ADVICE TO THE PROFESSION: MEDICAL ASSISTANCE IN DYING

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The *Medical Assistance in Dying (MAID)* policy sets out physicians' professional obligations regarding MAID and the *MAID: Legal Requirements* companion resource sets out the key legal obligations physicians have. This companion *Advice to the Profession* document provides additional information and guidance regarding the following: 1) interpreting/applying physicians' obligations; 2) tools/resources for physicians; and 3) information/resources for patients/caregivers.

1) Interpreting/Applying Physicians' Obligations

For the purposes of this section,

- "MAID provider" refers to the physician or nurse practitioner who: administers medications that cause a patient's death, or who prescribes or provides medications for a patient to self-administer, after first assessing the patient and determining that the patient meets all of the eligibility criteria and safeguards.
- "MAID assessor" refers to the physician or nurse practitioner who assesses the patient and provides a written opinion confirming that the patient meets all of the eligibility criteria.

When and how do I discuss MAID with patients?

Physicians will have to use their professional judgment to determine if, when, and how to discuss MAID with their patients. The Canadian Association of MAID Assessors and Providers (CAMAP) has a clinical guidance document on Bringing up MAID as a clinical care option, which includes the following:

- The appropriate timing of discussions regarding MAID is determined by the clinical context and the specific circumstances of the patient.
- When discussing MAID as a treatment option, be aware of the physician-patient power dynamic and ensure MAID is presented as *one* of the treatment options, and not as a coercive recommendation to pursue that option.
- It is important to approach discussions regarding MAID from a place of respect and trust and allow for sufficient time to have such sensitive conversations.

Also, the Centre for Effective Practice provides some guidance on how to navigate a patient's request for MAID, including the importance of carefully exploring and understanding the patient's suffering, as well as the psychosocial or non-medical conditions and circumstances that may be motivating the patient's request.

Are uninsured patients eligible for MAID? Can I charge patients for the activities involved in assessing patients for and/or providing MAID?

No. Only patients who are eligible for health services funded by a government in Canada can be eligible for MAID. As the activities involved in assessing patients for and/or providing MAID are publicly insured services for publicly insured patients, MAID providers/assessors are not able to charge patients for these activities.

What is a grievous and irremediable medical condition?

A patient must have a grievous and irremediable medical condition to be eligible for MAID. As set out in the *Criminal Code*, a patient has a grievous and irremediable medical condition if:

i. They have a serious and incurable illness, disease, or disability that is not a mental illness;

ii. They are in an advanced state of irreversible decline in capability; and

iii. 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.

The federal government has clarified that "incurable" should be interpreted as including the limitation "by any means acceptable to the patient".

Also, the federal government has clarified that a patient can be in an advanced state of irreversible decline in capability in general terms, while still having moments of slight improvement. The loss of capability can be sudden or gradual, and ongoing or stabilized.

What if I'm not sure if a patient meets the eligibility criteria, or if I find a patient is ineligible for MAID?

In some cases, it may be difficult to determine whether the patient is eligible for MAID and MAID providers/assessors may wish to consider discussing the case with another physician or health care professional[1] to help them make that determination. However, you would need to form your own professional opinion regarding the patient's eligibility

[1] If the discussion includes sharing the patient's personal health information, the patient would need to provide express consent for the physician to disclose that information to a physician or health care professional who is outside of the circle of care. See the College's *Protecting Personal Health Information* policy for more information.

and take sole responsibility for that determination if you are the MAID provider/assessor.

If you are not able to form your own opinion regarding whether the patient meets the eligibility criteria or if you conclude that a patient does not meet the eligibility criteria for MAID, you will need to clearly and sensitively communicate this information to the patient as soon as is reasonable. You may wish to inform the patient that they are entitled to make a request for MAID to another MAID provider/assessor, who would reassess the patient using the eligibility criteria. If the patient indicates that they would like to be reassessed, you will need to consider whether the patient requires any assistance finding another MAID provider/assessor (e.g., by connecting them with the Care Coordination Service).

In addition to the documentation requirements set out in the policy, it may be prudent for physicians to note whether they discussed the case with another physician or nurse practitioner in making their determination, along with any discussions they had with the patient and/or any subsequent steps they took to help the patient get reassessed in circumstances where physicians were not able to form an opinion or concluded the patient does not meet the eligibility criteria.

What if a patient does not want to tell their family and/or friends about their decision to pursue MAID or a patient's family and/or friends disagree with their choice to pursue MAID?

It can be very challenging to navigate these situations and when they arise, it is important to keep in mind that it is ultimately a capable patient's right to decide which clinically appropriate treatment options they pursue and who they want to share this decision with.

Can requests for MAID be made through an advance directive or the patient's substitute decision-maker? Is final express consent required immediately before MAID is provided?

All requests for MAID must be made directly by the patient and cannot be made through an advance directive or by the patient's substitute decision-maker. The *Criminal Code* specifies that MAID is available only to patients who are capable of making decisions with respect to their health.

Immediately before providing MAID, the MAID provider must give the patient 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 medications are administered by the MAID provider, or immediately before the prescription or medications are provided to the patient for self-administration.

However, the recent legislative changes now permit patients to enter into a written arrangement that waives the requirement that the MAID provider obtain their final express consent immediately prior to administering MAID in two circumstances, as described in the in the *MAID: Legal Requirements* companion resource.[2, 3]

Is it necessary for the MAID provider to be present when the patient is self-administering MAID?

The *Criminal Code* does not require that the MAID provider be present during self-administration unless they have entered into a written arrangement that permits them to provide MAID if the patient (1) does not die within a specified period after self-administering the medications, and (2) has lost capacity to provide consent.

Given the risk of potential complications with self-administration, including the possibility that death might not be achieved, the MAID provider may want to encourage the patient to include them among those present during the self-administration even if there is no written arrangement. However, the MAID provider will have to explain that if there is no written arrangement, they cannot intervene and administer a second round of medications causing death if self-administration is prolonged or fails unless the patient is capable and can provide consent immediately prior to the provider administering MAID.

Can MAID providers/assessors be independent and objective when mentorship is involved?

No. Mentorship refers to the guidance provided by a physician who is perceived to have greater relevant knowledge, wisdom, or experience ("mentor") to another physician or nurse practitioner who is perceived to have less ("mentee"), and mentorship occurs regardless of the frequency of the guidance provided and the formality of the relationship. In practice, mentorship runs the risk of introducing either the appearance of, or actual, bias or lack of objectivity into the mentee's ability to conduct an independent MAID assessment.

Given the above, it is clear that postgraduate medical trainees and their mentor or supervisor cannot be the only MAID assessors who confirm the patient is eligible for MAID because this would not meet the legal requirement for independence.

The Criminal Code requires that MAID providers/assessors are independent from the patient requesting MAID; that is, the MAID provider/assessor cannot know or believe that they are connected to the patient making the request in a manner that would affect

[2] See Sections 241.2 (3.2)-(3.5) of the *Criminal Code* for more information. The federal government has provided guidance on implementing waivers of final consent on its MAID: Implementing the framework webpage.

[3] The Ministry of Health has developed Clinician Aids D-1 and D-2 for MAID providers and patients to use as templates for written arrangements.

their objectivity. How do I determine if the relationship I have with a patient or individual affects my objectivity?

MAID providers/assessors may want to consider the guidance on evaluating the nature of personal or close relationships set out in the College's *Advice to the Profession: Physician Treatment of Self, Family Members, or Other Close to Them* document. If the MAID provider/assessor believes that the nature of their relationship with the patient or individual would reasonably affect their emotional and/or clinical objectivity, they would not meet the independence requirement set out in the *Criminal Code*.

The applicability of some of the safeguards for MAID depend on whether the patient's natural death is reasonably foreseeable. How do I determine this?

The recent legislative changes have not altered the meaning of "reasonably foreseeable natural death". MAID providers/assessors can continue to rely on the guidance previously provided by the federal government and court to inform their assessment of whether a patient's natural death is reasonably foreseeable and therefore which procedural safeguards apply.

The guidance provided by the federal government includes the following:

- "Reasonably foreseeable natural death" requires a temporal, but flexible, connection between the patient's overall medical circumstances and their anticipated death.[4]
- A patient's condition does not have to be fatal or terminal for their natural death to be considered reasonably foreseeable.[5]
- "Reasonably foreseeable natural death" can result from a combination of multiple factors relevant to a patient's overall medical circumstances.[6]
- The nature of the illness causing the patient's 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 the patient's trajectory towards death. A patient's natural death is reasonably foreseeable if there is 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.[7]

[4] Legislative Background: MAID (Bill C-14); and House of Commons Standing Committee on Justice and Human Rights – Bill C-7, An Act to amend the Criminal Code (MAID).
[5] Legislative Background: MAID (Bill C-14); and Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision.
[6] Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision.
[7] MAID: Glossary.

- It is important to acknowledge that anticipating how long a patient has to live is difficult, and clinical estimation of life expectancy becomes even more difficult the further away death is expected.[8]

The guidance previously provided by the Court[9] regarding the meaning of "reasonably foreseeable natural death" includes the following:

> "[...] *natural death need not be imminent and* […] *what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan. Although it is impossible to imagine that this exercise of professional knowledge and judgment will ever be easy, in those cases where a prognosis can be made that death is imminent, then it may be easier to say that the natural death is reasonably foreseeable. Physicians, of course have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime."*

Other guidance on the meaning of "reasonably foreseeable natural death" that MAID providers/assessors might find helpful includes:

- If the MAID provider/assessor can reasonably predict when *or* how the patient will die, then it is likely enough to establish that the patient will have a "reasonably foreseeable natural death".[10]
- If the patient expresses an intent to refuse treatments that would prolong their life and they will inevitably die without those treatments, then it is likely that the patient will meet the threshold for a "reasonably foreseeable natural death".[11]

Ultimately, MAID providers/assessors will have to use their professional judgement to determine whether the patient's natural death is reasonably foreseeable.

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[8] Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision.

[9] *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759.

[10] Canadian Association of MAID Assessors and Providers. Clinical Practice Guideline on Reasonably Foreseeable Natural Death; and Downie, J. and Chandler, J. (2018). Interpreting Canada's Medical Assistance in Dying Legislation.

[11] Canadian Association of MAID Assessors and Providers. Clinical Practice Guideline on Reasonably Foreseeable Natural Death. Expert evidence submitted in *Lamb v. Canada (Attorney General)* included that if Ms. Lamb indicated an intent to stop bilevel positive airway pressure (BiPaP) therapy, and refuse treatment when she next developed pneumonia, it is likely that she would be found to meet the threshold for having a reasonably foreseeable death…Most would consider it sufficient that she expresses certain intent to refuse treatment when this occurs, as she will inevitable develop a chest infection in the future.

What does it mean to have "expertise" in the condition that is causing the patient's suffering? What role does this practitioner with "expertise" play?

The federal government has clarified that the expertise must be in the condition that is causing the patient the *greatest* suffering. In most cases, the condition that is causing the patient the greatest suffering will be the serious and incurable illness, disease, or disability; however, it can also be:

- Their state of advanced decline in capability.
- Their generalized pain associated with their multiple morbidities.
- A broader concept involving psychological, existential, or psychosocial suffering that flows from their state of decline *or* illness, disease, or disability.

Furthermore, a practitioner does not need to have a specialty designation or certification in order to be considered to have expertise in the patient's condition. Expertise regarding the condition could be obtained through education and training or experience (e.g., treating patients with a similar condition). It is possible that a family physician could be considered to have the necessary expertise if the condition causing the patient's unbearable suffering is within their scope of practice, and they have the knowledge, skill, and judgment to treat that condition, including being aware of reasonable and available treatments that may relieve that suffering.

If consultation with a practitioner with expertise is required (because neither the MAID provider nor the MAID assessor have expertise in the condition causing the patient's greatest suffering), the federal government has clarified that the practitioner with expertise would not be assessing the patient's eligibility for MAID. Instead, they would conduct a thorough assessment of the patient's status and treatment options, and provide advice regarding the reasonable and available services and/or treatment options that might relieve the patient's suffering. This may include advising on the nature or stage of the patient's condition or on the status of the patient's state of decline based on their knowledge of the trajectory associated with the condition. The information provided by the practitioner with expertise enables the MAID provider and MAID assessor to complete a fully informed assessment of the patient.

The federal government has also advised that the assessment information will need to be provided by the practitioner with expertise in writing, so both the MAID provider and MAID assessor will have access to it in its entirety.

What steps do I have to take to inform the patient of the means available to relieve their suffering? How do I know if the patient has "given serious consideration" to the reasonable and available means to relieve their suffering?

For patients whose natural death is not reasonably foreseeable, the *Criminal Code* requires that MAID providers inform patients of the means available to relieve their

suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care. Patients must be offered consultations with relevant professionals who provide those services or that care. Both the MAID provider and MAID assessor must discuss these options with the patient and agree that the patient has given serious consideration to the reasonable and available means to relieve their suffering.

The federal government has clarified that the MAID provider is responsible for providing the patient with a description of the reasonable and available services and/or treatments and their potential impact, and giving the patient the opportunity to speak with relevant professionals who provide these services and/or treatments.

The federal government has noted that the legislation does not specify a timeline within which the referral to these services and/or treatment must take place. If the patient expresses interest in accessing services and/or treatments which may relieve their suffering, but it will take significant time and/or or resources to access them, the federal government advises MAID providers to take great care in assessing whether the patient's request for MAID is informed and voluntary if they proceed with MAID as a result of the barriers to obtaining those other services and/or treatments.

Ultimately, MAID providers and MAID assessors will need to use their professional judgement to determine whether they agree that the patient has "given serious consideration" to the reasonable and available means to relieve their suffering. In doing so, MAID providers/assessors may want to consider asking the patient about their thought process (e.g., which services and/or treatments they considered, what they learned about each service or treatment including the expected risks and benefits, whether they can appreciate the reasonably foreseeable consequences of accessing each service or treatment, etc.). The federal government has clarified that the patient is not required to have tried the services and/or treatment.

How is "90 clear days between the date of the first eligibility assessment for MAID and the date MAID is provided" calculated?

The federal government has clarified that the 90-day assessment period begins on the day the patient starts to undergo their first MAID eligibility assessment (e.g., the day on which the MAID provider/assessor first considers or reflects on information that forms part of a MAID assessment, such as reviewing the patient's file or meeting with the patient).

Can assessments of patient eligibility or witnessing of patient requests for MAID be done virtually, or do they need to be done in person? Can other elements of the MAID process be done virtually?

The *Criminal Code* is silent on whether elements of the MAID process can be done virtually. That said, the Ontario government has indicated that virtual care technology can be used to assess a patient's request for MAID.

The College acknowledges that virtual care may be used to conduct patient eligibility assessments, witness requests for MAID, and for other aspects of the MAID process (e.g., consultations with practitioners who have expertise in the condition causing the patient's suffering, written arrangements for waiver of final consent, etc.) in the same circumstances this technology is used for all health care: when physicians can satisfy all their legal and professional obligations.

As with virtual care in general, MAID providers/assessors must contemplate the appropriateness of using this modality on a case-by-case basis, ensuring they can meet their legal and professional obligations as set out in the College's *Virtual Care* policy. Using virtual care for MAID may introduce risks that need to be mitigated in order to ensure compliance with the *Criminal Code* (e.g., ensuring voluntariness) and physicians' professional obligations. In addition to using their professional judgment, MAID providers/assessors may want to review any resources that have been developed to support these practices.

If a patient is found to be eligible for MAID but withdraws their request and then subsequently changes their mind and wants to receive MAID, do they have to restart the process and make a new request for MAID, or is the initial request still valid?

The *Criminal Code* is silent on the validity of withdrawn requests and the federal government has not provided guidance on this issue. As such, the College cannot comment on whether a withdrawn request is still valid or whether the process must be restarted. However, the College can suggest some factors that MAID providers/assessors may want to consider if the patient withdraws their request for MAID and subsequently wants to pursue MAID again:

- the reasons why the patient changed their mind (e.g., whether their symptoms are no longer being managed);
- whether the patient has voluntarily changed their mind (e.g., they made the decision freely, without undue influence from external pressures); and
- whether there are any changes to the patient's capacity to consent to MAID.

Do after-death plans need to be in place when MAID is administered in community settings?

Yes. It is important for MAID providers to confirm that there is an after-death plan in place for their patients. Where MAID providers are developing or contributing to the after-death plan, it would be prudent for them to consider the patient's circumstances, including their racial/ethnic/cultural background, values, beliefs, worldview, etc., along

with any specific needs they may have. The plan may include, but is not limited to, any of the following: removal of the patient's body; ethnic, cultural, or spiritual rituals, ceremonies, or practices at the end-of-life; supporting the patient's family and/or friends; reporting the death to the Office of the Chief Coroner for Ontario; and/or completing the medical certificate of death, where necessary.

I am a primary care provider and my patient is exploring MAID with another physician or nurse practitioner. What are my obligations to this patient?

Patients may still require comprehensive care, including managing the symptoms that have led to their desire to explore MAID, and you have an obligation to ensure that continuity of care is provided unless the physician-patient relationship has formally ended. If the patient's natural death is not reasonably foreseeable, the MAID provider/assessor who is exploring MAID with the patient may also need your assistance to treat the patient's suffering by means other than MAID.

2) Tools/Resources for Physicians

Please note: the list of tools/resources below is not exhaustive.

Exploring the Patient's Goals, Values, and Wishes:

- Serious Illness Conversation Guide: To help clinicians talk to seriously ill patients about their goals, values, and wishes.

Assessing the Patient's Medical Condition:

- Clinical Frailty Scale: To summarize the overall level of fitness or frailty of an older adult.
- ePrognosis: A repository of published geriatric prognostic indices where clinicians can go to obtain evidence-based information on patients' prognosis.

Assessing the Patient's Capacity:

- Aid to Capacity Evaluation (ACE): Helps to systematically evaluate capacity when a patient is facing a medical decision
- NICE Capacity and Consent Tool: Consent to Treatment and Decisional Mental Capacity and Capacity Assessment

Assessing the Patient's Vulnerability:

- Assessing Vulnerability in a System for Physician-Assisted Death in Canada
- Vulnerable Persons Standard

Process Maps for MAID:

- Process Map: Natural death is reasonably foreseeable
- Process Map: Natural death is NOT reasonably foreseeable

Legislation/Regulations, Government, and Organizations:

- *Criminal Code*, R.S.C., 1985, c. C-46
- *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166
- *Coroners Act*, R.S.O. 1990, c. C.37
- Government of Canada
- Government of Canada, MAID: Implementing the framework – for healthcare providers
- Government of Canada, Department of Justice
- Ministry of Health
- Clinician Registration for the Care Co-ordination Service (CCS) for MAID
- Canadian Association of MAID Assessors and Providers (CAMAP)
- Dying with Dignity

Educational/Professional Development Resources for MAID:

- Canadian Medical Association, Online Course (*Please note: requires CMA login*)
- Centre for Effective Practice
- University of Toronto, Postgraduate Medical Education

3) Information/Resources for Patients/Caregivers

Patients looking for information regarding MAID or assistance in accessing MAID can contact the Care Coordination Service (CCS). The CCS was established by the provincial government to help connect patients with willing providers of MAID-related services.

Patients may contact the CCS directly to receive information about end-of-life options in Ontario, including information about hospice care, other palliative care options in their communities, and MAID. Patients can also call the CCS to request to be connected to a MAID provider/assessor. The CCS can be reached toll free by calling 1-866-286-4023.

Resources for Patients/Caregivers (*Please note: this list is not exhaustive*):

- Health Canada: This website provides information for patients on obtaining MAID.

- Ministry of Health: This document provides information for patients on MAID.
- Dying with Dignity: This national human-rights charity is committed to improving the quality of dying, protecting end-of-life rights, and helping Canadians avoid unwanted suffering.
- Understanding MAID: For Individuals and Families: This booklet outlines key information on process and guidelines and answers common questions.
- Medical Assistance in Dying Q&A: This infographic answers five of the most common questions.
- 10 Myths about MAID: This infographic demystifies 10 common myths.
- Bridge C-14: This network helps individuals build meaningful connections of support through all stages of assisted death.
- Bridge 4 You: This organization provides compassionate “lived experience”, support and connection, to family members and friends as they help their loved one who is considering or planning for MAID.
- Grief and MAID: This module on MyGrief.ca supports people grieving a death with MAID or an anticipated MAID death.
- Bereaved Families of Ontario: This organization’s affiliates provide a safe, non-judgmental environment for families to discuss their experiences and learn about grief with others who have been there.