Medical Assistance in Dying (MAiD): CMA Consultation Report

June 2020
Executive Summary

In January of 2020, the Canadian Medical Association (CMA) launched a survey of physicians and learners to better understand their views on current issues surrounding Medical Assistance in Dying (MAiD) in Canada. Respondents (N = 6054) were medical students (N = 694), residents (N = 501), practicing physicians (N = 3840), retired physicians (N = 968), and “other” (N = 51). Fourteen percent of practicing physician and resident respondents (N = 615) were MAiD assessors and/or providers. Of those who were not MAiD assessors and/or providers (N = 4400; includes medical students), 31% were considering becoming one. Responses included thousands of comments.

A multi-phase mixed methods design was employed to inform the further development of CMA policy on key issues surrounding MAiD in Canada. In the first phase, quantitative and qualitative data were gathered concurrently to both measure the views of participants on key issues, and provide rich, narrative data to contextualize and expand upon quantitative results. Based on an analysis of phase one, data and amended legislation tabled by the Federal Government, a follow-up phase of qualitative data collection through roundtable discussions with physicians familiar with MAiD was undertaken to enhance the clarity of survey results.

General Findings: There were few areas of convergence in both the quantitative and qualitative data, suggesting that the medical profession remains divided on many aspects of MAiD. There were also many qualified answers in the quantitative data, with many selecting response options that include the words “in some cases” or “somewhat” agree/disagree. This again underscores the range of views in the profession and the complexity of the issues.

There is remarkable consistency between responses from assessors/providers and those considering becoming assessors/providers.

Data from both the survey and the roundtables revealed that many physicians feel that there is a need for the continued development of clinical guidance that would allow for ethical reflection among MAiD providers and assessors, help them exercise sound clinical judgment and support consistency in the application of the legal criteria.

Removal of the reasonably foreseeable death (RFD) eligibility criterion: A majority of providers/assessors indicated they would continue to provide MAiD with RFD removed, but of that majority, a significant number indicated they would only in some cases. Some saw its removal as making interpretation of other criteria more challenging, complex or subjective. Some also had concerns over how to appropriately assess those with mental disorders as a sole underlying medical condition in the absence of RFD. Broadening eligibility raises questions about the need for increased health system resources to ensure access to other care options (e.g. mental health, palliative care).
**Mental disorders as a sole underlying condition (MD-SUMC):** There is an even split between those who believe there should be eligibility for those with an MD-SUMC (at least in some cases), and those who do not. Many respondents called for additional criteria to clarify the parameters around assessing mental disorders and greater safeguards. Some called for the support of specialists during eligibility assessment.

**Advance requests:** There was a high level of support for allowing advance requests for those patients who have already met the MAiD eligibility criteria.

**Mature minors:** Although a majority felt that MAiD eligibility should be extended to mature minors, almost half of respondents indicated MAiD should only be available “in some cases.” Roundtable results suggest that support depends on context, especially the maturity of the individual.

**Conscientious objection:** There was strong support for CMA’s position to equally support conscientious objection and participation.
A. Overview

In January of 2020, the Canadian Medical Association (CMA) launched a survey of physicians and learners to better understand their views on current issues surrounding Medical Assistance in Dying (MAiD) in Canada. Further feedback was solicited at roundtable discussions hosted by the CMA with physicians familiar with MAiD.

The survey and consultation were initiated following the September 2019 Quebec Superior Court ruling (the Truchon decision).

1 The ruling deemed the reasonably foreseeable death eligibility criterion in federal and Quebec MAiD legislation to be unconstitutional. In response to the decision, the federal government tabled a bill (amending legislation) in February 2020 that would eliminate the reasonably foreseeable death eligibility criterion and make certain other changes, including allowing for a limited form of advance request.2 The survey was conducted before the bill was tabled.

Existing MAiD legislation also requires Parliament to conduct a legislative review of MAiD legislation that may lead to further amendments.3 The review must include a study of three areas relating to MAiD: requests by mature minors, advance requests, and requests where a mental disorder is the sole underlying medical condition.

B. Methods

A multi-phase mixed methods design was employed to inform the further development of CMA policy on key issues surrounding MAiD in Canada. In the first phase, quantitative and qualitative data were gathered concurrently to both measure the views of participants on key issues, and provide rich, narrative data to contextualize and expand upon quantitative results (Figure 1).4 Based on an analysis of phase one, data and amended legislation tabled by the Federal Government, a follow-up phase of qualitative data collection was undertaken to enhance the clarity of survey results.
A pragmatic approach was taken to determining both the *priority* (i.e., the importance of a given method over another) and *pacing* (i.e., the timing of quantitative and qualitative method employment) of data collection and analysis, with the aim of best addressing the project goal of further developing CMA policy on MAiD. In the first phase, equal priority was given to quantitative and qualitative data. While the survey contained a greater number of questions aimed at gathering quantitative data, participant views derived from open-ended questions were robustly analyzed. On the one hand, it was important to quantify the views of medical professionals to understand whether there was broad support for certain legislative changes. Conversely, the project is underpinned by the understanding that the tensions surrounding MAiD are deeply rooted in difficult emotions and a diversity of views on the justifiability of MAiD. Overall, the project leaned more heavily on qualitative methods of data collection and analysis, as the second phase necessitated a qualitative approach that captured the intricacies of the experiences primarily of MAiD assessors and providers in answer to questions of clarity brought up following phase one analyses and proposed legislative amendments.

**Participants**

The survey was circulated to all CMA Members to gain a diversity of perspectives as representative as possible of the Canadian medical profession. Respondents (*N* = 6054) were medical students (*N* = 694), residents (*N* = 501), practicing physicians (*N* = 3840), retired physicians (*N* = 968), and “other” (*N* = 51). Fourteen percent of practicing physician and resident respondents (*N* = 615) were MAiD assessors and/or providers, while 84% were not and 1% preferred not to disclose. Of those who were not MAiD assessors and/or providers (*N* = 4400; includes medical students), 31% were considering becoming one.

Roundtable discussions were held in Halifax (*N* = 10) and Vancouver (*N* = 13) in February 2020 and two virtual roundtables were held in June 2020 (to replace the roundtables cancelled due to the COVID-19 pandemic). Participants were invited based on their professional expertise as
assessors and providers of MAiD in Canada and/or their involvement in public discourse around MAiD.

**Data Collection**

Data were gathered using an online survey comprised of demographic questions and closed-and open-ended questions pertaining to the following current issues: (a) the removal of the reasonably foreseeable death eligibility criterion; (b) eligibility when a mental disorder is the sole underlying medical condition; (c) eligibility through advance requests; (d) eligibility of mature minors; and (e) conscientious objection to / participation in MAiD.

Roundtable discussions provided participants with an opportunity to share their clinical expertise and experiences on topics captured within the survey, but that required additional clarity. Discussions were led by a bioethicist and trained qualitative researcher and centered around the following topics: (a) the proposed amendments to Bill C-7; (b) issues / elements that should be included in the legislative review; and (c) which criteria / safeguards require clarification. Round-table discussions were not recorded to ensure participant comfort in sharing difficult subject-matter, however extensive notes were taken to summarize significant topics discussed.

**Data Analysis**

Demographic and closed-ended questions were used to summarize the sample and provide an indication of where respondent views clustered. The results of open-ended questions exploring current issues were grouped by topic, and each group was analyzed separately. Content analysis was used to identify both similar and divergent experiences and opinions of respondents. A step-wise approach to thematic development was taken, in that themes were initially derived using responses from assessors and providers, given that this group has experience implementing MAiD protocols. Responses from non-assessors and/or providers were then examined and data were incorporated into existing themes or organized into new themes. Core themes are thus drawn from respondents’ collective insights. Lastly, notes from the roundtable discussions were used to triangulate themes that emerged from open-ended survey questions and to ensure data saturation was met. Roundtable results are integrated throughout. No new themes emerged as a result of roundtable discussion, however roundtable participant insights are highlighted when they substantively add to a given theme. The resulting report is organized by topic of interest and includes summaries of emergent themes supported by quotations from respondents and / or notes from roundtable discussions.
C. Findings

1. Removal of the Reasonably Foreseeable Death (RFD) criterion

93% assessors/providers (N = 619) reported that they would continue to provide MAiD services if the RFD criterion were removed, with 39% of those reporting they would do so in some cases. However, respondents expressed both support for and objection to the removal of the RFD criterion, often supported by experiential evidence, personal and/or professional values. The criterion’s removal extends the scope of eligibility for MAiD, eliciting mixed views from respondents, who discussed the potential repercussions of expanded eligibility (positive and negative).

1.1 Anticipated Implications

On the one hand, some interpreted the criterion’s removal as (a) preventing the undue suffering of individuals previously (wrongfully) excluded from accessing MAiD, and (b) simplifying decision-making for patients and physicians by removing the ambiguity associated with the “reasonably foreseeable death” standard.

“I believe that the current inclusion of "reasonably foreseeable" is subjective, non-specific, and implies that suffering only occurs during the end stages of a terminal disease process. It limits access to a humane and autonomous medical service for those who may suffer with disease that is not imminently lethal, but either refractory to treatment or slowly progressive.” [Considering]

“I think this would, in some cases, make assessment easier when a patient is suffering significantly but timing of anticipated death is difficult to pinpoint.” [Assessor/Provider]

Conversely, others contended that the removal of the RFD criterion would potentially jeopardize the safety of populations who are vulnerable due to social determinants of health (e.g., social isolation, socio-economic status) or the nature of specific diseases (e.g., dementia, mental disorders). Finally, some raised questions about the need for increased health system resources to ensure access to other care (e.g. mental health, palliative care) options in response to broadening eligibility. Further, respondents and roundtable participants expressed concerns that the removal of the RFD criterion would (a) remove a signpost that guides the decision-
making of physicians and patients, (b) reduce consistency in interpretation of the remaining criteria (e.g., advanced state of irreversible decline in capability, serious and incurable illness, disease or disability),¹ (c) strain and diminish the system’s Health Human Resource (HHR; due to conscientious objection),² (d) fundamentally change the nature of MAiD (expanded beyond end-of-life cases) and the role of the physician, and (e) place a strain on the remaining providers.

“As a current provider, I feel removing [the RFD] clause will lead to the degradation of our profession. I did not start offering MAID in order to replace the chronic underfunding of social supports, income supports, and loneliness that are the root causes of a lot of the mental anguish we see in our patients.” [Assessor/Provider]

“In my opinion it will be more challenging / less clear cut as to who qualifies for MAID - more time would have to be spent delving into the nature and amount of their suffering and what makes it intolerable if the reasonably foreseeable death criteria is removed,” [Assessor/Provider]

“[I’m] worried about [an] increase [in] patient requests and decrease in [the] number of clinicians willing to participate in MAID work. I’m already at maximum MAiD workload and worried that I won’t be able to manage an increased workload.” [Assessor/Provider]

### 1.2 Anticipated Needs

Respondents both in support and against the RFD criterion’s removal expressed concerns about resulting negative consequences. Respondents (especially current assessors and providers) and roundtable participants discussed measures to safeguard patients and providers (e.g., legal and ethical support, changes to the MAiD assessment process, improved and appropriate access to social supports and other end-of-life care options, in particular palliative care), and outlined the resources and guidance (e.g., continuing professional development opportunities, clinical guidance and clinical practice guidelines, expert consultation) necessary for assessors and providers should the RFD criterion be removed.

“If this is removed - a more concerted effort to improve access to and funding for Palliative Care (education, community resources, respite, access to a robust patient-centered model of care) must accompany its removal. [Assessor/Provider]

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¹ About 70% of respondents (N = 5535) agree or strongly agree that current MAiD eligibility criteria are sufficiently clear.

² Forty-six percent of current assessors and providers (N = 619) indicated they would conscientiously object to provide MAiD (either outright [7%], or in some cases [39%]) if the RFD criterion is removed.
“Need for two professional opinions confirming irreversibility/incurability in the specialty concerned.” [Assessor/Provider]

“I agree that it should be the patient’s decision on when to die. However, I would appreciate guidelines/sessions/support to help determine how to advise/counsel patients on making this decision.” [Assessor/Provider]

Roundtable participants suggested that it would be most appropriate for clinical guidance to be developed by the profession. This could allow physicians to exercise their clinical judgment, support consistency in the application of the legal criteria, and would allow for ethical reflection.

In sum, there is broad support for the removal of the RFD criterion. Respondents believe that its removal will benefit many patients, however, are cautious about potential negative repercussions and identified a need for additional resources - especially in the form of clinical guidance and support for palliative care - when the criterion is removed.

2. Clarity

A majority of respondents (N = 5535) agreed that the remaining MAiD eligibility criteria are sufficiently clear, with a significant majority of assessors/providers agreeing (78%).

Respondents discussed the challenges relating to clarity in the eligibility criteria, with the most comments focusing on the “illness, disease or disability or state of decline causing enduring physical or psychological suffering” and “advanced state of irreversible decline in capability.” Some also identified the overarching “grievous and irremediable medical condition” as lacking clarity. The subjectivity of these criteria was the most frequently cited.

Under “The patient has a grievous and irremediable medical condition”, we need clarity in defining "an advanced state of irreversible decline in capability". There is wide interpretation of this criteria by Assessors across Canada. [Assessor/Provider]

The patient's perception of their disease, disability, or state of decline may vary significantly from that of the doctor, and also between doctors, so we need some objective criteria about degree of disability and state of decline. [Assessor/Provider]
Many roundtable participants emphasized that the continued development of clinical guidance on interpreting the MAiD eligibility criteria is important, particularly in the absence of the RFD criterion.

3. Mental disorder as the sole underlying medical condition

Survey respondents (N = 5173) and roundtable participants expressed a range of views both for and against allowing individuals suffering from a mental disorder as a sole underlying condition (MD-SUMC) eligible to receive MAiD (yes [10%], yes, in some cases [46%], no 44%) and outlined the challenges it would pose for assessors. Those in favor argued that excluding this group from MAiD access is discriminatory, stigmatizing, and minimizes the validity of their suffering. Further, those who supported expanding eligibility to MD-SUMC viewed MAiD as a compassionate alternative to suicide.

“Systematically excluding patients where a mental disorder is the sole underlying medical condition is discriminatory.” [Considering]

“I have met some people with such profound depression that I think it is true there is no effective treatment. With careful safeguards, I think it would be preferable if some such people could access MAID - in preference to suicide.” [Assessor/Provider]

On the other hand, survey respondents and roundtable participants expressed concerns that:

(a) treatments and supports for this group are not adequately accessible,
(b) scientific understanding of psychiatric disorders is insufficient,
(c) it is difficult or impossible to determine whether a request arises as a symptom of the patient’s disease or has been carefully considered,
(d) many patients who feel they are suffering intolerably would be responsive to treatment,
(e) informed consent is difficult or impossible to assess this patient population,
(f) the provision of MAiD to this patient population is counter to professional ethics and inconsistent with broader suicide prevention efforts, and
(g) the view among many psychiatrists that all or most mental disorders are treatable.

“There is a lack of consistency in promoting suicide prevention on the one hand, then euthanizing these same patients on the other hand.” [Not a provider, not considering]

“I treat patients with Schizophrenia and over the last 20 years treatments are such that the person can lead a good life so would not want to have things like stigma or even the symptoms of their illness play a role in the ask for MAiD.” [Considering]

“These are the issues - differentiating permanent suffering related to a condition unresponsive to available treatment vs. temporary suffering related to acute exacerbation of illness.” [Considering]

3.1 “In Some Cases”

Importantly, some were willing to assess or provide MAiD services to this population “in some cases”, often based on the type of mental disorder, the disease’s progression and treatment resistance, and perceptions of the patient’s capacity to consent. There was greater support expressed for the inclusion of neurological diseases (e.g., Alzheimer’s, Parkinson’s), which were viewed as having better understood disease processes compared to psychiatric disorders (e.g., Bipolar Disorder), especially those with depressive elements. Some respondents indicated being willing to provide MAiD to individuals whose sole underlying condition is a psychiatric disorder when the patient:

(a) Met standards of disease progression (e.g., demonstrable suffering, poor prognosis of recovery, poor quality of life),
(b) Had sought and received all reasonable treatment, and
(c) Was not requesting MAiD amidst a psychotic episode or with acute suicidal ideation – this was seen to preclude the individual from providing informed consent.

3.2: Anticipated Implications: HHR

Respondents and roundtable participants discussed a deficit of health human resources, particularly in psychiatry (e.g. to support assessors in assessing capacity or eligibility), as hindering the system’s capacity to expand MAiD services to patients whose sole underlying condition is a mental disorder. Further, a significant proportion (80%) of current MAiD assessors and providers (N = 581) indicated they would not
provide MAiD services to this population (18%) or would only do so “in some cases” (62%). Decisions to conscientiously object will no doubt alter the accessibility of MAiD, impacting some populations (e.g., rural, remote) more deeply than others.

“Currently it is nearly impossible to obtain a psychiatric assessment of a patient's capacity to consent to Medical Assistance in Dying. I suspect this will be equally if not more difficult to get second or third opinions regarding eligibility based on mental illness.” [Assessor/Provider]

“We would need access to excellent psychiatric care to be able to determine that the patient's suffering was truly irremediable (assuming, of course, the patient wanted treatment); this is woefully difficult to access presently.” [Assessor/Provider]

“I may opt to stop providing the service if it is opened up to non-life-threatening conditions – e.g. mental health. I would be afraid of medicolegal repercussions.” [Assessor/Provider]

### 3.3 Necessary Safeguards

Respondents and roundtable participants discussed measures to ensure appropriate provision of MAiD to patients whose sole underlying condition is a mental disorder. Specifically, changes to the MAiD process were suggested, including:

(a) Altered decision-making procedures, including the involvement of psychiatry and / or multidisciplinary teams in decision-making, either as a required safeguard or at the discretion of the assessor,

(b) An extended timeline – especially the period of reflection, and

(c) Additional guidelines or criteria to enhance the clarity of who is eligible.

“As a life-threatening condition is not diagnosed in the same way, the opinion of a psychiatrist independent from the attending psychiatrist—in an advisory capacity only—should be required to evaluate incurability, suffering and capacity to consent. This in addition to the two physicians already required by the law to validate the procedure.” [Assessor/Provider]

“I would support a need for a more extended assessment. Possibly a review panel.” [Assessor/Provider]

“I do believe that some additional safeguards will be necessary. Likely the simplest and most straightforward and reasonable would be an extension of the waiting period in order to allow time for a full examination of the patient’s situation, their response to treatment, the availability of treatment, etc. I would suggest a minimum 3-month waiting period.” [Assessor/Provider]
“In my mind, there would have to be clear distinction and clear guidelines made about severity, prognosis, and previously tried therapies with respect to the underlying mental health disorder.” [Assessor/Provider]

In sum, while some respondents felt persons living with mental disorders should have access to MAiD services (at least in some cases), there is no consensus among physicians. Respondents raised many challenges in determining eligibility, ensuring adequate health human resources. There appears to be support for additional safeguards among those who support some access for patients with a mental disorder.

4. Advance Requests (AR)

Respondents were asked questions relating to the two most commonly-discussed types of advance requests: (a) where the patient makes a request after they have met all the eligibility requirements for MAiD and (b) where the patient makes a request after they are diagnosed with a serious and incurable condition but before they have met all the MAiD requirements.

Support among survey respondents (N = 5172) for advance requests in cases where the patient has met all the eligibility requirements for MAiD was high with a combined 80% indicating either “yes” or “yes, in some cases.” Support was higher among assessors/providers, those considering and retirees. Respondents were more divided as to whether permitting MAiD where the patient had not yet met all the eligibility requirements.

Support among respondents (N = 5089) for advance requests in cases where the patient had not yet met all the MAiD eligibility requirements was lower, with a combined 67% indicating either “yes” or “yes, in some cases.”

Those in favour of ARs argued that such a mechanism respects patient autonomy and responds to a desire articulated by the patient community. Further, participants reasoned that allowing for ARs would reduce or eliminate the physical, psychological, and emotional suffering of patients (and their family) who fear losing
capacity before completing the MAiD process, and prevent premature deaths associated with this fear. On the other hand, participants against the use of ARs cited personal and professional ethical objections (often related to capacity to consent at the time of MAiD administration), and shared experiences where patients have adjusted to circumstances they previously believed would be intolerable to live with.

Some in the survey and in roundtables discussed challenges surrounding the notion of precedent autonomy and future self, where in making an advanced request, whether a patient can truly know how their future self will feel - whether they will truly view themselves as suffering intolerably as their past self anticipated. This would place a burden on physicians evaluating the request, which could be supported with further education and guidance on the role of assessment.

“A degree of caution is required as there is good evidence to document patients who have a change in their views and perspectives held which are made in a state of health compared to when they become ill.” [Not considering, not a provider]

“In the case of patients with dementia who made advance care plans prior to their illness, it would be ethically difficult to decide when to administer MAiD during their cognitive decline. Once their insight is diminished, some patients appear to suffer much less and the relevance of MAiD becomes very questionable.” [Assessor/Provider]

“People sometimes (often) change their minds when confronted with actual reality of MAiD (patients, proxies and MDs). Advance requests should require periodic updates/confirmation.” [Not considering, not a provider]

In regard to when an AR could be made (timing), participants held varying opinions that can be grouped into three general scenarios:

1. Before a diagnosis has been made, with respect to specific conditions (e.g., dementia, traumatic brain injury)
2. Following the diagnosis of a serious and incurable condition, but before the patient has reached an advanced state of decline (i.e., before all MAiD eligibility criteria have been met)
3. Only once all MAiD eligibility criteria have been met

“I believe advanced request for dementia should be expanded in the case of those not yet diagnosed. A criterion list could be drawn up for patients to review with expected deterioration so he/she can decide what level of dementia she would tolerate.”
[Assessor/Provider]

“If a patient with a serious and incurable condition makes an advanced request for MAiD, he/she should have access to MAiD before they have met all of the MAiD eligibility
criteria. For example, if I were diagnosed with an incurable brain tumour, it is possible that I would decide to request MAID before significant deterioration occurs because I wanted to avoid the pain and suffering that such inevitable deterioration might involve (both for me and my family members).” [Not considering, not a provider]

“In cases where patients have not yet met all the eligibility criteria (such as dementia), I think it will be very difficult for clinicians to provide MAID if the patient loses their capacity but is otherwise “well.”” [Assessor/Provider]

“I think it will be challenging to determine the timing of a MAiD provision, if an advance directive is given years in advance (e.g. a patient with mild Alzheimer’s dementia has an advance directive requesting MAiD when they progress to a moderate-severe stage of dementia).” [Assessor/Provider]

4.1 Anticipated Implications

Although there is support for the addition of ARs as a mechanism by which to request MAiD, respondents discussed practical and ethical challenges associated with altering MAiD procedures to allow for ARs. These challenges include:

(a) Mitigating any negative impact to assessors and providers
   i. Emotional impact of administering MAiD to a person who cannot consent at the time (survey and roundtables)
   ii. Potential increase in medicolegal risk

(b) Deciding when criteria set out in an AR have been met

(c) Managing the needs and complexities introduced by substitute decision-makers (SDM)
   i. Emotional toll on SDM
   ii. Conflict between the wants of the SDM and terms of the AR (survey and roundtables)
   iii. Conflict of interest – when SDM directly benefits from death

(d) The variability in provincial legislation relating to consent and advance directives, requiring a pan-Canadian approach to ensure consistency.

4.2 Characteristics of Advance Requests

Participants offered many suggestions regarding the process, content, and timing of making an AR for MAiD. Many suggested the involvement of experts (e.g., medical, legal, ethical) in (a) creating guidelines for instances where MAiD is requested but not all eligibility criteria have been met, and to (b) assist patients and physicians in decision-making.

“I think the patient should have access to a palliative care physician to review what the patient’s disease will mean to their quality of life and possible symptom burden.” [Assessor/Provider]
“If not all MAID eligibility criteria are met at the time of advance request (e.g. dementia), there needs to be a separate criteria for these circumstances, ideally developed by a panel of experts in geriatrics, palliative care, neurology, ethicists and learning from other jurisdictions where these requests are already provided.” [Considering]

Many respondents discussed the importance of having clear and specific terms within ARs in order to aid in decision-making and safeguard physicians.

“This advanced request would have to be very specific and probably written with a legal expert/health care expert. i.e.: in dementia, when the disease is so advanced that a person a) cannot do ADLs, b) has a MoCA score less than 15 that has not improved with medication, c) pt demonstrates distress more than 30% of the time, d) they continue to request to have MAID despite dementia etc.” [Assessor/Provider]

The standardization of AR forms was also suggested:

“A committee should come up with specific elements that need to be contained in an advanced directive requesting MAiD - i.e. very specific triggers, inclusions, exclusions so that the SDM has the most assurance of when the person would want it. A MAiD specific AD should be created.” [Assessor/Provider]

4.3 Administration of MAiD

The administration of MAiD was another area identified as challenging when an AR has been made but the patient has lost capacity to consent. Particularly, respondents discussed whether MAiD should even be administered in these situations and if so, who should decide that the procedure can be undertaken.

Capacity to consent. Respondents had mixed views as to whether a patient must have the capacity to consent to MAiD at the time of its administration in the case where an AR has been made. Even among those who were of the view that capacity to consent at the time of MAiD provision is not necessary, there was a consensus that the patient must assent to MAiD, that is, they must not actively resist the procedure.

Decision maker(s). Most respondents (N = 4795) reported that there is a role for both the patient’s substitute decision-maker and the physician in determining when MAiD should be administered if advance requests were permitted (68%). Others believe that it should be the role of the patient alone (15%) or physician alone (15%) to decide. Respondents had a variety of suggestions as to who should be involved in deciding at what point in time the criteria set out in an AR have been met, such as multiple decision-makers, including in the form of review panels and tribunals.
“Either the SDM and the physician together or potentially a tribunal (especially to deal with escalation of cases where there is disagreement between SDM and physician).”
[Assessor/Provider]

4.4 Anticipated Implications: HHR

A strong majority of respondents identifying as Assessors/providers (96%, N = 599) and those considering providing MAiD services (98%, N = 1115) indicated they would be willing or willing in some cases to continue to provide MAiD services or consider providing services if advance requests were permitted once a patient had met the MAiD eligibility criteria.

A smaller but still significant majority of assessors/providers (88%, N = 576) and those considering providing (88%, N = 1076) would be willing or willing in some cases to continue to provide MAiD services if advance requests were permitted where patients had not yet met all the MAiD eligibility criteria.
4.5 Safeguards

Finally, given the challenges outlined above, participants discussed safeguards that ought to be enacted should ARs be included in MAiD legislation to protect patients, their family, and providers. Suggested checks and balances included, but are not limited to, the inclusion of external evaluators, shared decision-making, and periodic reassessment of AR validity.

In sum, there is support for allowing requests for MAiD via AR, however it is clear the practical application of such a provision is complex and requires careful consideration, clear guidelines, and additional safeguards.

5. Mature Minors

Respondents (N = 4999) called on personal experience and clinical expertise to support views both in favor of (universally [17%] and “in some cases” [46%]) and against (37%) the extension of MAiD eligibility to mature minors. Support for mature minors’ eligibility was much lower among those not considering becoming an Assessor/Provider (universally [28%] and against [65%]) and higher among assessors/providers and those considering. Some who indicated they would assess and/or provide MAiD “in some cases” would do so when (a) all other eligibility criteria were met, and (b) the minor’s parent / guardian consented as well as the minor themselves. Roundtable results suggest that support depends on context and, in particular, the maturity of the individual.

Notably, many participants were adamant that mature minors not be eligible for MAiD when a mental disorder was the sole underlying condition for which they were requesting MAiD.

“I spent time working on a pediatric palliative care team and the prolonged suffering of slow and sometimes episodic decline is unnecessary and causes permanent psychological damage to family.” [Considering]
“The current criteria seem to make sense for this category. I would be hesitant to participate if the age eligibility AND mental health issues were both changed!” [Assessor/Provider]

“Mature minors have not attained complete development of their prefrontal cortices; therefore, I would feel uncomfortable supporting their choice of MAiD.” [Considering]

5.1 Anticipated Needs

Participants described additional supports needed for both physicians and patients and their families should access to MAiD be expanded to mature minors. For physicians, respondents suggested that (a) training, resources and emotional support, and (b) an altered MAiD process were necessary. More specifically, respondents suggested specialists be involved in the assessment (e.g., pediatric oncologists, social workers, ethicists), clear guidelines for assessing capacity of mature minors for MAiD be developed, and an extended timeline to demonstrate a persistent desire to access MAiD on the part of the minor be instituted.

“Provision of Medical Assistance in Dying to minors will be extremely stressful to providers. Enhanced support for Medical Assistance in Dying providers should be considered.” [Assessor/Provider]

“Clear criteria would have to be developed to ensure how capacity would be determined. [Considering]

“I think that the persistence of the wish to receive MAiD should be a criterion. A mature minor may have capacity but does not necessarily have the perspective of how things may change over time. We have to mitigate the impulsivity that a mature minor may show.” [Assessor/Provider]

Similarly, respondents identified additional supports necessary for patients and families requesting MAiD for a mature minor including enhanced psychiatric and social supports, and measures to support decision-making (e.g., third-party mediation, multidisciplinary approach).

“Access to specialty services especially social services, disability services, pediatric specialty and pediatric psychiatry will need to be enhanced.” [Assessor/Provider]

If MAiD is made available to this patient population, respondents suggested a number of supports and changes to MAiD protocols necessary to ensure safe, compassionate, and ethical service-provision. It is notable that a significant number of respondents felt they lacked the clinical experience to provide informed commentary and strongly suggested exploring this question with pediatric sub-specialties.
5.2 Anticipated Implications: HHR

A majority of assessors/providers (N = 555) reported that they would continue to provide MAiD services if mature minors were eligible (52%) or would “in some cases” (33%). Responses from those considering were almost identical (yes [50%], “in some cases” [34%] and no [16%]).

6. Conscientious Objection

Respondents (expressed a wide variety of views regarding the CMA’s stance on conscientious objection, with a significant majority of respondents (N = 5130) strongly or somewhat agreeing (74%) with CMA’s equal support of conscientious objection and conscientious participation.

The results suggest a high level of support that both conscientious objection and conscientious participation should be supported by the CMA.

“For physicians who fail to comply with either providing transfer of care of effective referral, significant consequences should be enforced (such as suspension of practice license, loss of hospital privileges, etc.)” [Assessor/Provider]
“I believe physicians regardless of moral stance should be required to refer patients to a provider or resource where they can access these services. It is unreasonable to protect physicians who refuse to carry out their duties that they are legally obliged to do under the guise of moral objection.” [Considering]

There was no consensus on the level of referral that should be provided by physicians who are unwilling or unable to provide MAiD. Notably, there was support for the view that the system should provide better access to MAiD so that referral is unnecessary.

“The difference between [transfer of care and effective referral] becomes negligible the further the Ministry of Health goes in establishing and publicizing streamlined access to MAID.” [Assessor/Provider]

“Since health care is provincially funded, the province should have an effective system in place for patients/physicians to facilitate referral for MAiD.” [Not a provider, not considering]

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3 An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), SC 2016, c 3.