MEDICAL ASSISTANCE IN DYING

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Companion Resources: Advice to the Profession

Other References:

- 10 Things the Patient Should Know
- Medical Assistance in Dying Resources
- Early Lessons Learned
- Centre for Effective Practice: Medical Assistance in Dying Resource
- Survey: Clinician Registration for the Care Co-ordination Service (CCS) for MAID
- Ministry of Health and Long-Term Care – Medical Assistance in Dying

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Capacity: A person is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision or lack of decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[1] Capacity to consent to a treatment can change over time, and varies according to the individual patient and the complexity of the specific treatment decision.

Effective Referral: taking positive action to ensure the patient is connected[2] to a non-objecting, available, and accessible[3] physician, other health-care professional, or agency.[4] For more information about an effective referral, see the companion *Advice to Profession* document.

Medical Assistance in Dying: In accordance with *federal* legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes a substance for an individual to self-administer to cause their own death.

Medical Practitioner: A physician who is entitled to practise medicine in Ontario, including postgraduate medical trainees.

Nurse Practitioner: A registered nurse who, under the laws of Ontario, is entitled to practise as a nurse practitioner and autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances, and treat patients.

Policy

Federal legislation establishes the legal framework for medical assistance in dying (MAID) in Canada, including eligibility criteria and safeguards that must be satisfied prior to providing MAID.[5,6]

1. Physicians **must** manage all requests for medical assistance in dying (MAID) in accordance with the expectations set out in this policy.[7]

Criteria for Medical Assistance in Dying

The federal legislation sets out the criteria that must be met in order for an individual to be eligible to access MAID.

2. Before providing MAID, physicians **must** be satisfied that the patient meets all of the eligibility criteria set out in federal legislation, which requires that the patient:
    a. be eligible for publicly funded health-services,
    b. be capable and at least 18 years of age,
    c. have a grievous and irremediable medical condition,
    d. make a request for MAID voluntarily and not as a result of external pressure, and
    e. provide informed consent to receive MAID after having been informed of the means available to relieve their suffering, including palliative care.
3. In order to assess the patient against the federal eligibility criteria, physicians **must** use their professional judgement.

Additional information and expectations relating to each criterion are set out below.

The individual must be eligible for publicly funded health services

4. As the activities involved in assessing patients for and providing MAID are insured services,[8] physicians **must not** charge patients directly for MAID or associated activities. Physicians are **advised** to refer to the OHIP Schedule of Benefits for further information.

The individual must be capable and at least 18 years of age[9]

5. Physicians **must** ensure the patient is able to understand and appreciate the history and prognosis of their medical condition, treatment options, the risks and benefits of their treatment options, and the certainty of death upon self-administering or having a physician administer the fatal dose of medication.
    a. As capacity is fluid and may change over time, physicians **must** be alert to potential changes in a patient's capacity.
    b. Physicians are **advised** to rely on existing practices and procedures for capacity assessments.

The individual's medical condition must be grievous and irremediable

According to the federal legislation, a person has a grievous and irremediable medical condition only if:

- they have a serious and incurable illness, disease, or disability;
- they are in an advance state of irreversible decline in capability;
- their illness, disease, disability, or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions they consider acceptable; and
- their natural death has become reasonably foreseeable, taking into account all of the medical circumstances (a prognosis need not have been made as to the specific length of time that they have to live).

6. As the definition of grievous and irremediable does not follow terminology typically used in a clinical context, physicians **must** use their professional judgment when assessing a patient for a grievous and irremediable medical condition.[10]
    a. Physicians are **advised** to obtain independent legal advice if they are uncertain about whether a patient meets this eligibility criterion.

The individual's request must be voluntary and not as a result of external pressure

7. Physicians **must** be satisfied that the patient's decision has been made freely, without undue influence from family members, healthcare providers, or others, and that they have made the request themselves, thoughtfully, and in a free and informed manner.

The individual must provide informed consent

8. As MAID can only be provided to a capable adult, physicians **must** obtain informed consent[11] directly from the patient, not the

substitute decision-maker of an incapable patient.

9. As part of obtaining informed consent, physicians **must:**
    a. Discuss all treatment options with the patient, including the associated risks and side effects, which includes informing the patient of means that are available to relieve their suffering, including palliative care.[12]
    b. Inform patients who are indicating a preference for self-administered MAID:
        i. of the potential complications associated with this option, including the possibility that death may not be achieved; and
        ii. that should their death be prolonged or not achieved, it will not be possible for the physician to intervene and administer a substance causing their death unless the patient is capable and can provide consent immediately prior to administering.

10. Physicians are also **advised** to encourage patients who choose to self-administer MAID to include the physician or nurse practitioner who prescribed the medication among those present when the medication is self-administered.

Conscientious Objection

The College recognizes that physicians have the right to limit the health services they provide for reasons of conscience or religion. For clarity, the College does not require physicians who have a conscientious or religious objection to MAID to provide MAID under any circumstances.[13]

However, physicians' freedom of conscience and religion must be balanced against the right of existing and potential patients to access care. The Supreme Court of Canada noted, in the *Carter*[14] case, that the rights of physicians and patients would have to be reconciled in any regime governing MAID. The Court of Appeal for Ontario has confirmed that where an irreconcilable conflict arises between a physician's interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails.[15]

While the federal legislation does not address the conscientious objections of health care providers, the College has outlined expectations, set out below, for physicians who have a conscientious or religious objection to MAID. These expectations accommodate the rights of objecting physicians to the greatest extent possible, while ensuring that patients' access to healthcare is not impeded.

11. Consistent with the expectations set out in the College's *Professional Obligations and Human Rights* policy, physicians who decline to provide MAID due to a conscientious objection:
    a. **must** do so in a manner that respects patient dignity and **must not** impede access to MAID.
    b. **must** communicate their objection to the patient directly and with sensitivity, informing the patient that the objection is due to personal and not clinical reasons.
    c. **must not** express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.
    d. **must** provide the patient with information about all options for care that may be available or appropriate to meet their clinical needs, concerns, and/or wishes and **must not** withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.
    e. **must not** abandon the patient and **must** provide the patient with an effective referral.[16,17]
        i. Physicians **must** make the effective referral in a timely manner and **must not** expose patients to adverse clinical outcomes due to a delay in making the effective referral.

Involvement of Postgraduate Medical Trainees

12. Postgraduate medical trainees can participate in the MAID process, but **must** do so within the terms, conditions, and limitations of their certificate of registration.[18]
13. Postgraduate medical trainees and other physician assessor involved in assessing a patient's eligibility for MAID **must** pay particular attention to ensuring that there is independence between the assessors. Specifically, the requirement for independence between the two assessors of a patient's eligibility for MAID is not satisfied if one assessor is a mentor or supervisor to the other.

Reporting Obligations

Depending on the circumstances, physicians who provide MAID or receive a written request for MAID have reporting obligations to both the Office of the Chief Coroner for Ontario (OCC) and Health Canada.

14. Physicians who provide MAID **must** report medically assisted deaths to the OCC.[19,20]
    a. Physicians **must** provide the OCC with any information about the facts and circumstances related to the medically assisted death that the OCC considers necessary to form an opinion as to whether the death ought to be investigated. Typically, providing the patient's medical record pertaining to the medically assisted death will suffice.
15. When a written request for MAID is received from the patient (in any form, including email or text message, although not necessary the written request required by the safeguard in the *Criminal Code*[21]) and a medically assisted death *does not* occur, physicians **must** make a report to Health Canada[22] in the following situations:
    a. The patient was found ineligible for MAID;
    b. The patient was referred to another practitioner or care coordination service;
    c. The patient died from another cause;
    d. The patient withdrew their request for MAID; or
    e. The physician prescribed a substance for MAID that to their knowledge did not result in a medically assisted death within the prescribed timeframe.
16. Physicians **must** make their report to Health Canada within 30 days of any of the above outcomes occurring, with the exception of provision 15 (e), in which case a report must be made between 90 and 120 days after the substance is prescribed. Physicians **must** make their report using the Canadian MAID Data Collection Portal.[23]

Medical Record Keeping

17. Physicians **must** comply with the expectations set out in the College's *Medical Records* In particular, physicians **must**:
    a. document each physician-patient encounter in the medical record, including encounters relating to MAID, which will include:
        i. a focused relevant history;
        ii. documentation of an assessment and appropriate focused physical exam (where indicated);
        iii. a provisional diagnosis (where indicated); and
        iv. a management plan;
    b. ensure that the record is legible and the information is understandable to other healthcare professionals; and
    c. ensure that the author of each entry in the medical record is identifiable.
18. Physicians **must**:
    a. document all oral and written requests for MAID, the dates they were made, and include a copy of the patient's written request in the medical record;[24]
    b. document each element of the patient's assessment in accordance with the criteria for MAID; and
    c. include a copy of their written opinion in the medical record.
19. Where MAID is provided, physicians **must** document the information needed to comply with their reporting obligations to the OCC, which includes but is not limited to:
    a. the steps taken to satisfy themselves that the patient's written request for MAID was signed by two independent witnesses;
    b. the start and end-date for the required 10-day reflection period between the signed request for MAID and the date on which MAID was provided;
    c. the rationale for shortening the 10-day reflection period, if applicable (i.e., both clinicians and/or nurse practitioners are of the opinion that the patient's death or loss of capacity is imminent);
    d. the time of the patient's death; and
    e. the medication protocol used (i.e., drug type(s) and dosages).
20. Physicians who decline to provide MAID **must** document that an effective referral was made, the date it was made, and the physician, practitioner, and/or agency to which the referral was made.

Completion of Death Certificate

21. If, after reviewing the report provided, the OCC determines that no investigation is needed, physicians who provided MAID **must** complete the medical certificate of death.[25]
22. When completing the death certificate[26] physicians:
    a. **must** list the illness, disease, or disability leading to the request for MAID as the cause of death; and
    b. **must not** make any reference to MAID or the drugs administered on the death certificate.

(https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying) Accessed 2021-01-05

Process Map for Medical Assistances in Dying

The process map that follows details the steps that physicians must undertake in relation to medical assistance in dying. It complies with federal legislation and outlines safeguards that must be adhered to, by law, prior to the provision of medical assistance in dying.

The federal legislation sets out safeguards that must be met before medical assistance in dying is provided. The process map that follows provides an illustration of how medical assistance in dying may be carried out, from initial patient inquiry to provision, in compliance with the federal legislation.

Nurse practitioners and other professionals are noted in the Process Map only to the extent necessary to reflect relevant provisions of the federal legislation. Expectations for the responsibilities and accountabilities of nurse practitioners, pharmacists and other health care providers are set by their respective regulatory bodies.

Physicians and nurse practitioners, along with those who support them, are protected from liability if acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.[27]

Initial Inquiry for Medical Assistance in Dying

Patient makes initial inquiry for medical assistance in dying to a physician or nurse practitioner.

Physicians who have a conscientious objection to medical assistance in dying are not obliged to proceed further through the process map and evaluate a patient's inquiry for medical assistance in dying. As described above, objecting physicians must provide the patient with an effective referral to a non-objecting physician, nurse practitioner, or agency. The objecting physician must document, in the medical record, the date on which the effective referral was made, and the physician, nurse practitioner and/or agency to which the patient was connected.

Safeguards for Medical Assistance in Dying

Physician or nurse practitioner assesses the patient against eligibility criteria for medical assistance in dying.

The physician or nurse practitioner must ensure that the patient meets the criteria for medical assistance in dying. As described above, the patient must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. Provide informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Where the patient's capacity or voluntariness is in question, the attending physician must refer the patient for a specialized capacity assessment.

With respect to the third element of the above criteria, a patient has a grievous and irremediable medical condition if:

- They have a serious and incurable illness, disease or disability;
- They are in an advanced state of irreversible decline in capability;
- 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
- Their natural death has become reasonably foreseeable,[28] taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the individual has to live.

If the physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to make a request for medical assistance in dying to another physician who would again assess the patient using the above criteria.

The physician must document the outcome of the patient's assessment in the medical record.

(https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying) Accessed 2021-01-05

Patient makes written request for medical assistance in dying before two independent witnesses.

The patient's request for medical assistance in dying must be made in writing. The written request must be signed and dated by the patient requesting medical assistance in dying on a date after the patient has been informed that they have a grievous and irremediable medical condition.

Physicians are advised that a patient may have been informed that they have a grievous and irremediable medical condition by a physician who is not involved in assessing their eligibility for medical assistance in dying. The federal legislation does not require that a patient be informed that they have a grievous and irremediable medical condition in the context of an eligibility assessment for medical assistance in dying. As long as the patient was informed that their condition is grievous and irremediable before making a formal written request for medical assistance in dying, these requirements of the federal legislation are met.

If the patient requesting medical assistance in dying is unable to sign and date the request, another person who is at least 18 years of age, who understands the nature of the request for medical assistance in dying, and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or material benefit resulting from the patient`s death, may do so in the patient's presence, on the patient's behalf, and under the patient's express direction.

The patient's request for medical assistance in dying must be signed and dated before two independent witnesses, who then must also sign and date the request. An independent witness is someone who is at least 18 years of age, and who understands the nature of the request for medical assistance in dying.

An individual may not act as an independent witness if they are a beneficiary under the patient's will, or are a recipient in any other way of a financial or other material benefit resulting from the patient's death; own or operate the health care facility at which the patient making the request is being treated; or are directly involved in providing the patient's healthcare and/or personal care.

Physicians must document the date of the patient's request for medical assistance in dying in the medical record. Additionally, physicians must document the steps taken to satisfy themselves that the patient's written request for medical assistance in dying was signed by two witnesses. A copy of the physician's written opinion regarding whether the patient meets the eligibility criteria must also be included in the medical record.

The physician or nurse practitioner must remind the patient of his/her ability to rescind the request at any time.

The physician or nurse practitioner must remind the patient that they may, at any time and in any manner, withdraw their request.

An independent second physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for medical assistance in dying.

A second physician or nurse practitioner must assess the patient in accordance with the criteria provided above, and provide their written opinion confirming that the requisite criteria for medical assistance in dying have been met.

The first and second physician or nurse practitioner assessing a patient's eligibility for medical assistance in dying must be independent of each other. This means that they must not:

- Be a mentor to, or be responsible for supervising the work of the other physician or nurse practitioner;
- Know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
- Know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

If the second physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to have another physician assess them against the criteria.

A 10-day period of reflection from date of request to provision of medical assistance in dying.

(https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying) Accessed 2021-01-05

A period of at least 10 clear days[29] must pass between the day on which the request for medical assistance in dying is signed by or on behalf of the patient, and the day on which medical assistance in dying is provided.

In accordance with federal legislation, this timeframe may be shortened if both the physician(s) and/or nurse practitioner(s) agree that death or loss of capacity to provide consent is imminent.

Physicians must document the start and end-date of the 10-day reflection period in the medical record, and their rationale for shortening the 10-day reflection period if applicable.

Physician or nurse practitioner informs the dispensing pharmacist that prescribed substance is intended for medical assistance in dying.

Medical assistance in dying includes both situations where the physician or nurse practitioner writes a prescription for medication that the patient self-administers, and situations where the physician or nurse practitioner is directly involved in administering an agent to end the patient's life.

Physician(s) and/or nurse practitioner(s) must inform the pharmacist of the purpose for which the substance is intended before the pharmacist dispenses the substance.

Physicians are advised to notify the pharmacist as early as possible (e.g. at the commencement of the reflection period) that medications for medical assistance in dying will likely be required. This will provide the pharmacist with sufficient time to obtain the required medications.

Physicians must exercise their professional judgement in determining the appropriate drug protocol to follow to achieve medical assistance in dying. The goals of any drug protocol for medical assistance in dying include ensuring the patient is comfortable, and that pain and anxiety are controlled.

Physicians must document the medication protocol utilized (i.e. drug type(s) and dosages) in the medical record.

College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the College's website.

Providing Medical Assistance in Dying

The patient must be capable not only at the time the request for medical assistance in dying is made, but also at the time they receive medical assistance in dying.

Immediately before providing medical assistance in dying, the physician(s) and/or nurse practitioner(s) involved must provide the patient with an opportunity to withdraw the request and if the patient wishes to proceed, confirm that the patient has provided express consent. This must occur either immediately before the medication is administered or immediately before the prescription is provided.

Where medical assistance in dying is provided, physicians must document the patient's time of death in the medical record.

Physicians and nurse practitioners who provide medical assistance in dying, and those who assist them throughout the process, are protected from liability if they are acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules. These protections would extend, for example, to pharmacists, any individual who supports a physician or nurse practitioner (not limited to regulated health professionals), or individuals who aid a patient to self-administer the fatal dose of medication.

Where the patient plans to self-administer the fatal dose of medication at home, physicians must help patients and caregivers assess whether this is a manageable option. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.

Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.

Reporting Requirements and Certification of Death

Physicians who provide medical assistance in dying must report the medically assisted death to the Office of the Chief Coroner for Ontario (OCC).[30,31] Upon notification, the OCC will determine whether the death ought to be investigated. If the OCC determines that an investigation is not required, the physician or nurse practitioner who provided medical assistance in dying completes the death certificate. If the OCC is of the opinion that an investigation is required, the OCC would complete the death certificate.[32]

When completing the death certificate for a medically assisted death, the illness, disease, or disability leading to the request for medical assistance in dying must be recorded as the underlying cause of death. The death certificate must not make reference to medical assistance in dying, or the drugs administered to achieve medical assistance in dying.[33]

Endnotes

1. Section 4(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. (hereinafter *HCCA*).

2. An effective referral does not necessarily, but may in certain circumstances, involve a 'referral' in the formal clinical sense, nor does it necessarily require that the physician conduct an assessment of the patient to determine whether they are a suitable candidate for the treatment to which they object (in the context of medical assistance in dying, this means that the physician is not required to assess whether the patient is eligible for medical assistance in dying prior to making the effective referral).

3. 'Available and accessible' means that the health-care provider must be in a location the patient can access, and operating and/or accepting patients at the time the effective referral is made.

4. In the hospital setting, practices may vary in accordance with hospital policies and procedures.

5. The framework was enabled through amendments to the *Criminal Code*, R.S.C., 1985, c. C-46.

6. For more information and resources on medical assistance in dying, see the Ontario Ministry of Health's website: https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions

7. This policy will refer to nurse practitioners and pharmacists, where relevant, in order to reflect the language of the federal law. The policy does not set professional expectations and accountabilities for members of the College of Nurses of Ontario or members of the Ontario College of Pharmacists. For information on the professional accountabilities of nurse practitioners and other members of the College of Nurses of Ontario, please see the College of Nurses of Ontario document titled: Guidance on Nurses' Roles in Medical Assistance in Dying. For information on the professional accountabilities for members of the Ontario College of Pharmacists, please see the Ontario College of Pharmacists document titled: Medical Assistance in Dying: Guidance to Pharmacists and Pharmacy Technicians.

8. For example, counselling and prescribing.

9. This is notably different than Ontario's *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A, which does not specify an 'age of consent'.

10. Further details on interpreting the statutory definition of a grievous and irremediable medical condition can be found in companion resources authored by the federal government: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

11. The process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to MAID. More information on consent requirements can be found in the College's *Consent to Treatment* policy, which outlines the legal requirements of valid consent as set out in the *Health Care Consent Act, 1996*. In particular, in order for consent to be valid it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.

12. The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

13. The College also does not consider a request for medical assistance in dying to be an emergency.

14. *Carter v. Canada (Attorney General)*, 2015 SCC 5

15. See para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019 ONCA 393*

[16.] See the definition of effective referral provided in this policy and the companion *Advice to the Profession* document for more information and examples of what constitutes an 'effective referral'.

[17.] The Ministry of Health and Long-Term Care has established the Care Coordination Service (CCS) to allow clinicians, patients, and caregivers to access information about medical assistance in dying and end-of-life care options, and to connect patients with clinicians who provide medical assistance in dying. Clinicians seeking assistance in making an effective referral can call the CCS toll-free: 1-866-286-4023. If physicians have general questions about the CCS, or wish to register for the CCS as a willing provider, please contact the Ministry of Health and Long-Term Care at maidregistration@sasc.ca. The College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

[18.] Under section 11(8) of Ontario Regulation 865/93, made under the Medicine Act, 1991 (the "Registration

Regulation"), the following are terms, conditions and limitations of a certificate of registration authorizing postgraduate education:

1. The holder shall,
    1. Practise medicine only as required by the program in which the holder is enrolled,
    2. Prescribe drugs only for in-patients or out-patients of a clinical teaching unit that is formally affiliated with the department where he or she is properly practising medicine and to which postgraduate trainees are regularly assigned by the department as part of its program of postgraduate medical education, and

- Not charge a fee for medical services.

[19.] While the Office of the Chief Coroner for Ontario (OCC) must be notified of all medically assisted deaths, an investigation is not required unless the OCC deems one to be necessary. See Section 10.1(1) of the *Coroners Act,* R.S.O. 1990, c. C3 (hereinafter, "*Coroners Act*").

[20.] Following the provision of medical assistance in dying, the physician must notify a coroner by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death.

Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

[21.] The written request that is required as a safeguard in the *Criminal Code* must be duly signed, dated, and witnessed. The written request that triggers reporting requirements need not take this form.

[22.] For more information on physicians' reporting obligations, including reporting deadlines, please visit the Ministry of Health and Long-Term Care website: http://health.gov.on.ca/en/pro/programs/maid/#regulations

[23.] The Canadian MAID Data Collection Portal may be accessed via the Health Canada website: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary.html.

[24.] The Ministry of Health and Long-Term Care (MOHLTC) has developed clinician aids to support the provision of medical assistance in dying. These include forms to: (a) assist patients who request medical assistance in dying (http://bit.ly/29Sovs0); (b) assist physicians who provide medical assistance in dying (http://bit.ly/2a9M8Pf); and

(c) assist physicians who provide a written opinion confirming that the patient meets the eligibility criteria to receive medical assistance in dying (http://bit.ly/29Spk3Y).

[25.] If the OCC initiates an investigation, they will complete a replacement death certificate.

[26.] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of

Health, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

[27.] Liability protections extend to pharmacists, any individuals supporting physicians or nurse practitioners (not limited to regulated health professionals), and individuals who aid a patient to self-administer the fatal dose of medication, when acting in compliance with the federal

legislation and any applicable provincial or territorial laws, standards or rules.

[28.] The case of *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759, provides some assistance on what is meant by "reasonably foreseeable" in this context, stating at paras. 79 and 80:

[...] *natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.*

Although it is impossible to imagine that this exercise of professional knowledge and judgment will ever be easy, in those cases where a prognosis can be made that death is imminent, then it may be easier to say that the natural death is reasonably foreseeable. Physicians, of course have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.

[29.] The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day. Therefore, in the context of medical assistance in dying, the 10-day reflection period would commence on the day following the day on which the patient's request is made, and would end the day following the tenth day.

[30.] Section 10.1(2) of the *Coroners Act*.

[31.] Physicians notify the OCC of a medically assisted death by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

[32.] Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.

[33.] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.