Physician-Assisted Dying
Draft Guidance Document

Background

On February 6, 2015, the Supreme Court of Canada struck down the law prohibiting physician-assisted dying.[1] The court suspended that decision for 12 months. The effect of that decision is that, after February 6, 2016, it will not be illegal for a physician to assist a patient to die if:

1) The patient consents;
2) The patient has a grievous medical condition;
3) The condition is not remediable using treatments that the patient is willing to accept; and,
4) The patient's suffering is intolerable to the patient.

In the absence of federal, provincial or territorial legislation related to physician-assisted dying, it falls to the medical regulatory authorities in Canada to develop standards or guidance for physicians within their provinces or territories.

Introduction

This document is based upon the recommendations of the Advisory Group on Physician-Assisted Dying that was struck by the Federation of Medical Regulatory Authorities (FMRAC) in response to the aforementioned. That document was, in turn, based upon a draft framework from the Canadian Medical Association (CMA).

The College recognizes that there may be legislation in future which addresses some of the matters addressed in this document. Where such legislation exists, the provisions of that legislation will take priority over the provisions in this document if there is any inconsistency between the two.

The intention of this document is to provide guidance to physicians who are willing to participate in physician-assisted dying and to provide guidance to patients who seek to access physician-assisted dying.

[1] Carter v. Canada (Attorney General), 2015 SCC 5; https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html?resultIndex=1

Definition of "Physician-assisted dying" - For the purpose of this document, the College has adopted the definition of physician-assisted dying from the Supreme Court's decision in *Carter v. Canada*[2] as, "the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient."

Foundational Principles

The foundational principles used by the College in developing this document include:

1) *Respect for patient autonomy*: Competent adults are free to make decisions about their bodily integrity. Given the finality of physician-assisted dying, significant safeguards and standards are appropriate to ensure that respect for patient autonomy is based upon carefully developed principles to ensure informed patient consent and consistency with the principles established by the Supreme Court of Canada.

2) *Access*: Individuals who seek information about physician-assisted dying should have access to unbiased and accurate information. To the extent possible, all those who meet the criteria for physician-assisted dying and request it should have access to physician-assisted dying.

3) *Respect for physician values*: This document does not address the extent to which individual physicians may be expected to ensure that patients seeking information about physician-assisted dying receive that information or the extent to which physicians may be required to refer patients to another provider if the physician is unwilling to provide physician-assisted dying. Within the bounds of existing standards of practice, and subject to the obligation to practise without discrimination as required by the CMA *Code of Ethics* and human rights legislation, physicians can follow their conscience when deciding whether or not to provide physician-assisted dying.

4) *Consent and capacity*: All the requirements for informed consent must clearly be met. Consent is seen as an evolving process requiring physicians to continuously communicate with the patient. Communications include exploring the priorities, values and fears of the patient, providing information related to the patient's diagnosis and prognosis, providing treatment options including palliative care interventions and answering the patient's questions. Consent must be express and voluntary. Given the context, a patient's decisional capacity must be carefully assessed to ensure that the patient is able to understand the information provided and understands that the consequences of making a decision to access physician-assisted dying.

5) *Clarity:* Medical Regulatory Bodies should ensure, to the extent possible, that guidance or standards which they adopt:

a) provide guidance to patients and the public about the requirements which patients must meet to access physician-assisted dying;
b) advise patients what they can expect from physicians if they are considering physician-assisted dying; and,
c) clearly express what is expected of physicians.

6) *Dignity*: All patients, their family members and significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life.

7) *Accountability:* Physicians participating in physician-assisted dying must ensure that they have appropriate technical competencies as well as the ability to assess decisional capacity, or the ability to consult with a colleague to assess capacity in more complex situations.

8) *Duty to Provide Care:* Physicians have an obligation to provide ongoing care to patients unless their services are no longer required or wanted or until another suitable physician has assumed responsibility for the patient. Physicians should continue to provide appropriate and compassionate care to patients throughout the dying process regardless of the decisions they make with respect to physician-assisted dying.

1. Requirements for access to physician-assisted dying:

1.1 The attending physician in situations of physician-assisted dying must:

- Be qualified by specialty, training or experience to render a diagnosis and prognosis of the patient's illness, or be able to consult with a colleague who is so qualified to obtain the diagnosis and prognosis;
- Be qualified by specialty, training or experience to meet the requirements to provide physician-assisted dying;
- Be able to assess decisional capacity or be able to consult with a colleague to assess capacity in more complex situations; and,
- Have appropriate knowledge and technical competency to provide physician-assisted dying of the form to be administered.

1.2 Capacity

- The attending physician must be satisfied that the patient is:
  - Mentally capable of making an informed decision at the time of the requests and throughout the process; and,
  - Capable of giving consent to physician-assisted dying.
- If either the attending physician or the consulting physician is unsure whether the patient has capacity, the patient must be referred for further capacity assessment.

1.3 Voluntariness

- The attending physician must be satisfied, on reasonable grounds, that all of the following conditions are fulfilled:

  - The patient's decision to undergo physician-assisted dying has been made freely, without coercion or undue influence from family members, health care providers or others;
  - The patient has a clear and settled intention to end his or her own life after due consideration; and,
  - The patient has requested physician-assisted dying him/herself, thoughtfully and repeatedly, in a free and informed manner.

1.4 Informed Decision

- The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, the potential complications associated with the medication, and alternatives, including comfort care, palliative and hospice care, pain and symptom control and other available resources to avoid the loss of personal dignity. The physician must advise the patient of any counselling resources which are available to assist the patient. The attending physician must inform the patient of his or her right to rescind the request at any time. The attending physician has an obligation to take reasonable steps to ensure that the patient has understood the information that has been provided.

1.5 Consistency of Decision over time

- The attending physician must ensure that the patient has consistently expressed a desire for physician-assisted dying over a reasonable period of time. What is a reasonable period of time will be dependent on the patient's medical condition and other circumstances. As with any other medical intervention, the patient must consent to physician-assisted dying at the time that is provided by the physician.

1.6 Determining whether the **Carter** criteria are met

- A physician who assesses a patient for eligibility to access physician-assisted dying has an obligation to assess whether the patient meets the conditions established by the Supreme Court of Canada in the **Carter** decision. In addition to ensuring that the patient has provided informed consent to their death:

  1) The patient must have a grievous medical condition;
  2) That condition must not be remediable using treatments that the patient is willing to accept; and
  3) The patient's suffering must be intolerable to the patient.

- It is not possible to provide a practice guideline or treatment pathway which provides a detailed description of what a physician should do to ensure that those criteria are met. Patients will respond very differently to a grievous medical condition and will differ in the treatments which they are willing to accept. What is intolerable to a patient is subjective to the patient and what is intolerable suffering will significantly differ from one patient to another.
- However, physicians are expected to use appropriate medical judgment and follow a reasonable plan of assessment to ascertain whether the **Carter** criteria have been met for a specific patient.
- Physicians who are assessing a patient for eligibility for physician-assisted dying should consider whether to discuss the following matters with the patient to assist in the physician's determination.
- A physician should consider these issues from the patient's perspective and with reference to each dimension of suffering, both individually and in conjunction with each other. For most patients, suffering is not the simple sum of its parts but a complex constellation of different dimensions that serve to make it intolerable.

1) Current symptoms

Consider the patient's physical symptoms. Some symptoms which may be relevant, or which may lead to a discussion of the treatments available for such symptoms include: anxiety, ascites, bladder retention, cachexia, confusion, constipation, coughing, dehydration, depression, diarrhea, dry mouth, dysphagia, fever, hiccups, intestinal obstruction, nausea, pain (localized/forms), pressure sores, pruritus, shortness of breath, sleeping disorders, urinary/fecal incontinence, other symptoms.

2) Loss of function

Consider the patient's ability to function and the effect that loss of function may have on the specific patient. Some areas of loss of function which may be relevant to the patient include: the patient's ability to stand, walk, dress unassisted, wash, eat, drink, use the toilet, speak, hear, see, write, maintain consciousness and maintain concentration.

3) Expectation of progress of symptoms

Which symptoms have worsened and which will get worse? How does the patient experience these declines?

4) Expectation of progress of Loss of function

Which losses of function will stabilize and which will only decline further? How does the patient experience this?

5) Future suffering and available treatment

Which future suffering is anticipated? On what is this based? Is this realistic? Is this suffering treatable? If so, is it realistic to propose this treatment to the patient? If not, why? Does the patient wish to refuse treatment and is that refusal realistic in view of the anticipated consequences?

6) Suffering and personality

How does the patient describe his or her own character? Which symptoms trouble the patient the most, and why?

7) Suffering and personality-over-time (personal history)

What are the patient's religious beliefs and values? What was the patient's occupation? What are the patient's experiences with illness? What significance does his past have for the patient (loss of partners, experiences with violence)?

8) Environment

What is the patient's living situation? What care is available to the patient and what burden does the patient feel is placed on those who may provide care? What is the willingness and attitude of those who may assist the patient to obtain appropriate care? What length of time may caregivers be expected to provide care to the patient?

Acknowledgement

Much of the content of this section has been adapted from a document *The role of the physician in the voluntary termination of life* published by Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG).

1.7 The requirement of a second assessment

- The attending physician must consult a second physician before providing the patient with physician-assisted dying.
- The second physician must interact with the patient in order to meet the requirements of paragraph 1.8.

1.8 Documentation of Patient Wishes and Physician Assessment

- The attending physician and the consulting physician must complete a prescribed form to confirm that the patient meets the requirements for physician-assisted dying.
- The prescribed form to be completed by the attending physician should contain confirmation that the physician has advised the patient of counselling resources

which are available to assist the patient and that the physician has informed the patient of his or her right to rescind the request at any time.

- The prescribed form to be completed by the attending physician and the consulting physician should contain the following:

  - The physician's diagnosis and prognosis;
  - The physician's determination that the patient has a grievous medical condition that is not remediable using treatments that the patient is willing to accept and that the patient's suffering is intolerable to the patient; and,
  - The physician's determination that the patient is capable, acting voluntarily and has made an informed decision to seek physician-assisted dying.

- The patient must complete a prescribed form confirming that the patient has given informed consent to physician-assisted dying and that the requirements for physician-assisted dying have been met. Where a patient is mentally competent but incapable of completing such a form, a third party, independent of the physician and the patient, may complete the form on the patient's behalf based upon confirmation from the patient.

1.9 Documentation Requirements – the patient record

- The attending physician must document the following in the patient's medical record:

  - The information and documentation described in paragraph 1.8;
  - All oral and written requests by a patient for physician-assisted dying; and
  - A summary of discussions held with the patient relating to physician-assisted dying.

1.10 Report to the Coroner

- **The Coroner's Act, 1999** requires certain deaths to be reported to a coroner. A physician-assisted death is a reportable death and a physician participating in a physician-assisted death must comply with the requirements of that Act.

2. Standards for physician-assisted dying

1. The College of Physicians and Surgeons will establish standards for the performance of physician-assisted dying. Those standards are not yet developed.
2. The attending physician must be available to care for the patient until the patient's death, if the patient so requests.

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Submission to the College of Physicians and Surgeons of Saskatchewan

Re: *Physician-Assisted Dying Draft Guidance Document*

20 October, 2015

I. Introduction

I.1 The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience among health care workers. It does not take a position on the acceptability of morally contested procedures. For this reason, only a few points in the *Physician-Assisted Dying Draft Guidance Document* are addressed in this submission.

II. Scope of this submission

II.1 The Project makes some cautionary observations concerning the provision of information (Part III), specific recommendations concerning informed decision-making (Part IV) and one of the proposed standards (Part V), and offers a policy to ensure protection of physician freedom of conscience that can be applied to euthanasia and assisted suicide as well as other morally contested procedures (Part VI).

II.2 While it is outside the scope of Project interests, it seems prudent to point out that the draft document omits the Supreme Court of Canada requirement that candidates for euthanasia and physician assisted suicide must be *adults*.

III. Re: "unbiased and inaccurate information"

Guidance draft - Foundational Principles (2) Access

III.1 The draft document states: "Individuals who seek information about physician-assisted dying should have access to unbiased and accurate information."

III.2 Taken at face value, this is an entirely reasonable expectation. However, it must be understood that objecting physicians or health care workers who are explaining their own position to patients may make statements to the effect that they do not consider euthanasia and assisted suicide to be forms of medical treatment or palliative care. In the course of such conversations, they may also ethically distinguish

between withdrawal/refusal of treatment and killing patients or helping them to kill themselves.

III.3 Euthanasia/assisted suicide activists may take exception to statements or explanations of this kind, calling them biased and inaccurate. The College must not use this policy to try to force objecting physicians to express and live by the ethical beliefs of euthanasia/assisted suicide activists rather than their own.

IV. "certainty of death"

Guidance draft - 1.4 Informed Decision

IV.1 According to the draft, the patient must be informed of "the certainty of death upon taking the lethal medication" and "the potential complications associated with the medication."

IV.2 However, death is not always certain. Euthanasia and assisted suicide drugs do not always cause death as expected.[1] It is for this reason that Quebec euthanasia kits are to include two courses of medication.[2]

IV.3 Discussion with patients should include discussion of options available in the event that a lethal injection or prescribed drug does not kill the patient, and the patient should be asked to provide direction on this point. The relationship of this issue to physician freedom of conscience is addressed in Part V.

V. Responsible physician obligations

V.1 Pending the development of standards for the performance of physician assisted suicide and euthanasia, the *Draft Guidance Document* makes only a single statement:

> The attending physician must be available to care for the patient until the patient's death, if the patient so requests.

V.2 "Attending physician" in this context appears to refer to the physician who has agreed to assist with the patient's suicide or provide euthanasia rather than (for example) a family physician who has declined to do so, but who continues to be responsible for other aspects of patient care in accordance with Foundational Principle (8) in the document.

V.3 It would be helpful to make this explicit. To avoid ambiguity, it would also be helpful to use a specific term when referring to the physician who has agreed to assist with the patient's suicide or provide euthanasia (such as, "responsible physician" or "PAD physician"). The term "responsible physician" is used in this part.

V.4 Assisted suicide vs. euthanasia

V.4.1 A 2014 survey of Canadian Medical Association members indicated that more physicians were willing to participate in assisted suicide (27%) than euthanasia (20%).[3,4,5,6]

V.4.2 However, a physician who agrees to help a patient commit suicide would seem to have accepted an obligation to do something that will result in the patient's death, and to do it according to accepted standards. This obligation seems implicit in the agreement.

V.4.3 In the case of a failed physician-assisted suicide that incapacitates a patient, it is likely that the responsible physician will be expected to fulfil his commitment to help bring about the death of the patient by providing a lethal injection or finding someone willing to do so. The expectation would be stronger if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt.

V.4.4 Here the issue of physicians willing to assist in suicide but unwilling to provide euthanasia becomes acute. Those willing to assist with suicide but not euthanasia may be reluctant or unwilling to ask another colleague to kill the patient. Moreover, the *Carter* ruling limits the provision of euthanasia to competent patients. Thus, to ask physicians to kill a patient who has been rendered incompetent by a colleague's failed attempt would seem to expose them to prosecution for first degree murder or, at least, assisted suicide.

V5. Urgent situations

V.5.1 Some authorities have stated that a physician's obligation to provide treatment urgently needed to prevent imminent harm to patients does not extend to providing assisted suicide or euthanasia.[7] This presumes that, since the procedures require extensive preliminary consultation and preparation before they can be authorized, they can never be urgently required.

V.5.2 That presumption is challenged by testimony taken by the Quebec legislative committee studying what later became the province's euthanasia law (*An Act Respecting End of Life Care*). Representatives of the College of Pharmacists of Quebec agreed that the provision of euthanasia would not seem to involve "the same urgency" as other kinds of procedures, and that arrangements could normally be made to accommodate conscientious objection by pharmacists because the decision could be anticipated.[8] However, they also stated that situations may evolve more quickly than expected, and that (for example) palliative sedation might be urgently requested as a result of respiratory distress precipitated by sudden bleeding.[9]

V.5.3 The pharmacist representatives distinguished between making a decision that euthanasia or assisted suicide should be provided - a decision which might take days or weeks - and

a decision that a drug should be urgently provided to deal with an unanticipated and critical development in a patient's condition.[10]

V.5.4 Under the terms of the *Carter* ruling and the *Draft Guideline Document*, it is possible that a responsible physician might agree to provide euthanasia or assisted suicide on a given date and time, to accommodate (for example) the desire of geographically distant family members to be present at the patient's death. Between the time that decision is made and the appointed time, however, a sudden deterioration of the patient's condition may cause him to ask for immediate relief from pain or suffering by euthanasia or assisted suicide.

V.5.5 No problem will arise if the responsible physician is immediately available to fulfil the request. However, there is likely to be a problem if the responsible physician is absent or unavailable, and other physicians willing to kill the patient or assist in suicide cannot be conveniently found. This situation is more likely to arise if the originally appointed time for euthanasia/assisted suicide is some days later than the decision to provide the procedure.

V.6 Recommendations

V.6.1 In order to avoid conflicts of conscience occurring in particularly difficult circumstances, and to avoid conflicts of conscience among health care workers who may be involved in other aspects of the care or treatment of a patient:

1) Physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.

2) In all cases, the responsible physician should, immediately prior to administering or providing the lethal medication, obtain written direction from the patient as to what action should be taken if the prescribed or administered drugs fail to cause death. (NB. In the case of patients incapacitated by failed euthanasia/assisted suicide, it is not known if this would be legally sufficient to invoke the exemption from prosecution provided by *Carter*.)

3) The responsible physician should personally administer the lethal drug or be personally present when it is ingested, and remain with the patient until death ensues.

4) A responsible physician who has agreed to provide euthanasia or assisted suicide must be continuously available to do so from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request.

5) A responsible physician who has agreed to provide euthanasia or assisted suicide must also arrange for a second responsible physician to provide the procedure in the event that he is unable to be continuously present or is unable to act.

6) The second responsible physician must be continuously available to act in the place of the primary responsible physician.

VI. Suggested policy on physician exercise of freedom of conscience

VI.1 Appendix "A" provides a policy concerning the exercise of freedom of conscience by physicians that, in the Project's experience, would be acceptable to most objecting physicians, even with respect to euthanasia and assisted suicide. It is consistent with

- the *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999);
- the Canadian Medical Association *Code of Ethics* (2004);
- the Canadian Medical Protective Association publication, *Consent: A guide for Canadian physicians* (2006);
- the Canadian Medical Association's *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015)

VI.2 The policy provides seven alternative responses for objecting physicians, reflecting the fact that different ethical, moral or religious traditions may take different approaches to the issue of complicity in morally contested acts. Further, within some traditions, the facts of a particular case may influence the moral judgement of a physician.

VI.3 CMA guidance noted in VI.1 does not preclude the other alternatives in the suggested policy for reasons given by the Association to the Supreme Court of Canada:

> The CMA's purpose, in developing and setting policy, is not to override individual judgment or to mandate a standard of care.[11]
>
> The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience.[12]

VI.4 None of the responses obstruct patient access to euthanasia or assisted suicide. Some responses involve deliberate of facilitation of the services. It is up to the physician to decide which response to choose in each case.

Appendix "A"

Physician Exercise of Freedom of Conscience and Religion

AI. Introduction

AI.1 To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of Parts AII and AIII for services they are unwilling to provide for reasons of conscience or religion.

AII. Providing information to patients

AII.1 This Part highlights points of particular interest within the context of the exercise of freedom of conscience. It is not an exhaustive treatment of the subject of informed consent.

AII.2 In exercising freedom of conscience and religion, physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21[14]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Disclosure of information; Standard of disclosure.[15]
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 1.2, 5.2[16]

AII.3 Sufficient information is that which a reasonable patient in the place of the patient would want to have, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21[14]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (1), (2).

(4), (5)[15]

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 1.2, 5.2[16]

AII.4 Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

AII.5 Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician.

- Canadian Medical Association *Code of Ethics* (2004) para. 23[17]

AII.6 Physicians whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.

- Canadian Medical Association *Code of Ethics* (2004) para.45[18]

AII.7 The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21,[14] 22[19]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (3)[15]
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Foundational Principle (6), (10)[20]

AII.8 Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

AIII. Exercising freedom of conscience or religion

AIII.1 In exercising freedom of conscience and religion, physicians must adhere to the requirements of Part AII (Providing information to patients).

AIII.2 In general, and when providing information to facilitate informed decision making, physicians must give reasonable notice to patients of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 12,[21] 21[14]

AIII.3 Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted.

AIII.4 In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

AIII.5 Physicians who decline to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere, and provide information about how to find other service providers. Should the patient do so, physicians must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient.

- (CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10[13]
- Canadian Medical Association *Code of Ethics* (2004) para. 21[14]
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 5.2[22]

AIII.6 Alternatively, in response to a patient request, physicians may respond in one of the following ways, consistent with their moral, ethical or religious convictions:

a) by arranging for a transfer of care to another physician able to provide the service; or

b) by providing a formal referral to someone able to provide the service; or

c) by providing contact information for someone able to provide the service; or

d) by providing contact information for an agency or organization that will refer the patient to a service provider; or

e) by providing contact information for an agency or organization that provides information the patient may use to contact a service provider; or

f) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, heath care workers or sources of information about the services being sought by the patient.

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 5.2[22]

AIII.7 A physician's response under AIII.5 or AIII.6 must be timely. Timely responses will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

AIII.8 In acting pursuant to AIII.5 or AIII.6, physicians must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16, II.11[13]

- Canadian Medical Association *Code of Ethics* (2004) para. 19,[23] 21[14]

AIII.9 Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

AIII.10 Physicians who provide medical services in a health care facility must give reasonable notice to a medical administrator of the facility if religious, ethical or other conscientious convictions prevent them from providing certain procedures or services, and those procedures or services are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility.

AIV. Reminder: treatments in emergencies

AIV.1 Physicians must provide medical treatment that is within their competence when a patient is likely to die or suffer grave injury if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment.

- Canadian Medical Association *Code of Ethics* (2004) para. 18[24]

AIV.2 Physicians who fail to provide or arrange for medical treatment in such circumstances may be liable for negligence or malpractice.

Notes

1. Groenewoud JH, van der Heide A. Onwuteaka-Philipsen BD Willems DL van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *N Engl J Med* 2000; 342:551-556 February 24, 2000

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