

Bringing up Medical Assistance In Dying (MAID) as a clinical care option

The Canadian Association of MAID Assessors and Providers (CAMAP) intends to provide guidance to physicians, nurse practitioners, nurses and other allied healthcare professionals* on bringing up MAID as a clinical care option. We aim to facilitate equitable access to information about MAID for all patients across Canada. We also aim to find an acceptable compromise with healthcare professionals who conscientiously object to MAID, respecting their personal views, while working together to best serve patients.

Summary

There is no provision in the law that prohibits healthcare professionals from initiating a discussion about MAID or responding to questions about MAID from a patient. All healthcare professionals have a professional obligation to respond to questions about MAID from patients. Only physicians and nurse practitioners (jointly referred to hereafter as clinicians) involved in care planning and consent processes have a professional obligation to initiate a discussion about MAID if a patient might be eligible for MAID. The discussion should include all treatment options, including palliative care and the option of MAID. The appropriate timing of initiating a discussion about MAID is determined by the clinical context. Healthcare professionals must not discuss MAID with a patient with the aim of inducing, persuading, or convincing the patient to request MAID.

Holding a conscientious objection to MAID does not negate these obligations. Rather, it activates alternative duties to discuss the objection with the patient and to refer or transfer the care of the patient to a non-objecting clinician or other effective information-providing and access- facilitating resource. We recommend a unifying national guideline on this practise to facilitate the highest level of care.

Audience and recommendations

1. All healthcare professionals who may be involved in the care of a patient with a grievous and irremediable illness, disease or disability (Appendix 1), ought to have a basic understanding of the eligibility criteria for MAID. It is essential to not only identify which patients are potentially eligible and should receive adequate information as needed, but also to reduce harm by not bringing up MAID to patients who clearly would not qualify.
2. Nurses and allied healthcare professionals may engage in conversation with patients about MAID. They do not normally initiate discussion of treatment options, but would be expected to respond to a patient in the context of a therapeutic relationship.
3. This document intends to guide clinicians regarding their professional obligation to bringing up MAID as a care option for patients, when it is medically relevant and they are likely eligible for MAID. Full disclosure of all treatment options is required to fulfill informed consent criteria and support patient autonomy. Clinical judgement of the individual patient's context will determine when (or if) the option of MAID is discussed.
4. All healthcare professionals with conscientious objection to MAID should be aware of their professional responsibilities and accountabilities. A compromise is proposed to facilitate patient care, whilst respecting their beliefs.

*We use the widely accepted construct of "allied healthcare professional" with respect, awareness and an aim of inclusivity. We acknowledge the expertise and critical roles of more than 50 distinct and diverse health professional roles, some regulated and some not, found in healthcare today that are outside the traditional roles of medicine, nursing and pharmacy.

5. No healthcare professional should be prevented from bringing up and/or discussing MAID when they are legally permitted and professionally required to do so. This also applies to healthcare organizations that do not permit MAID on site. It is recommended that healthcare professionals seek advice from their regulatory bodies and indemnity organizations if their workplace regulations prohibit discussion of MAID and thus hinder their professional obligation to patients.
6. We recommend regulatory authorities, indemnity associations & health authorities provide consistent, clear messaging that informs and supports healthcare professionals' responsibilities regarding having conversations with patients about MAID as a clinical care option. A country wide standardization in policy is recommended for clinicians, based on the CPSO referral policy which has stood the test of the courts.

Relevant law

MAID legislation

The Canadian MAID law (*An Act to amend the Criminal Code and make related amendments to other Acts [medical assistance in dying]* commonly known as C-14) came into force in June 2016. It states:

Section 241 of the Act is replaced by the following:

Counselling or aiding suicide

(1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

(a) Counsels a person to die by suicide or abets a person in dying by suicide; or (b) Aids a person to die by suicide.

Exemption for medical assistance in dying

(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.

Exemption for person aiding practitioner

(3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

Exemption for pharmacist

(4) No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

Exemption for person aiding patient

(5) No person commits an offence under paragraph (1)(b) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying in accordance with section 241.2.

Clarification

(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.

Counselling, aiding, and abetting jurisprudence

“Counselling” for the purposes of s.241(1) “concerns speech that, assessed objectively, aims to induce, persuade or convince a person to commit suicide.” *R. v. Morin* 2014 QCCQ 1609. “The *actus reus* of aiding or abetting is doing (or, in some circumstances, omitting to do) something that assists or encourages the perpetrator to commit the offence. While it is common to speak of aiding and abetting together, the two concepts are distinct, and liability can flow from either one. Broadly speaking, “[t]o aid under s.21(1)(b) means to assist or help the actor. ...To abet within the meaning of s. 21(1)(c) includes encouraging, instigating, promoting or procuring the crime to be committed”: *R v Greyeyes*, 1997 CanLII 313 (SCC), [1997] 2 SCR 825, at para 26.” *R. v. Briscoe*, 2010 SCC 13 at para 14.

Relevance to bringing up MAID

To counsel a patient to die by suicide remains illegal. For the purposes of the *Criminal Code*, “to counsel” means to provide information with the aim of inducing, persuading, or convincing a person to die by suicide. By contrast, from a clinical perspective and in a therapeutic clinical relationship, “to counsel” means to inform and discuss. “Counsel” as commonly used for instance by a nurse, means communication, information sharing, active listening, patient education and the provision of psychological support. Counseling patients is within the accepted bounds of ethical nursing practise when patients request to die.^{1,2} The clinical perspective of the meaning of the word “counsel” has no bearing on the legal meaning. Therefore, so long as they do not have the aim of inducing, persuading, or convincing the patient to request MAID, any healthcare professional can legally provide information, initiate and engage in discussion, and educate patients about MAID. There is no legal restriction on who can raise the subject, i.e., the healthcare professional or patient. Healthcare professionals may wish to consider a risk-based approach. An increased risk is foreseeable if a healthcare professional systematically raises MAID without taking into account the specific context of the patient.

To avoid the risk of unduly influencing patients, clinicians should be aware of the clinician-patient power dynamic. It should be made clear that when discussing MAID as an option, that it is represented as one of the treatment options and not a coercive recommendation to a vulnerable patient. Similarly when a conscientious objecting physician mentions MAID, or their objection, it should be made clear their objection is personal and not a clinical recommendation.

Free and informed consent legal requirements

For consent to be legitimate, it must meet certain requirements. The consent must have been voluntary, the patient must have had the capacity to consent and the patient must have been properly informed.”³ For valid consent to or refusal of treatment, a patient must have been told about the material risks and potential benefits of the proposed treatment and all alternatives. This is the duty of clinicians and is not usually in the scope of work of other healthcare professionals. A patient must also have received answers to all of their questions. In order for consent to be considered **informed** the patient must receive information that a reasonable person in the same circumstances would require in order to make a decision about treatment. Such information must include the details of the treatments or other courses of action available, material risks, expected benefits, and side effects of the available treatments. Clinicians should consider whether MAID should be raised as part of informed consent discussions when a patient appears to be eligible for MAID.

If the patient has capacity to make choices about health care, and has a grievous and irremediable condition, then a clinician can have a discussion about clinical care options, including active treatment, palliative care, and MAID. If, on the other hand, a patient would not meet the legal eligibility criteria, MAID should not be offered as a treatment option. Where eligibility (including capacity) is uncertain, MAID should be raised with the caveat that eligibility would, as in all MAID cases, be assessed formally. If a clinician has conscientious objection to proposing MAID it activates additional duties.

When considering whether to discuss the option of MAID with the patient, healthcare professionals should also consider the voluntariness requirement of valid consent. Patients may not be able to fully exercise their right to refuse treatment proposed to them, that they find unacceptable, when they are not provided with all the medical and legal available options. If, for example, a patient is only offered withdrawal of life-sustaining treatment or palliative care, they may believe that those are the only options available to them, and they may feel compelled to choose from those options. With the full range of medically available options offered, including palliative care and MAID, the patient will be better able to choose freely, and consent voluntarily to an option that is acceptable to them.

The appropriate timing of the initiation of a discussion about MAID should be at the discretion of the clinician, taking into account all of the circumstances of each patient. For example, in almost all circumstances, it would be clinically inappropriate to initiate such a discussion immediately upon delivery of a diagnosis of a grievous and irremediable medical condition. However, once options for all treatment options including cessation of treatment are being presented to the patient, it would be appropriate to disclose the availability of MAID.

It is worth noting that there are exceptions to including MAID as a treatment option. MAID should not be raised if it is clinically inappropriate e.g. when a patient is clearly not capable to consent. It has been suggested that disclosure of the option of MAID might not be required if the healthcare professional “knows that” the patient objects to MAID. Great caution should be exercised in making a decision not to disclose a legally available service. First, patients sometimes change their minds – they may have expressed opposition to MAID while healthy and then desire it once confronted with a grievous and irremediable medical condition. Second, health care professionals may draw incorrect assumptions about a person’s views on MAID e.g., they may assume that a patient objects to MAID because she is a Roman Catholic nun and yet Roman Catholic nuns and others dedicated to a faith based way of life have requested MAID. Great sensitivity should be exercised in raising the possibility of MAID and an individualized approach is advised.

Ethical Considerations

Patient Autonomy

There are generally accepted ethical principles that guide healthcare professionals in their care of, and communication with patients. Examples of such principles include respect for patient autonomy (respect wishes); beneficence (to do good); and non-maleficence (to do no harm). These principles are articulated in the Canadian Medical Association (CMA) and Canadian Nurses Association (CNA) Code of Ethics, both of which have been reviewed and upheld after Bill C-14 was implemented.

The ethical principle of respect for patient autonomy is of paramount importance to the issue of whether, when, and how healthcare professionals can or should bring up MAID as a clinical care option with patients. To respect a patient’s autonomy, healthcare professionals are commonly required to provide all of the medically effective and legally available treatments as options for patients, even if they are at odds with their personal values, so that the patient can make a

considered choice among those treatment options (including provision, withholding, or withdrawal of treatment) and provide informed consent.

Gatekeeper role and obligation

By meeting the consent requirements discussed above, clinicians will fulfil their professional obligations as part of their inherent role as gatekeepers to the healthcare system. They are experts equipped with extensive knowledge of illness, disease, disability, the healthcare system, and treatment/management options, and are responsible for discussing the treatments available to patients to cure or comfort them. Patients, in most cases, do not have the same level of knowledge as the clinician, they are not able to independently create their treatment plan, and may not know which options to pursue or forego. Clinicians cannot expect a patient to be aware of all of the medical and legal available options for treatment of that patient's disease, illness or disability. The same can be said for patients with grievous and irremediable conditions who may qualify for MAID. Patients cannot be expected to know whether they would be eligible for MAID, a legal treatment option for their consideration,⁴ or how they would access it. At the time of life that a patient can qualify for MAID as per Bill C14 (grievous and irremediable illness, disease or disability; advanced state of decline in capability, intolerable suffering, reasonably foreseeable natural death), they may be particularly vulnerable to not knowing all their treatment options. Many Canadians are not aware that MAID is legal in Canada. Some patients may face obstacles to improvements in well-being or access to care, such as a bed bound state, lack of independence and resources (including internet & phone), communication difficulties (loss of speech, blindness, hearing loss), loss of privacy when dependent on caregivers, loss of autonomy, and a myriad of physical symptoms such as shortness of breath, severe fatigue, frailty, anxiety, and more.

Without being adequately informed of their treatment options in a timely manner, patients may not be able to access MAID, may lose decision-making capacity and become ineligible for MAID, suffer intolerably for longer, or have an end-of-life experience which may be unacceptable to them. When a patient is potentially eligible, not providing them with information about MAID can create a significant risk of harm to them and their family. The most common reasons for patients seeking MAID is loss of autonomy, including self-care and other activities of daily living (89.5%), decreased ability in participation in meaningful or enjoyable activities (89.5%) and loss of dignity (65.4%).¹ Physical symptoms such as inadequate pain control or concern about it is less common (35.3%). While some professionals may expect patients to express their intolerable suffering, to open the door for conversations about MAID, patients may not do so. This is especially likely in highly medicalized environments with focus on physical symptomology and also if patients are unaware that MAID is legal. Slippery slope arguments may influence clinicians to avoid bringing up MAID to patients with disabilities, due to fear of implying that their lives are not worth living. Understanding a patient's cultural background, spiritual beliefs, psychosocial experience, social determinants of health, illness experience and wishes would help facilitate design of a care plan.

Healthcare professionals may fear that bringing up MAID may lead to a complaint being lodged with a regulatory body, e.g. if deemed inappropriate or premature in the eye of the patient or patient's family. A complaint will be judged according to professional standards, not the views

of the patient or patient's family. However, not disclosing the option of MAID may also pose a risk of a complaint being made if a patient missed the opportunity to avail themselves of this option. Given the therapeutic benefit of MAID availability,⁵ and association of MAID with increased palliative care consultation,⁶ it could be a double therapeutic miss not to bring up MAID in conversation about clinical care options. Furthermore, not bringing up MAID can also lead to harm by prolongment of unwanted, unnecessary suffering and missed therapeutic reduction in existential anxiety. A case "Leo died the other day", has also been described after a young man committed suicide, despite good palliative care and support, his physician conflicted between mentioning MAID or not.⁷ Not only can this not be seen as a good death, but it caused harm to his family and his physician.

Health care professionals who work in environments where MAID is not supported face additional challenges. They still have a professional obligation to support patient autonomy and facilitate informed consent. The existence of MAID as a treatment option cannot be withheld. Clinicians have a duty-of-care obligation to provide quality care that is continuous and non-discriminatory. They should be fully aware of their organization's MAID policy and aware of risks associated with deviating from it. It is recommended that healthcare professionals seek advice from their regulatory bodies and indemnity organizations if their workplace regulations prohibit discussion of MAID and thus hinder their professional obligation to patients.

How to bring up MAID

Discussing the wish to hasten death is not upsetting to the majority (94.8%) of advanced cancer patients; 79.3% considered it important for the clinician to proactively assess the potential wish for hastened death and to discuss the topic, irrespective of whether the patients experienced the wish.⁸ Half of the patients in an ALS study could imagine asking for assisted dying. Two thirds communicated their wish to hasten death to relatives. No-one talked to a physician about it, yet half would have liked to do so.⁹ Patients with Huntington's Disease reported a lack of open discussion about assisted dying with medical professionals.¹⁰

There is no risk free method to bring up MAID. A respectful trusting patient-clinician relationship and enough time for such sensitive conversations are important. Patients for whom MAID may be an option should be given opportunities to discuss their prognosis and preferences for clinical care before their illness progression reduces their ability to engage in meaningful conversations. In a therapeutic relationship, understanding the patient's values, beliefs, goals and fears as well as previously expressed wishes, will significantly reduce the risk of harming a patient by bringing up MAID. If the patient's goals, fears, critical abilities, sources of strength, trade-offs and supports have not previously been explored, the Serious Illness Conversation Guide,¹¹ is a tested scripted tool to facilitate earlier and better conversation with a patient facing life limiting serious illness. It does not specifically address MAID, but understanding the patient's values and wishes will help clarify if MAID would be a treatment option to bring up or not. Furthermore, open ended questions such as "Is there anything about your spiritual beliefs you want to share that might help us care for you?" can also be helpful. Palliative care colleagues are experienced in broaching end of life discussions and can be valuable resources or team members. Many publications are available to help clinicians with difficult conversations at end of life.¹²⁻¹⁹ Previous advance care discussions may also be helpful to identify if a patient would

want to discuss MAID or not, bearing in mind they may have changed their mind in the interim. Bringing up MAID should always be done with sensitivity. The timing will be determined by the clinical context. Agencies can employ scripts²⁰ to help staff manage questions from patients.

Ethical Tensions

To explore ethical tensions that impact bringing up MAID we refer to the following sections of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK), 1982*, c 11.

Rights and freedoms in Canada

1. The *Canadian Charter of Rights and Freedoms* guarantee the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Fundamental freedoms

2. Everyone has the following fundamental freedoms: (a) freedom of conscience and religion... [...]

Legal Rights

7. Everyone has right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Equality before and under law and equal protection and benefit of law

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

As discussed above, clinicians are gatekeepers to the health-care system and in certain circumstances are professionally obliged, for the sake of patient autonomy and fulfillment of informed consent requirements, to bring up MAID as a clinical care option to patients. This conversation should arise and be incorporated when a discussion of palliative care, long term care, cessation or withdrawal of an active treatment option would occur - that is, when the patient has a grievous and irremediable medical condition. In these cases, clinicians have a professional obligation to their patients to bring up MAID. It is possible that this obligation may be in direct conflict with the clinician's personal values. Clinicians' general ethical duties include respecting patients' wishes and, where those aren't known, acting in accordance with the patients' values and beliefs, and where those aren't known, acting in the patients' best interests, regardless of the clinician's personal values.

Conscientious Objection

As noted by Health Canada, "Not all health care providers will be comfortable with medical assistance in dying. The federal practice may not be consistent with a provider's beliefs and values. The federal legislation does not force any person to provide or to help provide medical assistance in dying".²¹ A clear distinction should be made at this juncture between providing (the act of provision of MAID medications), helping to provide (e.g. assessment) and the professional obligation to support patient autonomy by giving information / referring for information which may or may not lead to the patient obtaining MAID. While healthcare professionals with conscientious objection may even see providing information as per the informed consent requirement or referral as "helping" (an absolutist position of moral proximity)²² and thus contrary to their beliefs, the legal obligation to inform has not been found to be an unconstitutional violation of the professional's beliefs,²³ and good arguments exist to reduce moral complicity.²²

The CMA Code of Ethics and Professionalism²⁴ captures the fundamental commitments of the medical profession. It includes to first consider the well-being of the patient, act to benefit the

patient, and take all reasonable steps to respect the autonomy of the patient. A commitment to altruism is echoed by provincial Colleges of Physicians and Surgeons.²⁵ Professional responsibilities in the patient-physician relationship recognize the inherent vulnerability of the patient, even if the patient is an active participant in their own care. The physician owes a duty of loyalty to protect and further the patient's best interests and goals of care. Physicians' duty of non-abandonment of the patient manifest in always acknowledging and responding to the patient's medical concerns and requests, whatever the physician's moral commitments may be. Physicians are required to inform patients when their moral commitments may influence their recommendations concerning the provision of the practice of any medical procedure or intervention as it pertains to the patient's needs or requests. The CNA Code of Ethics for nurses also reflects these fundamental principles of patient centered ethical care.

Conventional Compromise

In order to mitigate the ethical conflict that may arise when a clinician objects to a particular practice, one may consider the **Conventional Compromise** offered by Harvard Professor Dan Brock.²⁶ The Conventional Compromise seeks to clarify the conscientious objecting physician's ethical responsibilities by striking a balance between respecting the professional integrity of the physician and meeting the needs of the patient and society as a whole. It understands that neither the rights of physicians, nor the rights of patients can or should be respected absolutely. It aims to limit any infringement on physician or patient rights to that which can be justified. According to this model, the clinician may only conscientiously object to providing a particular service or intervention to their patient if the following three conditions are met: 1) The clinician informs the patient about the service or intervention if it is medically relevant to their medical condition; 2) the clinician refers the patient to another professional willing and able to provide the service or intervention; and 3) the referral does not impose an unreasonable burden on the patient. It is thus paramount that the patient is informed about the service, even if the clinician will not provide the service.

It is ethically appropriate to place the burden of managing the clinician's objection on the clinician and not on the vulnerable patient. While it would be completely unacceptable to abandon the patient, it would also not be fair to penalize the patient or disproportionately harm the patient by placing the clinician's religious freedom above the patient's right to security of person and freedom of conscience. While the *Charter* enables clinicians to limit their services based on conscience or religion, clinicians may not impede, directly or indirectly, access to services, thus unjustifiably infringing on the rights of patients to access those services. Patients should not have to choose between pursuing a potential treatment and sacrificing an existing therapeutic relationship, especially when significant social health determinants may also be present, limiting access to alternative care. It should be possible for clinicians to structure their work environment to accommodate the compromise. According to the conventional compromise model there are not only reasons to accept that conscientious objecting clinicians should inform their patients about particular interventions if they are medically relevant, but also that those physicians have an obligation to refer or transfer their patient to another professional.

Most provincial and territorial colleges have guidelines or standards their registrants are obliged to follow. A 2018 College of Physicians and Surgeons of Ontario (CPSO) court challenge,

(ruling upheld in May 2019), supported the clear and explicit requirement of obligatory referral, as it was determined that the balance of competing rights favours patient dignity and autonomy above a physician's conscientious objection to refer. The CPSO's policy stood the test of the courts. We feel it is important that standards of care be at the highest level and see benefit in standardization of policy across the country.

The "duty to refer"²⁶ includes not only informing a patient of a clinician's non-participation in a treatment or procedure, but also not causing distress. The patient has a right to discuss their condition and options for treatment (including the objected-to option) with another practitioner who does not have the same objection. The patient should also understand that the objection is moral and not due to clinical reasons.²⁷ If the patient does not know what the procedure is or that it is legal, the objecting clinician has an obligation to inform the patient of this fact.

Conscientious objection by other healthcare professionals should be based on the same ethical principles. The American Nurses Association's (ANA) guidance is clear that individual nurses can opt out of involvement based on personal dictates as long as patients' needs are accommodated through referral. Nurses are obliged to provide for the patient's safety, to avoid abandonment and withdraw only when assured that alternative sources of care are available to the patient.¹ Similarly the Canadian Nurses Association requires nurses to take all reasonable steps to ensure that the quality and continuity of care for clients are not compromised. They have to ensure safe, continued and respectful transfer of care to an alternate provider who can address the unique needs of the client.

A clinician with conscientious objection has a duty of care obligation to provide quality care that is continuous and non-discriminatory. According to the Conventional Compromise, they would mention MAID as a possible treatment option, if and when clinically warranted, discuss their moral objection and ensure continuity of care for their patient. Whether this is done by effective referral, effective transfer of care or provision of resource information is currently determined by varying provincial regulatory standards. This compromise reduces moral complicity as much as possible given the circumstances and ensures that the clinician does not have to discuss MAID in more detail and can choose their level of ongoing involvement in care.²⁸

Duties of those not routinely involved with MAID

Most medical specialists do not routinely work in areas that involve MAID, but they have the same responsibilities as those who do. They are expected to uphold patient autonomy, and provide adequate information for informed consent, whether supportive of MAID or objecting, if they have this information. Whilst the majority of MAID discussions are held by family physicians, palliative care physicians, and nurse practitioners, the issue of MAID is likely to be encountered by all physicians who assess patients on a regular basis. Very few medical specialties are void of discussions about the end of a patient's life. A palliative patient with advanced cancer or end stage COPD/CHF may for example present to an emergency room physician for a variety of reasons. A surgeon or orthopedic surgeon may encounter a patient with a surgical issue such as a hip fracture or gangrene, but not be a candidate for surgical repair due

to their comorbidities. In such circumstances all involved physicians share the duty to uphold autonomy and ensure informed consent.

Nurses and allied healthcare professionals may have patients in their care who are considering all their treatment options including MAID. Those healthcare professionals with sufficient knowledge should respond to questions. Those with insufficient knowledge should refer to a professional known not to be a conscientious objector, their provincial health authority or equivalent MAID Coordination office/centre. A basic understanding of the legal eligibility criteria for MAID is essential for all healthcare professionals to not only identify which patients are potentially eligible and should receive adequate information as needed, but also to reduce harm by not bringing up MAID to patients who clearly would not qualify.

References

1. DP Olsen, R Chan, R Lehto. Ethical nursing care when the terminally ill patient seeks death. Personal values and state laws differ, but clear ethical guidance exists. *AJN* 2017; 117, 7:50-55.
2. J Downie. Can nurse practitioners mention MAID to patients? *Impact Ethics* 2018, July 3.
3. KG Evans. Consent: A guide for Canadian physicians. CMAA handbook. 4th Ed 2004 updated 2016.
4. M Buchbinder. Aid-in-dying laws and the physician's duty to inform. *J Med Ethics* 2017; 43:666-669.
5. IM Ball, S Anderson. Availability of medical assistance in dying can be therapeutic. *CMAJ*. 2017 Mar 6;189(9):E372.
6. S Dierickx, L Deliens, J Kohen, K Chambaere. Euthanasia in Belgium: Trends in reported cases between 2003-2013. *CMAJ* 2016; Nov 1, 188(16):E407-E414.
7. S MacDonald. Leo died the other day. *CMAJ*. 2019, Jan 14:E49-50.
8. J Porta-Sales, I Crespo, C Montfore-Royo et al. The clinical evaluation of the wish to hasten death is not upsetting for advanced cancer patients: A cross sectional study. *Palliative Medicine Online*, 2019, 28 Jan. <https://journals.sagepub.com/doi/full/10.1177/0269216318824526>
9. R Stutzki, M Weber, S Reiter-Theil, U Simmen GD Borasio, RJ Jox. Attitudes towards hastened death in ALS: A prospective study of patients and family caregivers. *Amyotrophic lateral sclerosis and frontotemporal degeneration*, 2014; 15:68-76.
10. L Regan, NJ Preston, FJR Eccles, J Simpson. The views of adults with Huntington's Disease on assisted dying: A qualitative exploration. *Palliative Medicine* 2018, Vol 32(4) 708-715.
11. Ariadne labs. Serious Illness Conversation Guide. Ariadnelabs.org
12. M Pino, R Parry, V Land, C Faull, L Feathers, J Seymour. Engaging terminally ill patients in end of life talk. How experienced palliative medicine doctors navigate the dilemma of promoting discussions about dying. *PLoS ONE* 2016 11(5):e0156174.
13. RB Balaban. A physician's guide to talking about end-of-life care. *J Gen Intern Med*. 2000 Mar; 15(3):195-200
14. JJ You, RA Fowler, DK Heyland. Just ask: Discussing goals of care with patients in hospital with serious illness. *CMAJ*. 2014 Apr 1;186(6):425-432
15. RH Lehto, DP Olsen, RR Chan. When a patient discusses assisted dying. Nursing implications. *J hosp palli nurs*. 2016 Jun; 18(3):184-191.
16. RA Spence, CD Blanke, TJ Keating, CP Taylor. Responding to patient requests for hastened death: Physician aid in dying and the clinical oncologist. *J Onc Prac*. 2017 Oct; 13(10):693-699.
17. TW LeBlanc, J Tulsy. Discussing goals of care. *UpToDate*. Oct 2018.
18. M Harlos. Sit down, lean in. *Canadian Virtual Hospice*. [Sit Down, Lean In](http://SitDown.LeanIn)
19. C Pirschel. What to do when your patients talk about medical aid in dying. *Onc Nur Soc Voice*, Jul 2018.
20. Vancouver Island Health Authority Memorandum. VIHA Nov 2018. See attached as appendix 2.
21. Government of Canada. Medical Assistance in Dying. <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>
22. C Cowley. Conscientious objection in healthcare and the duty to refer. *J Med Ethics* 2017;43:207-212.

23. Vermont Alliance for Ethical Healthcare vs. Hoser. 2016.
<https://www.leagle.com/decision/infdco20170406e27>
24. Canadian Medical Association. CMA code of ethics. 2018.
25. College of Physicians and Surgeons of Ontario. The Practice Guide: Medical Professionalism and College Policies. 2007.
26. DW Brock. Conscientious refusal by `physicians and pharmacists: Who is obligated to do what and why? Theor Med Bioeth 2008; 29:187-200.
27. College of Physicians and Surgeons of Ontario. CPSO Professional Obligations and Human Rights. 2015.
28. Canadian Nurses Association. National framework on medical assistance in dying in Canada. 2017.

CAMAP Project team

Dr. T. Daws, Physician, MAID provider, BC, Project lead

Mr. J.T. Landry, Ethicist, ON

Dr. P. Viens, Physician, MAID provider, QC

Dr. R. Beuthin, Registered nurse, MAID coordinator, BC

Ms. E. Maynard, Nurse practitioner, MAID provider, NS

Dr. J.G. Reggler, Physician, MAID provider, BC

Mr. A.T.W. Kim, Medical student, BC

Ms. S. Lui, Medical student, BC

Contributor

Prof. J. Downie, Schulich School of Law, Dalhousie University, NS

Appendix 1

Grievous and Irremediable

Definition (from An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) S.C. 2016, c. 3, Assented to 2016-06-17:

241.2 (2): Grievous and irremediable medical condition

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) 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; and

(d) their natural death has become **reasonably foreseeable**, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Appendix 2

Excerpt of memorandum from Vancouver Island Health Authority (VIHA) to all nurses, 2018, published with permission.

MEMORANDUM

RE:Nurses providing information at end-of-life about care options including Medical Assistance in Dying (MAiD)

QUESTION: Nurses seek clarification: “Can I provide information to a patient at end-of-life about all their care options, including MAiD?”

NOTE: This response applies to all nurses, whether they have completed additional MAiD education or not.

ANSWER: a) Yes, if a patient asks. This aligns with Island Health Policy 12.6.28P [Medical Assistance in Dying: Responding to Patient Requests](#). **AND** b) Yes, even when a patient doesn’t ask directly but expresses a lack of information. This occurs in context of the situation and based on a **nurse’s assessment of a patient’s knowledge and information needs**. i.e. what the patient in that situation is asking, expressing and needing. A nurse is listening to determine a patient’s understanding of the situation and their understanding of what care options are available. As appropriate to the situation, a nurse provides information with empathy and non-judgement. That care professionals provide information is emphasized in [An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\) - Parliament of Canada](#):

Clarification

- **(5.1)** “For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.”

All the while keeping in mind this direction from BCCNP’s [Medical assistance in dying: FAQs](#)

Can I provide information to clients about medical assistance in dying?

- “Counselling a person to commit suicide is still a criminal offence. For the purposes of the *Criminal Code*, “counsel” means encourage, solicit or incite. Due to the criminal significance of the word “counsel,” you need to be mindful in your work with clients *not* to encourage, counsel, advise, recommend or in any way seek to influence a client to end their life (i.e. a nurse does not promote MAiD, or try to convince a client to choose MAiD as an EOL option).
- The Criminal Code permits health care professionals, including nurses, to provide information about the lawful provision of medical assistance in dying to a client. So nurses can provide information, engage in discussions and educate their clients about medical assistance in dying.” This also aligns with [BCCNP Standards, limits and conditions for MAiD](#) Standard.
- Registered nurses ensure that a client has access to the information that the client requires to understand all of their options and to make informed decisions about medical assistance in dying or other end-of-life options such as palliative care.”

The provision of information may initiate a further conversation that a nurse enters into based on their level of knowledge and competency about MAiD and all end-of-life care options. At any point a nurse may suggest that the patient speak to their primary care provider.

Script Scenarios:

Which may guide your conversation: At any time, you may choose to refer a patient’s inquiries to their treating physician/NP; MAiD coordinator maid@viha.ca; another staff member or supervisor.

1. **A patient is aware of MAiD and asks for information about the service:**

- *Yes, medical assistance in dying is an end-of-life option that is available to any eligible person in Canada, including here in Island Health. Can you tell me more about what information you are looking for, so I can clarify or direct you to someone who can answer your questions?*

2. A patient tells you he was told there is no treatment to cure his disease, and it will continue to progress. He wonders what options are available to him. When patient questions or comments are not specifically about MAiD, always start with exploring questions to better understand what the person is actually meaning and wanting.

- *Can you tell me more about what you mean, and what you are wanting to know more about? (As a person may be wanting to talk about their experience, referring to disease management options, service options, or options for dying.)*
- *Can you tell me more about what you understand about your illness? What you are hoping or worried about?*
- *Would you like me to tell you about all of the end-of-life options available?*
 - Ø *There are different kinds of services available, and people make choices depending on their own beliefs, needs, and circumstances. Palliative support - which can include accessing the specialist palliative physician and team - is available for care in homes, acute care, residential care, and in some communities' hospice beds for last weeks of life.*
 - Ø *Palliative care can be provided through a natural death or a medically assisted death.*

3. A patient tells you they asked their physician or NP about MAiD and were not satisfied with the answer:

- *Can you tell me more about what you were told, so I can either clarify or direct you to someone who is able to answer your questions?*
- *Medical assistance in dying legislation is still relatively new in Canada (2016), and being regularly updated, so it's important we get you up to date answers to any questions you may have.*

Note: In all health authorities, including Island Health, nurses and all employees are insured by Health Care Protection Program (HCPP), as care takes place in the care environment. Nurses have legal protection when they act in the spirit of the legislation and in accordance with Island Health's guidelines. (The Canadian Nurse Protection Society would be a secondary resource.)

Additional resources: [Medical Assistance in Dying \(MAiD\) | Island Health](#)(public)