



## Physician-Assisted Dying

1. **Access to holistic care and palliative care** – Chronic disease management and palliative care by their nature and purpose are to ameliorate symptoms and optimize functioning. The *Code of Ethics* states “physicians are required to provide appropriate care for patients, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.”
2. **Patient request for PAD** – Upon receiving a patient’s request for Physician Assisted Death (PAD), the physician must have a complete and full discussion about PAD with the patient. Physicians are expected to provide patients with all the information required to make informed choices about treatment, including diagnosis, the natural history and prognosis of the medical condition, treatment options and the associated risks and benefits, and to communicate the information in a way that is reasonably likely to be understood by the patient. Understanding the patient’s circumstances, perspective and reason for the request, as well as counseling patients on treatment options, is part of the role of the physician. For many who seek this option, a discussion of all end-of-life issues will be necessary. For others – such as those with chronic but non-terminal conditions – the decision may be less urgent and provide the opportunity to explore the patient’s personal values and concerns over time.
3. **Competent adult patient** – The SCC decision applies to **competent adults**. The Yukon Medical Council (YMC) recommends physicians take a careful and conservative approach to mature minors. PAD **cannot** be provided to patients who lack the capacity to make the decision, including when consent can only be provided by an alternate decision maker, is known by patient wishes or is provided through a personal directive. Two physicians (the accountable physician and a second physician) are required to independently document that the patient is fully informed, understands the information given, appreciates the foreseeable consequences of the decision and is able to communicate a decision based on that understanding. When it is unclear whether these criteria have been met, a psychiatric/psychological consult is required to examine the patient’s decision-making capacity (or limitations) in greater detail.
4. **Accountable physician** – A physician offering PAD as an option must have the appropriate qualifications and training to render a diagnosis and prognosis of the patient’s condition, assess the patient’s decision-making capacity, and have the technical knowledge and technical competence to provide PAD in a manner that is respectful of the patient’s context and wishes. The physician must be willing and able to collaborate with others in providing such care. Before proceeding with PAD, the YMC recommends physicians consult with the Canadian Medical Protective Association during this time of legislative uncertainty.

5. **Witnessed documentation** – A patient’s decision to proceed requires formal documentation, which may be oral and transcribed by another party, or written by the patient. The written request must be dated, signed by the patient and include the signature of two witnesses. The role of the witness is to confirm the identity of the patient requesting PAD, attest to the patient’s apparent understanding of the request being made and affirm the patient is acting voluntarily free of duress or coercion. One of these witnesses must be someone who is not: a relative; entitled to any portion of the estate; an owner, operator, or employee of a health care facility where the patient is receiving treatment; or the attending physician.
6. **Medical opinion** –While the SCC decision acknowledges the right of a competent adult to identify intolerable suffering, the physician’s role is to determine from a medical perspective whether or not the condition is “grievous and irremediable” (i.e., impossible to cure or put right). Making this determination will involve counseling the patient about other options for treatment and care. In some situations, a physician may offer the opinion the patient does not suffer from a grievous and irremediable condition. Where the patient and physician disagree, other resources may assist in resolving differences, for example a conflict resolution process. A conflict resolution resource is available from the Royal College of Physicians & Surgeons of Canada at:  
[http://www.royalcollege.ca/portal/page/portal/rc/resources/bioethics/primers/conflict\\_resolution](http://www.royalcollege.ca/portal/page/portal/rc/resources/bioethics/primers/conflict_resolution).
7. **Referral for psychiatric/psychological assessment** – If the patient’s physician has reason to believe the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired capacity, the patient must be referred for assessment and possible treatment. While chronic depression or other mental illness may itself represent a grievous and irremediable condition, the additional assessment is necessary to ensure the illness itself does not impair the patient’s capacity to make an informed decision. PAD should not proceed if the patient’s capacity is impaired.
8. **Second medical opinion** – A second physician is required to provide a medical opinion and to confirm the patient is a competent adult, has a grievous and irremediable medical condition and is making an informed and voluntary decision.
9. **Period of Reflection**– A period of reflection should follow the initial request in most cases, the length of time proportional to the urgency of the patient’s circumstances. For a patients with a non-terminal and slowly progressive condition, a reflective period of 14 days is recommended. If, after reflection, the patient wishes to proceed, then the physician must review all aspects of the PAD process with the patient and remind the patient of his/her opportunity to rescind the request at any time.

10. **Ongoing capacity** – A patient must maintain decision-making capacity for PAD to proceed. If at any time during the progression of a patient’s condition, the patient loses the capacity to understand information and appreciate the foreseeable consequences of his/her decision, PAD ceases to be an option. The requirement for ongoing capacity is the primary reason for not accepting personal directives as sufficient for PAD to proceed.

11. **Required information** – The following must be communicated to the patient, documented in the patient record, and a copy provided to the patient:

- a. patient’s diagnosis and prognosis;
- b. other treatment options (including comfort care, hospice care, and pain control);
- c. opportunity to rescind the request for PAD at any time;
- d. risks of taking the prescribed life-ending medication;
- e. probable consequences of taking the prescribed life-ending medication; and
- f. recommendation to seek legal opinion on life insurance implications.

12. **Individual medical record** – The following must be documented on the patient’s medical record:

- a. all written and oral requests made by the patient for PAD;
- b. physician’s diagnosis, prognosis and statement that the patient has decision-making capacity and is making an informed and voluntary decision;
- c. second medical opinion, including diagnosis, prognosis and statement that the patient is competent and is making an informed and voluntary decision;
- d. if performed, a report of the outcomes of the psychiatric/psychological assessment and treatment, including counseling;
- e. following the period of reflection (where applicable) and completion of all required documentation, the physician’s reminder to the patient of his/her opportunity to rescind the request and the patient’s final consent; and
- f. a note by the physician stating that all of the requirements have been met, indicating the steps taken and the medication prescribed or administered.

13. **Notification of death to the Coroner** – Until further notice, PAD must be reported to the Coroner.

14. **Notification of death to an oversight body** – The YMC believes a territorial multi-disciplinary committee should receive and review all PADs, as in other jurisdictions. Pending the establishment of such a committee in Yukon, **physicians are required to notify the YMC** when a death involves the assistance of a regulated member, and to provide all documents identified in 12 above with the notification.
15. **Conscientious objection** – Physicians may decline to provide PAD if doing so would violate their freedom of conscience. Paragraph 132 of the Carter decision says “In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying,” and further “we underline that the Charter rights of patients and physicians will need to be reconciled.” Conscientious objection is addressed in the YMC standard of practice *Moral or Religious Beliefs Affecting Medical Care*. A physician who declines to provide PAD must not abandon a patient who makes this request; the physician has a duty to treat the patient with dignity and respect. The physician is expected to provide sufficient information and resources to enable the patient to make his/her own informed choice and access all options for care, even if providing such information conflicts with the physician’s deeply held and considered moral or religious beliefs. This currently means arranging timely access to another physician or resource that will provide accurate information about all available medical options. Physicians must not provide false, misleading, intentionally confusing, coercive or materially incomplete information, and the physician’s communication and behaviour must not be demeaning to the patient or to the patient’s beliefs, lifestyle choices or values. The obligation to inform patients may be met by delegating this communication to another competent individual for whom the physician is responsible.
16. **Complaints arising** – In such an evolving environment, PAD-related complaints may be brought to the YMC. The YMC will manage these complaints as it does all complaints, with a focus on ensuring appropriate patient care, fairness and improving medical practice. In the experience of the YMC, inadequate communication is the root of most complaints. Whether participating in, providing or conscientiously declining to provide PAD, physicians should take extra care to ensure communication and documentation of these discussions is optimal.
17. **Challenges of allied health professionals** – The YMC recognizes PAD will touch other healthcare professionals. Patients seeking physician-assisted death will typically have many different healthcare providers; for example, patients with disabling neurologic conditions will often receive care from physiotherapists, occupational therapists, social workers, nurses, patient care aides, and nutritionists as well as their primary care physician, neurologist and other physician providers. In addition, the process of PAD, whether self-administration of medication by the patient (assisted suicide) or physician-administered medication (euthanasia) may require participation by pharmacists, nurses, palliative care team members and others. Physicians need to be sensitive to the impact of PAD on other members of the healthcare team, including their concerns about legal liability. (The Carter decision addresses only the role of physicians; other healthcare provider roles are not addressed). Other members of the healthcare team may have the same moral or religious objections when a patient seeks PAD.

18. **Social dialogue** – The YMC will continue to actively participate in the social dialogue examining how best to guide physicians in the care of patients who have “grievous and irremediable medical condition (including an illness, disease or disability) that causes suffering that is intolerable to the individual.” The treatment provided must reflect the World Health Organization definition of health as much more than disease management, but treatment of the patient in their own context. The YMC believes such holistic care is best provided through well-functioning teams, and all options for chronic disease management and palliative care need to be part of the wider conversation.

### Acknowledgements

The Yukon Medical Council wishes to acknowledge and thank the College of Physicians and Surgeons of Alberta (CPSA) for its support and for partnering with the Council in this advice to the profession. For further information on PAD Background and Principles, please refer to the CPSA website:

<http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/>