

Advice to the Profession:
Medical Assistance in Dying (MAID)

Regulatory authority for [*Physicians/Nurses*] of [*jurisdiction*]



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1. Is it necessary to assess capacity to consent to MAID?

Yes. A person who wishes to access MAID must have the decision-making capacity to give a free and informed consent to receive MAID and this must be established before MAID is provided. Consent given by a substitute decision-maker must not be acted upon even if the substitute decision-maker has been consenting to other kinds of interventions on behalf of the person.

In addition to being familiar with any legal and regulatory requirements for capacity, practitioners should familiarize themselves with rigorous and established capacity assessment methods and tools.

Greater thoroughness in the process of assessing capacity is required for decisions with greater complexity or risk.

Capacity to consent to an intervention is context, task, and time specific. For individuals with fluctuating capacity, efforts should be made to assess capacity when they are at their best level of cognitive function. Reasonable efforts should be made to ensure that the assessment is adapted to the individual's needs. For example, assessors and providers should be alert to sensory, language, and speech deficits as well as slowed processing related to situations such as high doses of pain medications or ongoing substance use disorder and should make reasonable efforts to ameliorate them in the context of MAID discussions. In some cases, it may be necessary for assessors and providers to undertake serial assessments of a person's decision-making capacity in order to have enough information to make a judgment. Care must also be taken to ensure that the approach to the assessment is culturally appropriate.

As with all clinical care, the assessment of capacity in different cases can range from relatively straightforward to very challenging. Assessors and providers should be alert to situations in which capacity assessment requires additional knowledge and experience in this area and, in such cases, should seek assistance through consultation with colleagues.

The presence or a history of illness that may adversely affect capacity or a previous finding of incapacity to consent to a treatment or intervention including incapacity to receive MAID, does not automatically mean a person is **currently** incapable of consenting to MAID. Similarly, a past history of suicidality does not mean that a person is necessarily incapable of consenting to MAID. Capacity needs to be assessed in the context of the current request.

Assessors and providers must document the reasoning and evidence upon which their assessment of capacity was based supporting their finding of capacity or incapacity.

2. What is irremediability?

The legal term ‘irremediable’ is part of the MAID eligibility criterion ‘grievous and irremediable medical condition.’ This criterion is defined in the *Criminal Code* by way of three components: a serious and **incurable** illness, disease or disability; an advanced state of **irreversible** decline in capability; and enduring and intolerable suffering that **cannot be relieved** by means acceptable to the person. Because the expression ‘grievous and irremediable medical condition’ is already defined in this way in the *Criminal Code*, MAID assessors must establish whether this criterion is fulfilled by ensuring all of the three components are met. This is further explained under Questions 3 and 4.

3a) How do I assess incurability?

A person who requests MAID may believe that they have a serious and incurable illness, disease, or disability. However, it is the assessor and provider who must be of the opinion that the person has a serious and incurable illness, disease, or disability.

‘Incurable’ means there are no reasonable treatments remaining, where reasonable is determined through a process of the clinician and patient together exploring the recognized, available, and potentially effective treatments in light of the person’s overall state of health, beliefs, values, and goals of care.

At the time of the MAID eligibility assessment, assessors and providers should explore treatment attempts made up to that point including their duration and intensity, outcomes of those treatments, and severity and duration of illness, disease, or disability.

3b) Is there a specific number of treatment trials a person has to have had before they can be considered to have an incurable condition?

No. It is not possible to give a specific number of treatments a person must have tried that will apply to all medical conditions leading to a MAID request. Each condition has its own treatment approach including standard or recognized treatments for that condition. To understand the range of treatment options available, clinicians can refer to recognized clinical practice guidelines for the specific condition underlying a person’s MAID request, or where guidelines do not exist, to the scientific literature and clinicians experienced in treating the condition.

The incurability of the illness, disease, or disability does not require that a person has attempted every potential option for intervention irrespective of the potential harms, nor that a person must attempt interventions that exist somewhere in the world but are inaccessible to them. At the same time, a capable person cannot refuse all or most interventions and automatically render themselves incurable for the purposes of accessing MAID. An assessor or

provider cannot form an opinion about MAID eligibility in the absence of evidence required to form that opinion, i.e., that there are no reasonable treatments remaining where reasonable is determined through a process of the clinician and patient together exploring the recognized, available, and potentially effective treatments in light of the patient's overall state of health, beliefs, values, and goals of care.

4. How do I assess an advanced state of irreversible decline in capability?

A person who requests MAID may believe that they are in an advanced state of irreversible decline in capability. However, it is the assessor and provider who must be of the opinion that the person is in an advanced state of irreversible decline in capability.

'Capability' refers to a person's functioning (physical, social, occupational, or other important areas), not the symptoms of their condition. 'Function' should be understood as the ability to undertake those activities that are meaningful to the person. 'Advanced state of decline' means the reduction in function is severe.

For example, a person may have incurable symptoms of a disorder, but this does not mean that they are in a state of decline or, if they are in a state of decline, that it is advanced and irreversible. The opposite is also true, as someone can be in an advanced state of irreversible decline in capability but still have potential for symptom improvement.

'Irreversible' means there are no reasonable interventions remaining, where reasonable is determined through a process of the clinician and patient together exploring the recognized, available, and potentially effective interventions in light of the patient's values, overall state of health, beliefs, values, and goals of care.

At the time of the MAID eligibility assessment, assessors and providers should explore attempts at interventions made up to that point, outcomes of those interventions, and severity and duration of illness, disease, or disability. How many interventions, how many kinds of interventions, and over what period of time will vary according to the requester's baseline function as well as functional goals.

The irreversibility of decline does not require that a person has attempted every potential intervention irrespective of the potential harms, nor that a person must attempt interventions that exist somewhere in the world but are inaccessible to them. At the same time, a capable person cannot refuse all or most interventions and automatically render themselves in an advanced state of irreversible decline for the purposes of accessing MAID. An assessor or provider cannot form an opinion about MAID eligibility in absence of the evidence required to form that opinion, i.e., that there are no reasonable interventions remaining where reasonable is determined through a process of the clinician and patient together exploring the recognized,

available, and potentially effective interventions in light of the patient's overall state of health, beliefs, values, and goals of care.

5. What does it mean to make a voluntary request?

As in all clinical care, MAID assessors and providers must be satisfied that the person's decision to request MAID has been made freely, without undue influence (contemporaneous or past) from family members, health care providers, or others.

Undue influence occurs when a person is not able to act in their own interests because of the interference by others.

This undue influence may occur as a result of current or past pressure. For example, past abusive relationships may have been sufficiently severe that the person is not able to do what is good for them, but rather evaluates decisions according to what the abuser thinks or thought was good for them. However, having experienced trauma does not mean that that one cannot make a voluntary request.

The practitioner must assess whether the voluntariness of a person's request has been compromised (e.g., by incentives or threats). Practitioners should speak with the requester alone as part of the assessment process. If that is not possible because the requester requires supports (whether physical supports or for communication), the person providing support should not be someone who might be a source of undue influence. The practitioner should ask questions that will help to identify undue influence, such as interpersonal dependencies or past abuse that may leave the requester vulnerable. The practitioner should take steps to eliminate threats to voluntariness, and this may require serial assessments.

A person's request may not be voluntary at one time, but voluntary at a later time and vice versa. The assessor and provider must be satisfied the request is voluntary when it is made and the provider must be satisfied it is voluntary when MAID is provided.

6. How do I assess whether a person's request for MAID is a form of suicidal ideation?

It is important to remember that suicidality (thoughts or wishes to be dead, plans, notes) can arise at any time during the life span, including at the end of life. Completed suicide is not exclusive to persons with mental disorders, but as a group, persons with mental disorders are at higher risk of completed suicide as are certain other demographic groups such as Indigenous persons and military veterans. It is also important to remember that not all individuals with mental disorders experience suicidality, including those for whom suicidality is a potential symptom of the condition (a person can have such a condition without having that symptom).

At an individual level, anyone with suicidal ideation may require active suicide prevention efforts whether or not they belong to a high risk group. Similarly, a MAID request by a person who belongs to a high risk group should not be assumed to be evidence of suicidality. There is debate about whether to consider a request for MAID as a form suicidal ideation. However, without needing to resolve that debate, clinical management in other situations of life-ending decision-making can point practitioners towards appropriate management of MAID requests by persons with mental disorders.

For example, if a person states that they wish to discontinue a life-maintaining treatment (e.g., renal dialysis), the treating clinicians will undertake several complementary and contemporaneous actions. They will assess the person's capacity to consent to or refuse dialysis. They might request a psychiatric consultation – including on an urgent basis – if they have reason to believe there is a psychiatric disorder influencing the person's decision-making capacity. If the person suddenly stopped attending dialysis without notice, particularly if it is impulsive or seemingly inconsistent with a person's prior stated wishes, the practitioner might ask the person to come to hospital or be brought by family, or if the person is refusing to come, request that the police bring the person to hospital against their will due to dangerousness to self due to mental state or mental disorder as defined under provincial/territorial laws. Finally, and in parallel, clinicians will try to explore the problems making dialysis difficult to endure and propose solutions that might address these problems. This latter step will be undertaken whether the person is capable or incapable, voluntary or involuntary. These different actions will be guided by knowledge of the person's past behaviour, whether or not there is an untreated or unstable psychiatric disorder, and whether the person had made references or allusions to wanting to end their life, made plans to end their life, or undertaken actions to further those plans such as researching means and self-harming behaviours.

A similar approach can be taken towards a person (including a person whose mental disorder is their sole underlying medical condition) who makes a MAID request. Whether or not to request an urgent psychiatric consultation and engage in suicide prevention efforts (voluntarily or involuntarily) will depend on the extent to which the person's mental disorder is untreated or unstable as well as their associated risk behaviours as mentioned above.

Clinicians should always be alert to the possibility of acute suicidality and should mobilize individual suicide prevention efforts where appropriate. These will often include referral to mental health resources for assessment and follow-up. MAID eligibility assessments must not be undertaken in circumstances of acute suicidality.

Please see the Appendix to this document, Helpful Resources, for additional information about the management of suicidality.

7. If a person with a mental disorder makes a MAID request, could this be grounds for an application for involuntary hospitalization based on dangerousness to self?

By itself, a request for MAID by a person with a mental disorder should not be interpreted as dangerousness to self as understood in provincial/territorial mental health legislation. The majority of MAID requests by persons with mental disorders (including where it is the sole underlying medical condition) will fall under Track 2 and require a minimum 90-day period from the time the assessment begins to provision of MAID (should the person be eligible). Therefore, the requirement of proximate harm to self in the mental health legislation of most provinces and territories permitting involuntary hospitalization is not met by the simple fact of making a MAID request.

Persons who are involuntarily hospitalized or subject to Community Treatment Orders are not automatically excluded from making MAID requests. Practitioners should be up to date about the relevant policies in respect of how to handle MAID requests in these contexts in their province or territory.

8. What if a requester refuses to allow the assessors to obtain collateral history and/or access to the person's health records?

Obtaining 'collateral history' (discussions with people who know and interact with the person such as those within the person's social circle and past or current treating clinicians) and reviewing past health records is often an essential part of clinical assessments. Assessors and providers must obtain collateral information and review health records as necessary to complete a thorough MAID eligibility assessment. Assessors and providers must have the requester's consent to seek collateral information and, in most jurisdictions, to obtain past health records, including documentation of past MAID assessments.

Where a requester refuses to consent to the assessors communicating with other clinicians, family members or other significant contacts, and/or for access to health records, the reasons for refusal should be explored. There may be good reasons that led to the refusal. For example, there may be a history of serious conflict or abuse in the relationship such that the requester may fear that seeking collateral information may reactivate conflict or abuse. In such cases, the practitioner can work with the requester to seek alternative sources of needed information. Alternatively, the requester may misunderstand the rights of a person who gives collateral information. For example, they may believe that a person giving collateral history can veto the MAID request (which they cannot). In such cases, the practitioner should clarify the purpose of seeking collateral information and how such information will be used.

If, however, a requester refuses consent to access collateral information and/or records without sufficient reason and the assessor believes in good faith that the information is needed to form the opinion about eligibility, the assessor must explain to the requester that the assessment cannot be completed because of this refusal and therefore, they cannot be found eligible for MAID.

9a) One of the Track 2 safeguards is that before a practitioner provides MAID they have to ensure the person has been informed of the means available to relieve suffering. What does this involve?

This requirement is a legislated safeguard that applies only to Track 2 MAID requests. As such, it is an important means of protection for this group of requesters.

The *Criminal Code* provides a list of examples of means that could relieve a person's suffering. These include: counselling services; mental health and disability support services; community services; and palliative care. Community services must be taken to include housing and income support.

This list is not exhaustive and individual practitioners or MAID programs may be aware of other means available in their areas or professional networks that could relieve suffering. The means available that must be discussed with the requester are those that are reasonable and recognized.

The *Criminal Code* also requires that the requester be offered consultations with relevant professionals who provide those services or that care. Providers have the responsibility to ensure this requirement is fulfilled but may work in a multidisciplinary network or team in which colleagues assist with this process. Assessors and providers should themselves strive to become knowledgeable about existing resources and competent in system navigation.

9b) One of the Track 2 safeguards is that a person has to have given 'serious consideration' to the means available to relieve suffering. What does this mean? Is this different from the person having capacity?

This requirement is a legislated safeguard that applies only to Track 2 MAID requests. As such, it is an important means of protection for this group of requesters.

Capacity to provide informed consent to receive MAID is a separate legislative requirement from the requirement for a person to have given serious consideration to the means available to relieve suffering.

Serious consideration requires the *exercise* of decision-making capacity not only *possessing* decision-making capacity. In other words, a person must actually understand and appreciate the different elements of the decision, not merely have the ability to understand and appreciate. ‘Serious’ means that the consideration must be careful and non-impulsive. Serious consideration includes a genuine openness to the means available to relieve suffering.

In cases where a mental disorder is the primary motivating condition causing a person’s suffering, establishing that the person has given ‘serious consideration’ to the means available to relieve suffering requires an awareness of how the symptoms of the mental disorder may impact the person’s ability to consider options in this manner.

10. Do I need special training to assess MAID eligibility and provide MAID?

As with any other practice that is new to a clinician, practitioners should pursue the necessary training to develop the professional competencies required. For MAID, this should include training in capacity assessment, trauma-informed care, and cultural safety and humility. Clinicians should also ensure that they have training that is appropriate to the kinds of MAID cases in which they are involved.

Training may take the form of participating in classes or courses offered within undergraduate or postgraduate health professional training programs or by professional associations, regional health authorities, provincial and territorial ministries of health and/or working with experienced MAID assessors and providers.

11a) Do medical specialists have to be the assessors for certain types of MAID requests?

No. The *Criminal Code* requires that assessors and providers who do not have expertise in the condition causing the person’s suffering consult with a physician or nurse practitioner with such expertise. In other words, if neither of the assessors has this expertise themselves, they must ensure they consult with someone who does. Depending on the case, they may require this expertise in matters of diagnosis, treatment options, and capacity assessment, among others.

The choice of the person with expertise (or people, if multiple types of expertise are required) should be directly related to the knowledge and experience that is required by the case. Although the person with expertise is not legally required to be a medical specialist, the clinical opinions being sought will often require specialty-level knowledge and experience. For example, in the majority of cases where the requester has a mental disorder as a sole underlying medical condition (MD-SUMC), a psychiatrist or even a psychiatric subspecialist will likely be the person with expertise. However, there may be MD-SUMC requests in which the

specifics of the person's condition mean that the person with expertise should be a geriatrician, a neurologist, or a consultant from addictions medicine.

It is essential that everyone involved understand that the person with expertise is not being asked to assess the person's eligibility for MAID.

11b) What does it mean to 'consult with' a physician or nurse practitioner with expertise?

If neither of the two clinicians who are involved in assessing a person's request for MAID have expertise in the condition causing the person's suffering, they must consult with a physician or nurse practitioner who has this expertise. In this context, to 'consult with' means to seek out the expertise in areas where the assessor or provider do not have the necessary degree of knowledge and experience. Input of different types may be needed such as: elaboration on therapeutic options, diagnostic clarification, or evaluation of the adequacy of past treatments. 'Consult with' is not limited to the meaning of 'consultation' as it is laid out, for example, in physician fee schedules. Depending on the clinical question being asked, it may require one or more meetings with the person requesting MAID or it may require one or more case discussions with the assessor and/or provider.

12. What if an eligible person wishes to proceed with MAID without informing family and/or friends?

Assessors and providers must not disclose that a person has requested or received MAID to a person's family or friends without the express consent to do so from the person. That said, a person's family and friends can be harmed if they are not aware that their loved one has requested or received MAID. Assessors and providers should explain the potential harms of non-disclosure to the person but must respect a capable person's privacy and confidentiality.

13a) What are social determinants of health and what is structural vulnerability?

The social determinants of health are the non-medical factors that influence health outcomes.¹ These include income, education, employment, housing status, race, and ethnicity among several others. But why would differences in these non-health related factors influence health outcomes? This is due to social, political, and economic structures.

¹ https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

For example, a higher income may be associated with better health outcomes, but an individual's efforts to increase their income (through further education) may be constrained by systemic barriers (like tuition fees, lack of accessible childcare, or poor public transit) that are difficult to overcome. A person is 'structurally vulnerable' with respect to health, when systemic barriers work against the person achieving better health outcomes.

In addition, there may be negative conclusions or stereotypes drawn about people in situations of structural vulnerability. For example, one may characterize an individual as making poor choices (not pursuing education) rather than focusing on the social forces that led to those choices.

13b) What are practitioners' responsibilities with respect to structural vulnerabilities in the context of MAID requests?

Because systemic barriers and biases are part of the fabric of our society, they cannot be undone by a single practitioner in the course of an individual MAID assessment. What then are practitioners' responsibilities?

As in all clinical practice, practitioners should strive to be aware of structural vulnerability and how associated systemic barriers and biases against MAID requesters may have affected their interactions in the healthcare system and their ability to access appropriate resources. For example, certain groups such as people living with disabilities, and racialized and Indigenous persons have been subject to long-standing discrimination in and by the health system. In their assessments of individuals requesting MAID, practitioners must work to keep systemic biases out of their assessment.

There may be situations in which a practitioner finds themselves in the following dilemma: a person fulfills the eligibility criteria for MAID but the means that could relieve suffering are not available due to systemic barriers. On the one hand, providing MAID might lead the practitioner to believe they are complicit with societal failures. On the other, not providing MAID to a person who wishes to access it and fulfills the eligibility criteria might lead the practitioner to believe they are forcing the requester to live in a state of intolerable suffering. As in all clinical practice, practitioners must navigate these tensions by focusing on informing requesters about all available options and doing whatever is in their power to remove barriers and biases encountered by individual requesters. Of course, a clinician is never compelled to provide MAID in the face of such a dilemma.

13c) What if a requester must wait to gain access to a treatment or intervention that is aimed at relieving their suffering?

If a requester can gain access in a reasonable timeframe to an established and effective intervention aimed at alleviating the suffering related to the request for MAID, the assessor should advise the requester that they cannot form the opinion that the person is eligible for MAID (reasonable is determined through a process of the clinician and person together exploring how much time the person can wait in light of their overall state of health, beliefs, values, and goals of care).


14. When is it appropriate to initiate discussion about MAID as an option?

This question has been raised because of concerns that in some situations people do not know that MAID is legal and do not know to ask about it or are denied information about MAID when they wish to receive it. On the other hand, concerns have also been raised that if clinicians raise the topic themselves this may communicate a lack of hope about the person's future health or constitute pressure to consider MAID when a person does not want it.

As in all situations of clinical care, practitioners have a responsibility to respond to patients' questions and requests for information about MAID either directly themselves or by ensuring contact with an individual or a MAID program which can provide the information. A practitioner must either answer questions and provide information or ensure the person can get answers and information from appropriate alternative sources of information in a timely fashion.

As in all situations of clinical care, practitioners have a responsibility to explore patients' values and discuss their goals for care. Practitioners should always provide information about treatment options and services that are appropriate to the patient's condition, in light of these values and goals of care. If a practitioner has determined that MAID is consistent with a patient's values and goals of care and has good reason to believe that the person might be eligible to receive MAID, the practitioner must inform the patient about MAID. The practitioner must also indicate an openness to discussing the topic and be attentive to the patient's wishes about further dialogue. The timing of initiating a conversation about MAID should be determined by the practitioner, using their professional judgment, and should be undertaken with care, skill, and sensitivity. If a practitioner is not willing to initiate a discussion about MAID, they must provide an effective [*referral/transfer of care*] to another [*physician/nurse practitioner*] or program who is willing to initiate the discussion.

If a practitioner is aware that MAID is not consistent with a patient's values and goals of care, they should not initiate a discussion about MAID.



In either case, the practitioner should document that the conversation has or has not taken place and their rationale for the decision.

15. What if I receive threats from requesters or family members?

In some cases, assessors and providers have received threats from requesters or family members that they will file complaints to regulatory authorities or hospital complaint officers, initiate lawsuits, or even act violently towards them or colleagues.

If a requester makes threats, they should receive a clear statement from the assessor and/or provider that MAID eligibility assessments cannot proceed in circumstances of aggression and fear.

With respect to threats from family members, assessors and providers should remain non-defensive but should seek advice from institutions, insurers, and trusted colleagues.

Appendix – Helpful Resources

Assessment and provision flowchart (Ontario)

[Centre for Effective Practice: Medical Assistance in Dying](#)

Initiating a Discussion about MAID

[Canadian Association of MAID Assessors and Providers \(CAMAP\): Bringing up MAID as a clinical care option](#)

[Canadian Medical Protective Association \(CMPA\): Patient-centred communication](#)

Capacity and Informed Consent

[CMPA: Informed Consent](#)

[CAMAP: Assessment for Capacity to give Informed Consent for MAID](#)

Cultural Safety and Humility

[National Collaborating Centre for Indigenous Health: Cultural Safety Collection](#)

[Ministère de la santé et des services sociaux du Québec : La sécurisation culturelle en santé et en services sociaux](#) (French only)

Managing Suicidality

[Centre for Addiction and Mental Health: Managing Suicidality](#)

[UpToDate: Suicidal ideation and behaviour in adults](#)

[Sadek, Joseph \(2019\): A Clinician's Guide to Suicide Risk Assessment and Management](#)

Lebel, G., Ste-Marie, R., Boudrias, N., & Montreuil, M. (2018). [Cadre de référence du Guide d'évaluation de la personne à risque suicidaire \(GÉRIS\)](#). CIUSSS de l'Ouest-de-l'Île-de-Montréal (French only)



Trauma-informed Care

[Klinik Community Health Centre: The Trauma Toolkit, Second Edition](#)

[BC Mental Health & Substance Use Services: Trauma-informed Practice](#)

[Trauma-informed care and suicide](#)

Structural Vulnerability

[Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care - PubMed \(nih.gov\)](#)