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Policy

Medical Assistance in Dying

The "*Policy on Medical Assistance in Dying*" has been developed by the College of Physicians and Surgeons of Prince Edward Island as a guidance document for physicians following the Supreme Court Decision Carter v. Canada (Attorney General 2015). It was 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.

Legal Background:

On February 6, 2015, the Supreme Court of Canada struck down the law prohibiting physician-assisted dying.[1] The Court suspended that decision for 12 months. The effect of that decision is that, after there is no Federal legislation changing the Criminal Code, it will not be illegal for a physician to assist a patient to die if:

1) the patient consents;
2) the patient has a grievous medical condition;
3) the condition is not remediable using treatments that the patient is willing to accept; and
4) the patient's suffering is intolerable to the patient; and, in the absence of Federal and Provincial legislation governing medical assistance in dying,

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 undo influence.
4) The principles of informed consent can apply.

"*On January 15, 2016, the Supreme Court of Canada gave the federal government additional time, until June 6, 2016, to further consider the necessary amendments to the law. During this time, or until new legislation is passed, those who wish to seek physician-assisted dying may apply to the court in their jurisdiction for an exemption from the current law prohibiting physician-assisted dying. Without such an*

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

exemption, it remains illegal for anyone, including physicians, to counsel, aid, or abet a person to commit suicide".[2]

In the current absence of federal, provincial or territorial legislation related to medical assistance in dying, it falls to the medical regulatory authorities in Canada to develop standards or guidance for physicians within their provinces or territories.

Federal or Provincial legislation, when developed, will supersede this document where applicable, and may require its revision.

Any court order providing for judicial authorization for medical assistance in dying will take precedence over this Policy.

The document itself is 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. That document was developed from the Canadian Medical Association's (CMA) draft framework.

Any court order providing for judicial authorization for physician-assisted death will take precedence over this policy.

Ethical Background

Relevant excerpts from the…
CMA Code of Ethics 2004 **(**Adopted by Council 2005**)**

1. Consider first the well-being of the patient.
3. Provide for appropriate care for your patient, including physical comfort and spiritual and psychosocial support even when cure is no longer possible.
11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.
12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.
21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.
23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others.
24. Respect the right of a competent patient to accept or reject any medical care recommended
43. Recognize the responsibility of physicians to promote equitable access to health care resources
54. Protect and enhance your own health and wellbeing by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.

2 CMPA publication January 2016 "*What the Supreme Court of Canada decision on physician-assisted dying means for physicians*"

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 principles established by the Supreme Court of Canada.
2) *Access*: 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 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*: Medical Regulatory Authorities should ensure, to the extent possible that guidance or standards which they adopt:
    (a) Provide guidance to patients and the public about the requirements which patient 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.

For the purpose of this document, the College has adopted the definition of medical assistance in dying from the Supreme Court's decision in *Carter v. Canada* as "*the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient*".[3]

[3] Policy on Physician-Assisted Dying, College of Physicians and Surgeons of Saskatchewan Statement

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[4]
Grievous and Irremediable Medical condition…	…A medical condition, including an illness, disease, or disability, which meets all of the following criteria in accordance with the requirements of this Statement: • It has been confirmed by a clinical diagnosis made by at least two physicians and • It is grievous in that it is serious and the current or impending associated symptoms are constant or enduring and cause severe physical or psychological pain or suffering; and • It is irremediable in that: ▪ There are no medical treatments to cure the condition or alleviate the associated symptoms which make it grievous; or: ▪ Medical treatments, which are available to cure the condition or alleviate the associated symptoms, which make it grievous, are not acceptable to the patient.
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 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 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 information, with the patient's consent, to the patient or to other physicians 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 or service

A physician may delegate such communication responsibilities to another person who is competent to do so and for whom the physician is responsible.

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

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;

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

- 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:

The Carter Decision only applies to adult patients. The age of 18 is the age defined by the Age of Majority Act, RSPEI 1988, c A-8as the age at which a person ceases to be a minor. The College recommends that physicians only consider patients who are 18 years of age or older for possible medical assistance in dying.

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 is unsure if the patient has sufficient capacity, the patient must be referred for further capacity assessment.

The Carter decision only applies to patients who clearly consent to ending their lives. Unless the requirements for consent are further defined in the future, the College recommends that physicians only consider patients for possible medical assistance in dying if the patient remains competent at all stages of the process, until the time of 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 and the administering physician 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 Supreme Court of Canada in the Carter decision[5].

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[5] **Carter decision patient criteria:**

1) A physician must determine if the patient has
   - i. A grievous medical condition
   - ii. A condition that is not remediable using treatments that the patient is willing to accept, and
   - iii. A condition that is causing the patient to suffer in a way, which is intolerable to the patient.

When it is unclear whether or not these criteria have been met, a psychiatric/psychological consultation is necessary to examine the patient's capacity to make such a decision. When a patient rejects a treatment that is considered reasonable a psychiatric opinion must always be sought.

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 before providing the patient with medical assistance in dying, such consultant acting within his scope of his practice to interact directly with the patient and provide an independent opinion.
9. Keep a detailed record of such discussions.
10. Obtain consent from the patient at the time of medical assistance in dying. Consent forms are to be completed by the administering physicians and any consulting physician. (*forms to be developed*)

The Physician's Continuing Responsibility

Includes the following:

1. Where death has taken place in a situation covered by this policy, currently it is a reportable death[6]; therefore the coroner must be notified.

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

Please refer to the document "*A Physician's Obligation Regarding Medical Assistance in Dying (MAID)"* at www.cpspei.ca/Publications/Guidelines

[6] Coroner's Act, RSPEI 1988, c C-25.1