the autonomy of the patient.

Never participate in or support practices that violate basic human rights.

Professional Responsibilities:

1. Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons.

2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.

3. Act according to your conscience and respect differences of conscience among your colleagues; however, meet your duty of non-abandonment to the patient by always acknowledging and responding to the patient's medical concerns and requests whatever your moral commitments may be.

4. Inform the patient when your moral commitments may influence your recommendation concerning provision of, or practice of any medical procedure or intervention as it pertains to the patient's needs or requests.

5. Communicate information accurately and honestly with the patient in a manner that the patient understands and can apply and confirm the patient's understanding.

6. Recommend evidence-informed treatment options; recognize that inappropriate use or overuse of treatments or resources can lead to ineffective, and at times harmful, patient care and seek to avoid or mitigate this.

11. Empower the patient to make informed decisions regarding their health by communicating with and helping the patient (or, where appropriate, their substitute decision-maker) navigate reasonable therapeutic options to determine the best course of action consistent with their goals of care; communicate with and help the patient assess material risks and benefits before consenting to any treatment or intervention.

12. Respect the decisions of the competent patient to accept or reject any recommended assessment, treatment, or plan of care.

14. Accommodate a patient with cognitive impairments to participate, as much as possible, in decisions that affect them; in such cases, acknowledge and support the positive roles of families and caregivers in medical decision-making and collaborate with them, where authorized by the patient's substitute decision-maker, in discerning and making decisions about the patient's goals of care and best interests.

17. Respect the patient's reasonable request for a second opinion from a recognized medical expert.

23. Enter into associations, contracts, and agreements that maintain your professional integrity, consistent with evidence-informed decision-making, and safeguard the interests of the patient or public.

29. Seek help from colleagues and appropriate medical care from qualified professionals for personal and professional problems that might adversely affect your health and your services to patients.

30. Cultivate training and practice environments that provide physical and psychological safety and encourage help-seeking behaviours.

36. Support interdisciplinary team-based practices; foster team collaboration and a shared accountability for patient care.

40. Support the profession's responsibility to promote equitable access to health care resources and to promote resource stewardship.

41. Provide opinions consistent with the current and widely accepted views of the profession when interpreting scientific knowledge to the public; clearly indicate when you present an opinion that is contrary to the accepted views of the profession.

Foundational principles used in developing this document:

1) *Respect for patient autonomy*. Competent adults are free to make decisions about their bodily integrity. Given the finality of medical assistance in dying, significant safeguards and standards are appropriate to ensure that respect for patient autonomy is based upon carefully developed principles to ensure informed patient consent, and consistency with the law.
2) A*ccess*: Individuals who seek information about medical assistance in dying should have access to unbiased and accurate information. To the extent possible, all those who meet the criteria for medical assistance in dying and request it should have access to medical assistance in dying.
3) *Respect for physician values*: Within the bounds of existing standards of practice and subject to the expectations in this document and the obligation to practice without discrimination as required by the CMA Code of Ethics and Professionalism (2018) and human rights legislation, physicians can follow their conscience when deciding whether or not to provide medical assistance in dying.
4) *Consent and capacity*: All the requirements for informed consent must clearly be met. Consent is seen as an evolving process requiring physicians to continuously communicate with the patient. Communications include exploring the priorities, values and fears of the patient, providing treatment options including palliative care interventions and answering the patient's questions. Consent must be express and voluntary. Given the context, a patient's decisional capacity must be carefully assessed to ensure that the patient is able to understand the information provided and understands that the consequences of making a decision to access medical assistance in dying.

5) *Clarity*: The College should ensure, to the extent possible that guidance or standards which it adopts:
   (a) Provide guidance to patients and the public about the requirements which patients must meet to access medical assistance in dying;
   (b) Advise patients what they can expect from physicians if they are considering medical assistance in dying; and
   (c) Clearly express what is expected of physicians.
6) *Dignity*: All patients, their family members and significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life.
7) *Accountability*: Physicians participating in medical assistance in dying must ensure that they have appropriate technical competencies as well as the ability to assess decisional capacity, or the ability to consult with a colleague to assess capacity in more complex situations.
8) *Duty to Provide Care*: Physicians have an obligation to provide ongoing care to patients unless their services are no longer required or wanted or until another suitable physician has assumed responsibility for the patient. Physicians should continue to provide appropriate and compassionate care to patients throughout the dying process regardless of the decisions they make with respect to medical assistance in dying. [2]

Definitions:

For the purpose of this document, the College has adopted the following three definitions from the amended Criminal Code, section 241.1:
Medical assistance in dying means (a) "the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death."

A *medical practitioner* is a physician who is entitled to practice medicine under the laws of a province.

A *nurse practitioner* is a registered nurse who, under the laws of the province, is entitled to practice as a nurse practitioner - or under an equivalent designation - and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.

Other relevant definitions:

Euthanasia…	…Death by another person with the intent to end life to alleviate suffering (*physician-administered, physician-hastened death)*
Suicide…	…The taking of one's own life. This may be the result of a mental illness, or for other reasons.
Assisted suicide…	…Suicide which was carried out with the provision of the means to do so by another person (*patient – administered, physician-hastened death)*
Continuous Palliative Sedation…	…The administration of medication at the end of life to a person in palliative care with the intent to alleviate suffering[3]
Patient…	…The person making a request for medical assistance in dying.
Physician…	…A member of the College who is registered on the medical registers of Prince Edward Island, excluding those on the education register.
Attending physician…	…A physician who is the primary care giver to the patient seeking physician-assisted dying
Consulting physician…	…A physician who is consulted to conduct an assessment or provide advice or an opinion relevant to one or

[2] College of Physicians and Surgeons of Saskatchewan

[3] Canadian Society of Palliative Care Physicians, submission to the External Panel on options for a legislative response to Carter v. Canada Oct 2015

	more of the requirements of this Statement.
Administering physician…	…The physician who provides or administers medication to intentionally bring about the patient's death. This physician may be the attending physician, or the consulting physician, provided that at least two physicians are involved and have independently assessed the patient.

Standards:

Communication:

A physician who for conscientious reasons declines to provide medical assistance in dying must

a. Disclose that fact to the patient,
b. Continue to treat the patient with dignity and respect, and provide medical care until no longer required or wanted, or until another physician has assumed responsibility for the patient, and
c. Provide, or arrange to be provided, the patient's chart and sufficient medical information, with the patient's consent, to the patient or to other physicians or *nurse practitioners* involved in the process
    i) To enable the patient to make his/her own informed choice and access all options for care, including palliative care
    ii) To enable access to another physician, *nurse practitioner* or service

A physician, or delegate, must be respectful, must provide sufficient, timely medical information, and must not be confusing, coercive, or provide incomplete information.

A physician may delegate the responsibility for communication of information regarding medical assistance in dying to another person (who is competent to do so and for whom the physician is responsible), or to another agency.

Training:

The physician involved in providing medical assistance in dying must:

- Be qualified by specialty training or experience to render a diagnosis and prognosis of the patient's illness, or be able to consult with a colleague who is so qualified to obtain the diagnosis and prognosis;
- Be qualified by specialty, training or experience to meet the requirements to provide medical assistance in dying;
- Be able to assess decisional capacity or be able to consult with a colleague to assess capacity in more complex situations, and,
- Have appropriate knowledge and technical competency to provide medical assistance in dying of the form to be administered.

Patient Eligibility:

Adult:

Medical assistance in dying only applies to adult patients, at least 18 years of age.

Capacity:

The attending physician must be satisfied that the patient is:

- Mentally capable of making an informed decision at the time of the requests and throughout the process, and
- Capable of giving informed consent to medical assistance in dying

If the attending physician or the consulting physician/nurse practitioner is unsure if the patient has sufficient capacity, the patient must be referred for further capacity assessment.

Medical assistance in dying only applies to patients who clearly consent to ending their lives. Unless the requirements for consent are further defined in the future, immediately before providing medical assistance in dying, the patient must be given the opportunity to withdraw their request and they must be capable to give express consent to receive medical assistance in dying.

Voluntariness:
The attending physician must be completely satisfied, on reasonable grounds, that all of the following conditions are fulfilled:

1. The attending physician, the consulting physician*/nurse practitioner* and the administering physician/nurse practitioner must be satisfied that the decision to undergo medical assistance in dying has been made freely, independent of coercion or undue influence from any person, including family members, and health care workers
2. The patient him/herself has requested medical assistance in dying thoughtfully and repeatedly, in a free and informed manner.
3. The patient maintains a clear and settled intention to end his or her own life, after making an informed decision.

Informed Decision:
The attending physician must:

1. Assess that a patient requesting medical assistance in dying meets the conditions established by the amended Criminal Code.
2. Ensure that the patient has consistently expressed a desire for medical assistance in dying over a reasonable period of time, which may vary depending on the patient's medical condition and other circumstances.
3. Disclose to the patient, information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, the potential complications associated with the medication, and alternatives, including comfort care, palliative and hospice are, pain and symptom control, and other available resources to avoid the loss of personal dignity.
4. Advise the patient of any counseling resources, which are available to assist the patient
5. Assist a patient to access resources, which may provide an alternative to medical assistance in dying if the patient wishes to access those resources.
6. Inform the patient of his or her right to rescind the request at any time.
7. Take reasonable steps to ensure that the patient has understood the information that has been provided.
8. Consult a second physician *or nurse practitioner* before providing the patient with medical assistance in dying, such consultant acting within the scope of his/her practice to interact directly with the patient and provide an independent opinion on capacity and/or eligibility.
9. Keep a detailed record of such discussions.
10. Obtain consent from the patient at the time of medical assistance in dying. Consent forms (provided by Health PEI or the College) are to be completed by the administering physician (or *nurse practitioner*), and one of the attending or consulting physicians (or *nurse practitioner*).

A Physician's Obligation

This section must be read in the context of relevant evolving federal and provincial legislation, which supersedes this Policy. For relevant federal reporting requirements (including time frames for reporting) under the Regulations for the Monitoring of Medical Assistance in Dying (Nov, 2018), please refer to the Government of Canada website Guidance document found at https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary/document.html#7.1

Medical assistance in dying has been declared a right under the amended Criminal Code. Therefore it is important that each physician consider the pros and cons and decide in advance whether or not the physician would participate if ever called upon to do so.

Each physician may find him/her self in one of the 3 following situations:

1. **The physician decides either for conscientious or religious reasons not to participate. The physician should advise all his/her patients of that fact, perhaps by posting a notice in the office.**

If a request is received anyway, the physician must not act as a barrier to the patient requesting the services, solely on the basis of the physician's beliefs. The physician, or delegate, must provide a copy of the patient's chart and sufficient medical information, with the patient's consent, to the patient or to other physicians or *nurse practitioners* involved in the process. The provision of information on medical assistance in dying may be delegated to another person (who is competent to do so and for whom the physician is responsible), or to another agency. A recommended course of action might be to transfer the care of the patient to another physician, *nurse practitioner* or service.

Federal reporting is required by this physician only if the patient was referred or their care transferred to another physician/nurse practitioner or service for the purpose of requesting MAID.

2. **The physician decides to participate, but only to the degree of providing information, assessing eligibility for medical assistance in dying, referring to another independent consultant physician or *nurse practitioner* who will also assess eligibility, and referring to the appropriate physician, *nurse practitioner* or agency who will/may carry out the procedure. (*The consultant physician or nurse practitioner may be the practitioner who will carry out the procedure).***

   Federal reporting is required by the referring physician.

Responsibilities The physician shall:

a. Check that the patient is eligible for health services funded by a government in Canada.
b. Be familiar with the Law, Regulations, and College Policy regarding Medical Assistance in Dying.
c. Ensure the patient is a competent adult: over 18 years of age, and has the capacity to consent, consulting with other physicians or *nurse practitioners* if necessary.
d. Ensure the request has not been completed under any coercion.
e. Ensure the written request for medical assistance in dying is on the appropriate form (as per Health PEI Policy and provided by Health PEI or the College) and is dated after the documented time when the patient was informed that the patient's natural death has become reasonably foreseeable.
f. Ensure the request has been witnessed by 2 independent persons, who are at least 18 years of age and who understand the nature of the request for medical assistance in dying, except if 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; are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides; are directly involved in

providing health care services to the person making the request; or directly provide personal care to the person making the request.

g. Carefully review the medical record and form an opinion as to whether the criteria are met, thus making the patient eligible for medical assistance in dying.
h. Advise the patient that their request may be withdrawn at any time.
i. Consult another physician or *nurse practitioner* who is independent, preferably from the specialty area related to the patient's suffering, and provide that physician or *nurse practitioner* with all the clinical information required for that practitioner to form an opinion regarding the patient's eligibility for medical assistance in dying. [The physicians or nurse practitioners are independent if they (a) are not a mentor to the other practitioner or responsible for supervising their work; (b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any 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 (c) do not 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.]
j. Ensure that the consultant's opinion is in writing and indicates the request is reasonable.
k. Refer the patient to the appropriate physician, *nurse practitioner* or agency who will carry out the procedure.
l. Complete the death certificate if not already done by the administering physician/ *nurse practitioner*.
m. Complete any reports required by the coroner, government, insurance agency or any other required organization if not done by the administering physician/ *nurse practitioner*. Federal reporting is required by the participating physician.

3. The physician plans participate: to assess eligibility and to carry out the procedure

Responsibilities <u>The physician shall</u>:

a. Check that the patient is eligible for health services funded by a government in Canada.
b. Be familiar with the Law, Regulations, and College Policy regarding Medical Assistance in Dying.
c. Ensure the patient is a competent adult: over 18 years of age, and has the capacity to consent, consulting with other physicians or *nurse practitioners* as necessary.
d. Ensure the request has not been completed under any coercion.
e. Ensure the written request is on the appropriate form (as per Health PEI Policy and provided by Health PEI or the College) and is dated after the documented time when the patient was informed that the patient's natural death has become reasonably foreseeable.
f. Ensure that the request has been witnessed and dated by 2 independent persons, who are at least 18 years of age and who understand the nature of the request for medical assistance in dying, except if 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; are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person

resides; are directly involved in providing health care services to the person making the request; or directly provide personal care to the person making the request.

g. Carefully review the medical record, and form an opinion as to whether the criteria are met, thus making the patient eligible for medical assistance in dying.
h. Advise the patient that their request may be withdrawn at any time.
i. Consult another physician or *nurse practitioner*, who is independent, preferably from the specialty area related to the patient's suffering, and provide that physician or *nurse practitioner* with all the clinical information required for that practitioner to form an opinion regarding the patient's eligibility for medical assistance in dying. . [The physicians or *nurse practitioners* are independent if they (a) are not a mentor to the other practitioner or responsible for supervising their work; (b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any 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 (c) do not 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.]
j. Ensure that the consultant's opinion is in writing and indicates the request is reasonable.
k. Ensure that there have been at least 10 "clear" days between the date on which the request was signed by or on behalf of the patient and the date on which the medical assistance in dying is provided –or if both practitioners are of the opinion that the patient's death, or the loss of their capacity to provide informed consent, is imminent-any shorter period that the first practitioner considers appropriate in the circumstances.
l. Notify the pharmacist as soon as possible after the request for medical assistance in dying is signed.
m. Decide on the appropriate venue for the delivery of the service.
n. Arrange to have a nurse to assist.
o. Start an adequate IV line, or arrange for it to be started.
p. Ensure the IV is running properly.
q. Confirm with the patient that he/she wishes to proceed.
r. Carry out the termination of life according to best practices and Health PEI Policy.
s. The physician shall obtain the medications (including narcan) and bring them to the site if they are to be administered at home. (In a hospital, the pharmacist should deliver the medications)
t. The physician should ensure safe handling and storage of the medication.
u. The physician should ensure any unused medications are returned to the pharmacy.
v. The physician must ensure death has occurred.
w. Carefully keep a record of the event including, but not limited to, the time of administering the agents, the effect on the patient and time of death.
x. Notify the coroner.
y. Complete the death certificate and any other documentation.
z. Complete any reports required by the coroner, government, insurance agency or any other required organization.
   Federal reporting is required by the administering physician.

Where death has taken place in a situation covered by this Policy, currently it is a reportable death; therefore the coroner must be notified**.** [4]

The attending, consulting and administering physicians must cooperate with any pre or post death review or enquiry, including the completion of any required forms.

MAID Forms

Physicians participating in a medically assisted death outside of a Health PEI facility may obtain the required MAID forms to be used by contacting the College office.

Revised and Approved by Council, November 4, 2019

[4] Coroner's Act, PEI