



## MEDICAL ASSISTANCE IN DYING

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### RATIONALE

The legalization of medical assistance in dying (MAiD) raises a host of complex ethical and practical challenges that have implications for both policy and practice. The CMA supports maintaining the balance between three equally legitimate considerations: respecting decisional autonomy for those eligible Canadians who are seeking access, protecting vulnerable persons through careful attention to safeguards, and creating an environment in which practitioners are able to adhere to their moral commitments.

Recognizing the educational, legislative, regulatory and practice changes that will result, the CMA recommends that legislative and regulatory processes be coordinated at the federal and provincial/territorial levels to consistently guide health systems, practitioners and patients. To that end, the CMA calls for rigorous information gathering at all levels and for experience with and research on the impacts of this new practice to be reported as it unfolds. The CMA encourages medical schools to incorporate reflective training opportunities at the undergraduate and postgraduate levels that address all aspects of medical practice that might be affected by this new intervention. Further, CMA recognizes the opportunity that exists for all health systems and practitioners to facilitate effective patient access to information about all end-of-life care options.

The CMA acknowledges the importance of understanding that other acts within the realm of end-of-life care are distinct from the practice of medical assistance in dying. Further, the provision of specific assessments for eligibility to access medical assistance in dying is a distinct service unrelated to consultations for general palliative end-of-life care.

It is important that physicians be aware of this distinction and the relationship between legal, medical and ethical norms with respect to medical assistance in dying. The judicial and legislative branches of government have made changes to Canadian law in this area. Society has placed assistance in dying within the realm of regulated medical practitioners. Physicians' ethical norms and duties, arising from long-standing traditions that entail moral commitments to preserve and protect life, have not changed. The CMA supports the right of all physicians to

follow their conscience when deciding whether to provide or otherwise participate in assistance in dying as per the legislation governing medical assistance in dying. The CMA equally supports conscientious participation in and conscientious objection to assistance in dying by physicians.

## SCOPE OF POLICY

This policy aims to provide guidance on key considerations in a way that is consistent with a physician's ethical, professional and legal obligations. Physicians should be aware of the federal and provincial laws in the jurisdiction in which they practise, the standards and expectations outlined by their respective regulatory authority, advice from the Canadian Medical Protective Association as well as the policies and procedures of the setting(s) in which they practise (e.g., regional health authority or hospital).

## RELEVANT FOUNDATIONAL CONSIDERATIONS

The following considerations underpin the CMA's position on what ought to constitute the basis of any evolving legislation, regulation or guideline on the implementation of medical assistance in dying. These considerations are not ranked according to priority or importance. As with any foundational considerations, they provide a starting point for ethical reflection, and their application requires further thought and interpretation when conflicts arise.

- 1. *Respect for autonomy*:** The CMA upholds the importance of respect for decisional autonomy by competent patients — such persons are free to make informed choices and autonomous decisions about their bodily integrity, their personal aims and their care that are consistent with their personal values and beliefs. CMA also asserts that persons have inherent dignity regardless of their circumstances. Services ought to be delivered, and processes and treatments ought to be applied, in ways that strive to preserve and enhance dignity. End-of-life care strives to maintain the integrity of personhood even as bodily functions deteriorate in advance of death.
- 2. *Respect for vulnerability*:** In consideration of the importance of a patient's decision regarding medical assistance in dying, and the permanence of death if medical assistance in dying is chosen by a patient, the CMA believes that careful and non-judgmental exploration with patients of the reasons they are seeking assistance in dying is always warranted. Care in this regard assists physicians to fulfill the duty to ensure that conditions of vulnerability have been identified and addressed satisfactorily. Physicians should maintain diligent attention to identifying undue coercive influences on the patient. Legislation and regulations, through a carefully designed and monitored system of safeguards, should aim to minimize harm to all patients and should also address issues of vulnerability and potential coercion.
- 3. *Respect for freedom of conscience*:** The CMA believes that physicians must be able to follow their conscience without discrimination when deciding whether or not to provide or participate in assistance in dying. The CMA supports physicians who, for reasons of moral

commitments to patients and for any other reasons of conscience, will not participate in decisional guidance about, eligibility assessments for, or provision of medical assistance in dying. To enable physicians to adhere to such moral commitments without causing undue delay for patients pursuing this intervention, health systems will need to implement an easily accessible mechanism to which patients can have direct access. Further, the CMA believes that physicians' general employment or contract opportunities should not be influenced by their decisions to participate in, or not participate in, any or all aspects of medical assistance in dying with patients. The right of patients to seek medical assistance in dying does not compel individual physicians to provide it. Learners should be equally free to follow their conscience without risk to their evaluations and training advancement.

- 4. *Accountability:*** Physicians providing or otherwise participating in assistance in dying must ensure they have the requisite training and the appropriate competencies, and the ability to assess a patient's decisional capacity or the ability to consult with a colleague to assess capacity in more complex situations. Physicians are expected to use appropriate medical judgment to make a determination of eligibility by (1) assessing the capacity of an adult to consent to the termination of life and (2) determining whether the patient has explored their options (and the putative impacts of any of the options). If the patient wishes to continue seeking medical assistance in dying, physicians are expected to use appropriate medical judgment to determine whether s/he meets the eligibility criteria as per the legislation governing medical assistance in dying. This ought to be a shared decision, and it should be made as part of a deliberative process in the context of the patient–physician relationship. The CMA encourages physicians to participate in accountability processes within their jurisdictions that ensure equitable access to all end-of-life options, including palliative and end-of-life care provided by skilled practitioners, in service of their patients' needs and values. To that end, the CMA believes that a federal oversight body and reporting regime should be established to ensure that all processes are followed.

## ADDITIONAL CONSIDERATIONS: PHYSICIAN DUTIES

- 5. *Duty of non-abandonment:*** Physicians have an obligation to respond to a request for assistance in dying, regardless of how their moral commitment is expressed. Patients should never be abandoned and must always be supported by their physician and other members of their care team. The patient's physician ought to explore the reasons motivating the request and be sensitive to issues of culture and background throughout the dying process, regardless of the decisions the patient makes with respect to assistance in dying. There should be no undue delay in providing access to assistance in dying and all other end-of-life options, either from a clinical, system or facility perspective. For those who choose to provide assistance in dying, the duty of non-abandonment means that physicians have a duty to be available to patients during the act of ending their life. Physicians should be present or immediately available to manage any unexpected complications during the medical procedure, whether the chemical administration is done by the patient or by a regulated practitioner.

6. **Duty to support interdisciplinary teams:** The CMA advocates that physicians work within, and support other members of, interdisciplinary teams, pay close attention to the impacts of participation and non-participation in medical assistance in dying on their non-physician colleagues, and demonstrate solidarity with their team members as they navigate new legal and ethical territory together.
7. **Duty to learners:** The CMA recognizes the importance of unique moral considerations within learning environments. Learners are encouraged to reflect on their moral understanding of and views about assistance in dying and to seek a wide range of views and experiences from their patients and from their teachers and colleagues.

## ADDRESSING ADHERENCE TO MORAL COMMITMENTS

CMA's position on conscientious participation and conscientious objection aims to harmonize two legitimate considerations: (1) effective patient access to a legally permissible medical service and (2) protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience.

- a. The CMA believes that physicians are not obligated to fulfill a patient's request for assistance in dying but that all physicians are obligated to respond to a patient's request. This means that physicians who choose not to provide or otherwise participate in assistance in dying are:
  - i. not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will provide assistance in dying to the patient; but
  - ii. are still required to fulfill their duty of non-abandonment by responding to a patient's request for assistance in dying.

There should be no discrimination against a physician who chooses not to provide or otherwise participate in assistance in dying.

- b. The CMA believes that physicians are obligated to respond to a patient's request for assistance in dying in a timely fashion. This means that physicians are obligated to, regardless of their beliefs:
  - i. provide the patient with complete information on all options available, including assistance in dying;
  - ii. advise the patient on how to access any separate central information, counselling and referral service; and
  - iii. transfer care of the patient to another physician or another institution, if the patient requests it, for the assessment and treatment of the patient's medical condition and exploration of relevant options. If relevant, such options may include palliative care, mental health care and, if the patient meets the eligibility criteria, provision of assistance in dying. The duty of non-abandonment still applies in all other aspects of the patient's care.

- c. Physicians are expected to make available relevant medical records (i.e., diagnosis, pathology, treatment and consults) to the physician accepting care of the patient when authorized by the patient to do so.
- d. Physicians are expected to act in good faith. They are expected to never abandon or discriminate against a patient requesting assistance in dying and to not impede or block access to a request for assistance in dying. Physicians should inform their patients of the fact and implications of their conscientious objection. No physician may require a patient to make a commitment not to seek assistance in dying as a condition of acceptance or retention of the patient.

## GLOSSARY

### WHAT MEDICAL ASSISTANCE IN DYING (MAID) ENCOMPASSES

1. **Medical assistance in dying** encompasses the assessment of a patient for eligibility for assistance in dying, deliberation with the patient, accompaniment of the patient through the process of deciding and, if so chosen by the patient, the provision of assistance in dying, which refers to:
  - a. The administering by a medical practitioner or nurse 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 death.
2. The Supreme Court of Canada in *Carter* used the terms **physician-assisted dying** and **physician-assisted death**.

These terms refer to both of the following:

  - a. **Voluntary euthanasia**, or *physician-administered assistance in dying*:  
The physician takes the final act that will end the individual's life via, usually, the intravenous administration of a lethal substance, at the request and with the consent of a patient
  - b. **Assisted suicide**, or *physician-prescribed, self-administered assistance in dying*:  
An individual performs the final act to end their life by, usually, ingesting a lethal substance prescribed or provided by the physician, at the request and with the consent of the patient.
3. Other commonly used terms are **hastened death**, *physician-administered hastened death* and *physician-prescribed, patient-administered hastened death*.
  - a. These terms are proposed to make a clear distinction between palliative care and other practices that hasten or bring about death, such as through the legitimate removal of life-sustaining interventions or via the provision or administration of chemicals.
4. **Medical aid in dying** has a distinct technical and legal meaning within Quebec, described in Bill 52, and is limited to physicians administering the lethal substance at the request of the individual.

### WHAT IT DOES NOT ENCOMPASS

1. **Palliative care** is an integrated approach that aims to relieve suffering and improve the quality of life of those facing life-limiting acute or chronic conditions by means of early identification, assessment and treatment of pain and other symptoms.
2. **Continuous palliative sedation therapy<sup>1</sup>** refers to complete sedation, with the intent of rendering the patient unable to experience the environment, sensation or thoughts, until

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1 Consensus statement on continuous palliative sedation therapy: [www.chpca.net/media/343120/final\\_cpst\\_framework.pdf](http://www.chpca.net/media/343120/final_cpst_framework.pdf)

the patient dies naturally from the underlying illness.

3. ***Withdrawing or withholding treatment or treatment cessation*** refers to withdrawing or withholding life-prolonging treatment where it is no longer indicated or desired.
4. ***Voluntary refusal of hydration and nutrition*** is the conscious and active choice to refuse and to discontinue food and fluid, orally or parenterally, with the intention of hastening death.

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