



Standard of Practice:

Medical Assistance in Dying (2017)

A **Standard of Practice** is the minimum standard of professional behavior and ethical conduct expected by the College on a specific issue.

Medical Assistance in Dying

Preamble

On February 6, 2015, the Supreme Court of Canada issued a ruling in *Carter v Canada (Attorney General)* striking down certain provisions of the *Criminal Code of Canada* relating to medically assisted death. The federal government passed related legislative amendments in *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* on June 17, 2016 (SC 2015, c 3).

It is now legal for a qualified medical professional in Canada to assist an adult patient to die, where specified criteria have been met. Risks associated with medical assistance in dying can be limited through a carefully designed and monitored system of procedural safeguards and oversight. These can be found in standards of practice such as this one, regional health authority internal rules and regulations, legislation (federal or provincial), and other sources.

Physicians are encouraged to consult legal counsel, for example through the CMPA, to discuss unique or specific circumstances which may arise, or to obtain specific advice regarding the current state of the law relating to medical assistance in death. The College recognizes and anticipates that this Standard may require amendment as additional legislative responses emerge.

Standard of Practice

1. Foundational Principles

1.1 This Standard should be interpreted in a manner that:

- (a) respects the autonomy of patients, such that capable adults are free to make decisions about medical assistance in dying within the criteria established in this Standard;
- (b) simultaneously respects the right of physicians to refuse to provide this intervention in instances where a patient does not meet the legislative criteria, or the physician declines on personal grounds;
- (c) maintains the dignity of patients and treats patients, their family members, and others involved in end-of-life decisions with respect;
- (d) encourages equitable access to medical assistance in dying;
- (e) recognizes an appropriate balance between freedom of conscience of the physician and the patient's right to life, liberty and security of the person.

2. **Purpose of Standard**

2.1 This Standard:

- (a) provides information that will assist physicians and the public to understand the criteria and procedural requirements that must be met regarding medical assistance in dying;
- (b) outlines specific requirements for medical assistance in dying, including the criteria that must be met for a patient to be eligible;
- (c) outlines the procedures to be followed by licensed Newfoundland and Labrador physicians who are approached by patients to request medical assistance in dying;
- (d) provides document templates to assist physicians and patients involved in medical assistance in dying;
- (e) emphasizes the importance of complying with reporting requirements, and oversight mechanisms, if any, relating to medical assistance in dying.

3. **Definitions**

3.1 Certain terms have a specific meaning in this Standard.

- (a) **adult** means a person who has attained the age of 18 years, and it does not include a mature minor for the purposes of this Standard;
- (b) **capacity** means the ability to understand the subject matter in respect of which a health care decision must be made, and to appreciate the consequences of that decision;

- (c) **eligibility criteria** means the criteria set out in this Standard, which must be met by a patient in order to access medical assistance in dying, and “eligible” and “eligibility” have corresponding meanings;
- (d) **First Clinician** means the qualified medical professional, whether physician (excluding a resident, per section 4.3 of this Standard) or nurse practitioner, who bears primary responsibility for overseeing all aspects of the medical aid in dying process. The First Clinician, where s/he is a qualified physician, performs the duties set out in section 10 of this Standard;
- (e) **independent witness** means an individual who is at least 18 years of age, who understands the nature and consequences of medical assistance in dying, and who is not excluded from acting as a witness to a patient’s request for medical aid in dying for any reason, including the limitations set out in the *Criminal Code of Canada*, section 241.2, or any other legislative requirement;
- (f) **medical assistance in dying** describes the situation where a medical professional or other individual administers medication, or provides access to medication for self-administration by a patient, which intentionally brings about the patient’s death, at the request of the patient;
- (g) **medication** means medication prescribed by the First Clinician in a dose and quantity intended to bring about the end of the patient’s life;
- (h) **nurse practitioner** is a qualified registered nurse who is licensed by the applicable regulatory body to practice as a nurse practitioner, in accordance with any and all applicable legislative and regulatory requirements;
- (i) **palliative care** means care provided to people of any age who have a life limiting illness, with little or no prospect of cure, and for whom the primary goal is quality of life, through the prevention and relief of pain and other distressing symptoms, intending neither to hasten nor postpone death, and offering support to patients and their families;
- (j) **patient** means an adult who seeks medical assistance in dying;
- (k) **physician** means an individual who holds a full or provisional license from the College of Physicians and Surgeons of Newfoundland and Labrador which does not restrict the individual from providing medical assistance in dying.
- (l) **resident** means an individual who is registered on the Educational Register of the College to participate in postgraduate medical training in the province. It includes a resident who has been granted a provisional or full license to

engage in medical practice for a short duration, in accordance with the College's Standard of Practice *Moonlighting by Students in Postgraduate Training*;

- (m) **Second Clinician** is the qualified medical professional, whether physician (excluding a resident, per section 4.3 of this Standard) or nurse practitioner, who is primarily responsible for providing a written opinion to the First Clinician evaluating the patient under the eligibility criteria. The Second Clinician, where s/he is a qualified physician, is required to perform the duties set out in Section 11 of this Standard;
- (n) **Standard** means this *Standard of Practice on Medical Assistance in Dying*;
- (o) **treatment** includes refusal to treat, withholding treatment, or withdrawal of treatment.

4. **Application**

- 4.1 This Standard applies to all physicians.
- 4.2 A physician, excluding a resident, may act as the First or Second Clinician only in accordance with this Standard.
- 4.3 A physician **may not** act as the First or Second Clinician:
 - (a) for the physician's own family member. A family member includes the spouse, parent, child, grandparent, grandchild, aunt/uncle, niece/nephew or stepfamily of the physician, and also includes any person who is unrelated by blood but who resides in the same household and is in a relationship akin to that of family with the physician.
 - (b) for any patient with whom circumstances place the physician in a real or perceived conflict of interest (for example, where the physician is a beneficiary of the patient's estate), including any relationship that may affect the physician's objectivity within the meaning of the *Criminal Code of Canada*, section 241.2(6).
 - (c) where the physician is in a mentorship or business relationship with the other Clinician which places him or her in a position of direct or indirect authority or supervisory responsibility for the Clinician, regardless of whether the other Clinician is a physician or nurse practitioner.
 - (d) where relevant restrictions or limitations on the physician's medical license prevent him or her from providing medical assistance in dying for any reason.

- 4.4 Residents **may not** perform the role of the First or Second Clinician under this Standard.
- (a) Residents may be engaged in the medical assistance in death process in an assisting or learning capacity only, in keeping with the ordinary role of a resident in providing supervised medical care to consenting patients. This is not intended to reduce the obligation of the First or Second Clinician to personally evaluate the patient.
- 4.5 The *Criminal Code of Canada* provides that a nurse practitioner who is licensed and qualified by his or her scope of practice, and by provincial legislation, may participate in medically assisted death. Nothing in this Standard is intended to prevent a nurse practitioner, where legislation and other regulatory guidance permits, from providing medical assistance in dying to a patient.
- (a) For greater certainty, a nurse practitioner may perform a function equivalent to the First or Second Clinician under this Standard, in keeping with applicable legislation, and standards of practice issued by the appropriate regulatory body governing the conduct of nurse practitioners in the province.

5. Physician Guidance

- 5.1 This Standard should be interpreted in the context of federal and provincial legislation relating to medical assistance in dying. Nothing in this Standard reduces a physician's obligation to comply with any and all applicable laws, including any obligations to report to or seek approvals from an oversight body. Moreover, to the extent that anything in this Standard may be inconsistent with legislative requirements, legislation will always take precedence.
- 5.2 Medical assistance in dying is a new intervention available to patients in Canada. It is advisable for Clinicians to consult with the Canadian Medical Protective Association (CMPA) or other legal counsel prior to providing medical assistance in dying, and in individual circumstances as required.
- 5.3 Clinicians should be cognizant of their own emotional, physical, and mental well-being. While patients and their families are obviously directly impacted by an individual's choice to seek medical assistance in dying, Clinicians may also find themselves affected by this process. Clinicians are strongly encouraged to seek advice and guidance from wellness programs that are available to them, including those offered by the Canadian Medical Association (CMA) or its local branch, the Newfoundland and Labrador Medical Association (NLMA), employer wellness programs, or from other sources.

6. Responsibilities of Physicians who Decline to Participate

- 6.1 No physician can be compelled to prescribe or administer medication for the purpose of ending a patient's life.

- 6.2 Physicians unwilling to participate in medical assistance in dying for personal, moral, religious, or ethical reasons are expected to freely offer accurate information to patients. No physician may provide false, misleading, intentionally confusing, coercive, or materially incomplete information to patients.
- 6.3 The College recommends that a physician who declines to participate in medical assistance in dying offer the patient timely access to another medical professional (or appropriate information resource, clinic or facility, care provider, health authority, or organization) who is:
- (a) available to assist the patient;
 - (b) accessible to the patient; and
 - (c) willing to provide medical assistance in dying to a patient who meets the eligibility criteria.
- 6.4 A physician who declines to provide medical assistance in dying to a patient may not terminate the doctor-patient relationship on that basis alone. At all times, the physician must abide by other relevant College standards of practice.
- 6.5 The objecting physician should:
- (a) Provide access to all relevant medical records to any Clinician who is providing services to the patient related to medical assistance in dying; **and**
 - (b) Continue to provide medical services unrelated to medical assistance in dying, unless the patient requests otherwise, or until another suitable physician has assumed responsibility for the person's ongoing care.

7. Responsibilities of All Physicians

- 7.1 Any physician who is approached by a patient for information on medical assistance in dying has an obligation to discuss the subject with the patient, the first time it is raised by the patient, regardless of whether he or she objects to personally providing this service.
- 7.2 During the first visit where the patient requests or mentions medical assistance in dying, **all** physicians have an obligation to:
- (a) engage in a fulsome discussion as to the reasons behind the patient's request, and answer any questions the patient may pose to the best of the physician's knowledge and ability;
 - (b) ensure that the patient has information about (and, if appropriate, a referral to) any other service that may be of benefit to the patient, including a referral

to palliative care, pain specialist, or psychiatry; or non-physician services such as physiotherapy, occupational therapy, counseling, and so on; and advise the patient whether the physician is willing to personally participate in medical assistance in dying; and

- (c) provide the patient with access to further information as appropriate.

8. Patient Eligibility Criteria

8.1 A Clinician may provide medical assistance in dying only in circumstances where all of the criteria listed in this section are met by the patient, in the medical opinion of the Clinician exercised in good faith.

- (a) The patient must be an adult.
- (b) The patient must be capable of giving consent to medical assistance in dying throughout the process.
- (c) The Clinician reasonably believes that the patient's decision to seek medical assistance in dying has been arrived at freely and voluntarily, without coercion or undue influence.
- (d) The patient's choice to seek medical assistance in dying is based on accurate information as to the process and its consequences.
- (e) The patient has personally requested medical assistance in death (i.e. not through a substitute decision maker or family member).
- (f) The patient has previously been informed of treatment options which are available to him or her, including palliative care, and the patient has determined that s/he does not wish to pursue such alternative options.
- (g) The patient has a grievous and irremediable medical condition, which may include an illness, disease, or disability.
- (h) The patient is in an advanced state of irreversible decline in capability.
- (i) The patient's natural death is reasonably foreseeable, taking into account the medical circumstances. There is no requirement of a prognosis that specifically anticipates the length of time the patient may have remaining.
- (j) The grievous and irremediable medical condition must cause enduring suffering that is intolerable to the patient in the circumstances of his or her condition. To meet the "irremediable" requirement, a patient is not required to undertake treatments that are unacceptable to the patient.

- (k) The patient has made the request for medical assistance in dying in writing, signed by the patient in the presence of two independent witnesses (subject to reasonable accommodation to permit accessibility by patients who may have limitations).

8.2 The patient must be competent to give consent when the Clinician provides medical assistance in dying. A Clinician must not act on a purported request for medical assistance in dying set out in any advance directive, including a directive made pursuant to the *Advance Health Care Directives Act*.

9. **Qualifications of the Clinician**

9.1 Physicians who wish to act as the First or Second Clinician are strongly encouraged to complete available training or continuing professional education courses relating to medical assistance in dying offered through reputable sources, such as the Canadian Medical Association (CMA).

9.2 Clinicians should proactively evaluate their own scope of practice in light of their training, experience, and qualifications, vis-à-vis the specific grievous and irremediable condition experienced by the patient. Clinicians are responsible to determine whether the patient's diagnosis and prognosis is a matter on which the Clinician is competent to opine, or whether consultation is warranted.

9.3 All physicians have a continuous duty to follow the Canadian Medical Association *Code of Ethics*, and the College's *By-Law No. 5: Code of Ethics*, each of which sets out physicians' ethical obligations toward patients. It is the responsibility of each Clinician to abide by the highest standard of professional conduct at all times, including during the medical assistance in dying process.

9.4 The First or Second Clinician may seek assistance for the patient from other medical professionals, including nurses, social workers, psychologists, and therapists. The College nonetheless emphasizes that the First Clinician should remain involved in all aspects of the medical assistance in dying process to the extent reasonably practicable.

10. **Duties of First Clinician**

The First Clinician is primarily responsible for overseeing the medically assisted dying process. S/he may obtain that role by a referral from another medical professional, or by direct consultation from a patient. S/he is responsible to fulfill the following obligations:

- **Receive the patient's initial inquiry for medical assistance in dying**
- **Evaluate the patient**
- **Provide a referral for a second assessment**

- **Receive the patient’s written request for medical assistance in dying**
- **Communicate with the patient and with the patient’s family**
- **Observe an appropriate waiting period**
- **Provide medical assistance in dying**
- **Document in medical record**

10.1 Receive the patient’s initial inquiry for medical assistance in dying

- (a) During the first visit where the patient requests or mentions medical assistance in dying, **the First Clinician** shall:
- (i) engage in a fulsome discussion as to the reasons behind the patient’s request, and answer any questions the patient may pose to the best of the physician’s knowledge and ability;
 - (ii) ensure that the patient has information about (and, if appropriate, a referral to) any other service that may be of benefit to the patient, including a referral to palliative care, pain specialist, or psychiatry; or non-physician services such as physiotherapy, occupational therapy, counseling, and so on; and
 - (iii) provide the patient with access to further information as appropriate.

10.2 Evaluate the patient

- (a) The First Clinician is responsible for conducting a thorough and careful assessment of the patient in light of the eligibility criteria set out above.
- (b) The First Clinician shall personally assess whether the patient meets the eligibility criteria:
- (i) on his or her own medical assessment of the patient, possibly in combination with the opinions of one or more other medical professionals (other than that of the Second Clinician);
 - (ii) on his or her own assessment of the patient’s voluntariness and consent to participate in the process. It may be appropriate for the Clinician to have a private discussion with the patient (i.e. in the absence of the patient’s family), if there are any concerns about coercion or pressure from other individuals; and

- (iii) on his or her own assessment of the patient's understanding of the process and its consequences, and after addressing any questions or concerns the patient, or patient's family, may have.
- (c) The assessment of the patient's competence to consent, and the voluntariness and genuineness of the patient's wish to be assisted in dying, is an ongoing obligation. If at any time during the process the First Clinician becomes aware of information or circumstances to suggest the patient no longer meets the eligibility criteria, the First Clinician shall address this with the patient.
- (d) The First Clinician is not prevented from discussing with the patient any possible management options of which the patient may not be aware, which may assist to relieve or abate the suffering experienced by the patient on an immediate basis, and to facilitate access to those options if appropriate.

10.3 Provide a referral for a second assessment, and consider additional consultation

- (a) After the First Clinician has conducted his or her assessment of the patient, and provided he or she is satisfied that the patient meets the eligibility criteria, the First Clinician shall arrange for referral to the Second Clinician, who shall also assess the patient's compliance with the eligibility criteria and provide a written opinion.
- (b) After the Second Clinician has assessed the patient, the First Clinician must review the documentation provided. The First Clinician should be satisfied that the Second Clinician has also concluded that the patient meets the eligibility criteria. The First Clinician and Second Clinician may find it necessary to discuss the matter with one another.
- (c) It is possible that the specific circumstances applicable to a patient may warrant a separate consultation and assessment by a qualified specialist, for example, in respect of the "irremediable" nature of the medical condition, or a patient's prognosis. The First or Second Clinician may choose to seek additional consultation to supplement their own assessments of the patient.

10.4 Receive the patient's written request for medical assistance in dying

- (a) The patient should make, or confirm, his or her request in writing, signed and dated by the patient in the presence of two independent witnesses. The request must be dated after the patient has been diagnosed with the grievous and irremediable condition relevant to the request.
- (b) In the case of a patient who has accessibility challenges (physical or mental disability, illiteracy, language barriers, or otherwise), the First Clinician may make reasonable accommodations to ensure effective communication with the patient.

- (c) The written request from the patient must be maintained in the medical record. If it is necessary, it is the duty of the First Clinician to seek clarification or further information from the patient as to his or her specific wishes, and record these adequately.
- (d) Though it is not mandatory, and provided the patient agrees, the First Clinician may consider whether using a video recording device to confirm the individual's consent might be appropriate in certain cases. Any resulting video must be safeguarded privately, in the same fashion as any other aspect of patient medical records. Clinicians are reminded that a written request from the patient is nonetheless mandatory.
- (e) The best practice is that the First Clinician confirm the patient's request **in writing** within a short timeframe, and maintain a copy in the medical record. This communication provides an opportunity to inform patients of the next steps in the process. Clinicians may wish to seek advice from CMPA with respect to the contents of this communication.

10.5 Communicate with the patient and with the patient's family

- (a) The First Clinician is the primary point of contact for the patient, keeping him or her informed throughout the medical assistance in death process and being responsive to any questions which may arise. The patient's family may be a part of this process.
- (b) The First Clinician is encouraged to communicate with the patient's family during the process, to the extent that is acceptable to the patient. As with other medical interventions, the First Clinician (or another medical professional) may provide access to supportive care for family members which are appropriate in the circumstances, including counselling, social work, and other resources.
- (c) The First Clinician shall advise the patient, both verbally and in writing, of the patient's right to rescind the request for medical assistance in dying, and confirm that the patient's wishes have not changed at appropriate times.

10.6 Observe an Appropriate Waiting Period

- (a) There is a legislative requirement of at least 10 clear days' wait time between the date on which the patient makes the request for medical assistance in dying, and the day on which the patient receives the service.
- (b) The waiting period may be shortened to a different timeframe only where both the First and Second Clinician are of the opinion that the patient's natural death, or loss of the patient's capacity to provide informed consent to death, is imminent.

10.7 Assist the patient

- (a) The First Clinician must be satisfied that the patient continues to meet the eligibility criteria when the medication is prescribed or administered.
- (b) The First Clinician should be prepared, if all requirements of this Standard are met, to prescribe and/or administer medication to the patient. There is some risk that a patient may experience complications during, or resulting from, the administration of a life-ending dose of medication.
- (c) In order to allow timely intervention in the event of a complication, where the First Clinician causes the administration of a lethal dose of medication to a patient, the First Clinician should remain with the patient until the patient's death has been confirmed.
- (d) If the patient chooses to self-administer medication to cause his or her own death, the First Clinician shall clearly communicate any necessary instructions to the patient, including any possible risks or complications, and take reasonable measures to ensure that the patient understands.
- (e) The First Clinician is not required to remain with the patient until death is confirmed **only** where the patient has been provided with a prescription for a lethal dose of medication, and the patient self-administers such dose (with or without the assistance of family members or other individuals), outside of a clinical, care home, or hospital setting.

10.8 Document in Medical Record

Keeping an adequate and careful record of a patient's request to be assisted in death is of fundamental importance. The medical record is intended to benefit and protect physician and patient alike. Given the seriousness of the condition experienced by the patient, combined with the irreversible nature of the intervention itself, a physician's failure to comply with the requirements of this Standard with respect to record-keeping will be treated as a serious matter by the College.

- (a) The presence of a consultation letter from the Second Clinician, confirming the patient's eligibility for medical assistance in death, in the First Clinician's file is **mandatory, without exception**.
- (b) The First Clinician must keep careful and complete records of interactions with the patient, the First Clinician's objective and subjective impressions of the patient's wishes, including any and all required forms and documents.
- (c) The medical record should include substantive details regarding the nature of the discussion with the patient. It should not be limited to "ticking boxes", such as those often seen in electronic medical records. The College views

the medical aid in dying process as warranting thorough and considered documentation at every stage of the process.

- (d) If, at any time, the patient rescinds the request for medical assistance in dying, the First Clinician must clearly document the patient's choice to rescind. If the patient subsequently makes another request for medical assistance in dying, the First Clinician must restart the process, including meeting the record-keeping and independent assessment criteria, in the same way as if the process had not previously commenced.

11. **Duties of Second Clinician**

The Second Clinician assesses the patient under the eligibility criteria at the request of the First Clinician. S/he is responsible to fulfill the following obligations:

- **Assess the patient**
- **Provide a documented opinion to First Clinician**

11.1 **Assess the patient**

- (a) Upon receipt of a referral from the First Clinician, the Second Clinician should make arrangements to assess the patient within a reasonably expeditious timeframe.
- (b) The Second Clinician will personally assess whether the patient meets the eligibility criteria:
- (i) on his or her own medical assessment of the patient, possibly in combination with the opinions of one or more other medical professionals (other than that of the Second Clinician);
and
 - (ii) on his or her own assessment of the patient's understanding of the nature and consequences of the process, and the patient's voluntariness and consent to participate. It may be appropriate for the Clinician to have a private discussion with the patient (i.e. in the absence of the patient's family), if there are any concerns about coercion or pressure from other individuals.

11.2 **Provide a documented opinion**

- (a) The Second Clinician shall provide a written opinion to the First Clinician, documenting his or her assessment of the patient in the context of the eligibility criteria.

- (b) The Second Clinician shall directly consult with the First Clinician, if the best interests of the patient indicate that such consultation is necessary.

12. Prescription

12.1 The First Clinician must write the prescription for the patient's medication:

- (a) Where the medication is intended for self-administration by the patient, whether or not the patient is assisted by another individual (such as a family member) to prepare, obtain, or ingest the medication;

or

- (b) Where the medication will be administered to the patient by the First Clinician, usually in a clinic, care home, or hospital setting.

12.2 The First Clinician shall inform the receiving pharmacist of the intended purpose of the prescription, i.e. a lethal dose prescribed to provide medical assistance in dying to the patient.

13. Documentation

13.1 To provide assistance to Clinicians, this Standard encloses the following documents:

- Assistance to Clinicians: Documentation of Medically Assisted Death;
- Declaration of Intention for Medical Assistance in Dying.

Clinicians who wish to provide medical assistance in death to requesting patients are not mandated to use the templates enclosed with this Standard.

14. Reporting Requirements

14.1 The First Clinician is responsible for completing the patient's death certificate in accordance with the *Vital Statistics Act* and any other applicable legislation or regulations.

14.2 In the absence of legislative or regulatory guidance, the College recommends the cause of death appearing on the death certificate be the grievous and irremediable medical condition that qualified the patient to be eligible for medical assistance in dying. Medical assistance in dying should be noted as the mechanism of death.

14.3 The First Clinician must comply with any federal or provincial legislation or regulation which requires reporting on participation in medical assistance in dying.

Document History

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Framework for review:

1. Six months following initial approval date;
2. Twelve months following initial approval date;
3. Thereafter, on a three-year cycle; and
4. As required by legislative or other contextual change.

Assistance to Physicians:

Documentation of Medically Assisted Death

The College of Physicians and Surgeons of Newfoundland and Labrador's *Standard of Practice on Medical Assistance in Dying* requires careful documentation of the process in the patient's medical record. It is appropriate that the First Clinician communicate in writing with patients who seek this intervention.

The College wishes to emphasize that this intervention requires careful, thoughtful consideration from patient and physician alike.

Upon receipt of the patient's signed and dated declaration of intention to seek medical assistance in death, the First Clinician should engage in a discussion with and assessment of the patient. Following this meeting, the First Clinician is strongly encouraged to communicate in writing with the patient, regarding the outcome of the visit and any follow-up which may occur.

This letter may address some or all of the following topics, which list is not exhaustive:

- The First Clinician's intentions with respect to referring the patient for a consultation by the Second Clinician, including the timeline, the identity of the Second Clinician (if known), and any other consultations which are warranted;
- The nature of the prescription which the First Clinician intends to use, including any specific risks and complications relating to the medication which will be prescribed;
- Acknowledging the patient's expressed desire to seek death, and advising the patient that his or her consent to death may be revoked at any time;
- Information relating to the manner in which the patient's death will be carried out, including its location, the presence or absence of family members, and the like;
- The anticipated timeline for the patient's death, taking into account legislative requirements for a waiting period;
- Clinicians are strongly discouraged from relying on a "form letter". Each letter should contain comments relating to the nature of the grievous and irremediable medical condition experienced by the patient, including the reasons why the physician has concluded that the patient satisfies the medical and legal criteria (or, the reasons why not);
- Information on how to contact the First Clinician;

- Contact information for other supports which may be available to the patient, including therapist, social worker, psychologist, or other professionals who may assist.

As medical assistance in dying is a new intervention in Canada, physicians are encouraged to contact CMPA for advice in individual cases.

Declaration of Intention for Medical Assistance in Dying

Patient's full name:	
MCP Number:	
Telephone number:	
Home address:	

I, _____, formally declare that I have a grievous and irremediable medical condition for which treatment options are limited (or for which the available treatments are not acceptable, or are intolerable, to me), that my natural death is reasonably foreseeable, and that as a result I wish to seek medical assistance in dying.

I give my unreserved and voluntary consent to my physician, _____, to bring about my death through medical intervention. **I have discussed the procedure with my physician, and I have received answers to any questions or concerns that I may have.**

I understand that:

- The intended result of this medical intervention is my death.
- **If, at any time, I no longer wish to proceed with medical assistance in dying, I should communicate this to my physician. I am not obligated to follow through.**
- I must follow any instructions given by my physician, including dosing instructions for my lethal prescription, strictly and correctly.
- I will be assessed by at least two physicians or nurse practitioners, independently of one another, to determine whether I meet the medical and legal criteria to receive this intervention. I acknowledge that they will determine whether I qualify under Canadian law for medical assistance in dying.

I am signing this Declaration voluntarily, and of my own individual free will, without duress, coercion, or undue influence from any other person (including my family).

I have reviewed, and I fully understand the meaning of, this Declaration.

I have signed this Declaration in the presence of two independent witnesses, each of whom is satisfied of my identity and my voluntary intention to avail of medical assistance in dying.

First Independent Witness

Patient's Signature

Second Independent Witness

Date