Appendix "A"

Overview of Regulatory Guidance for Physicians on Physician-Assisted Death in Canada (current to February 1, 2016)

	Quebec[1]	CPSBC	CPSA	CPSS	CPSM	CPSO	CPSNB	CPSNS (under consultation)	CMA
Age Requirement	18 years old.	Competent adult, no further clarification.	Competent adult includes mature minors.	18 years old.	18 years old.	Competent adult, no further clarification.	Any patient who can legally consent, which is the age of 16 in NB.	19 years old.	Competent adult, no further clarification.
Duty to Refer/ Conscientious Objection	Objecting physician must notify designated health authority who will find another physician to consider the request.	Objecting physician is required to provide an effective transfer of care by advising the patient that other physicians may be available to see them, or by suggesting the patient visit an alternate physician or service.	Objecting physician must arrange timely access to another physician or resource that will provide accurate information about all available medical options.	Objecting physician is expected to arrange timely access to another physician or resources, or offer the patient information and advice about all the medical options available.	Objecting physician must provide the patient with timely access to a resource that will provide accurate information about PAD.	Objecting physician must make an effective referral to another health-care provider. Effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency.	Even if the physician is reluctant to provide an active referral, they remain obligated to provide information to the patient regarding resources which may be directly accessible.	Objecting physician must make an effective referral to a central organization or, if not willing to do so, provide the patient with contact information for that organization who will maintain a list of physicians willing to consider the request.	Objecting physician is expected to advise the patient on how to access any separate central information, counseling and referral service.

[1] Based upon provisions of Quebec's *An Act Respecting End of Life Care*.

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Grievous and Irremediable Medical Condition	Patient must be at the end of life, suffer from a serious and incurable illness, be in an advanced state of irreversible decline in capability, and experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the person deems tolerable. The CMQ Practice Guide provides guidance on these requirements.	No guidance.	No guidance, but states that chronic depression or other mental illness may itself represent a grievous and irremediable condition.	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	Grievous, in that it is very serious and the current or impending associated symptoms are enduring and cause severe physical or psychological pain or suffering; and irremediable in that there are no medical treatments to cure the condition or alleviate the associated symptoms which make it grievous; or the medical treatments which are available to cure the condition or alleviate the associated symptoms which make it grievous are	'Grievous' is a legal term that applies to serious, non-trivial conditions that have a significant impact on the patient's well-being. 'Irremediable' is a broad term capturing both terminal and non-terminal conditions. 'Irremediable' does not require the patient to undertake treatments that are not acceptable to the individual. The criterion that an individual experience intolerable suffering is subjective, meaning that it is assessed	The patient must have an illness for which there is no cure, nor reasonable amelioration. The illness will eventually cause the patient's death, but this need not be within any predictable time. The patient must be suffering and this must be considered in the broadest sense. Suffering is by nature subjective and it is a challenge for physicians to directly assess such. There can be a possibility of assisting a patient with unresponsive depression if suffering	No guidance, but states that if the grievous and irremediable medical condition is primarily a mental illness, then either the first or second physician must be a psychiatrist or their assessment of eligibility of the patient must be informed by a psychiatric opinion.	It is grievous in that it is serious or severe and the current or impending associated symptoms or prognosis are constant or enduring and cause severe physical or psychological suffering that is intolerable to the patient. What constitutes enduring and intolerable suffering is based on the patient's subjective interpretation. It is irremediable in that it is not able to be cured or made right to alleviate the symptoms which make it

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				differ from one patient to another.	not acceptable to the patient. Where the grievous and irremediable medical condition is of a psychiatric nature, the determination must be performed after an independent psychiatric assessment.	from the individual's perspective.	appears truly severe and there is truly no likelihood of a cure, but in those situations, physicians must only proceed with extraordinary caution.		grievous, or it is not amenable to further treatments or interventions that are acceptable to the patient, or it is not remediable by other means acceptable to the patient. A patient is not required to have tried all available standard of care interventions or possible therapies offered to them for this definition to apply.
Advance Medical Directives	Not possible to request medical aid in dying by way of advance medical	PAD cannot be provided to patients who are not able to give consent including when consent is	PAD cannot be provided to patients who lack the capacity to make the decision,	Attending physician must be satisfied that the patient is mentally capable of	If at any time the patient loses his/her medical decision making capacity, PAD	During this time of regulatory uncertainty, requests for PAD must be made by the	Any consent must be from the patient himself/herself, no substitute decision-maker could request	Physicians cannot act on a request for PAD set out in a Personal Directive or similar	Not directly discussed, but appears to indicate advance directives are

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	directives.	given by an alternate or substitute decision-maker, or through a personal advance directive.	including when consent can only be provided by a substitute decision-maker, is known by patient wishes or is provided through a personal directive.	making an informed decision at the time of the request and throughout the process, until the time of PAD.	can no longer be provided to the patient.	patient, and not through an advance directive, or the patient's substitute decision-maker.	PAD, nor could PAD be requested by way of advanced directives.	document.	not permitted. The patient is mentally capable of making an informed decision at the time of the request(s). Before undertaking assisted dying, the attending physician must wait no longer than 48 hours, or as soon as is practicable, after the written request is received, and must hen assess the patient for capacity and voluntariness.
Oversight	Physicians who provide medical aid in dying in an institution must notify the institution's	The medical certificate of death should indicate PAD arising out of the underlying grievous and	A provincial multi-disciplinary committee should receive and review all PADs. Pending	The *Coroner's Act, 1999* requires certain deaths to be reported to a coroner. A physician-	Physicians must ensure that the requirements of physicians set out in *The Fatality*	Supports the establishment of a formal oversight and reporting mechanism that would	No oversight committee or authority. Such creates a high risk of invading the patient's and physician's	Recommends that the government of NS appoint an oversight body to perform a monitoring	There should be a formal oversight body and reporting mechanism that collects data from the

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	Council of physicians, dentists and pharmacists (CPDP) within 10 days of administering aid in dying. Physicians practicing in a private health facility must inform the CMQ within the same timeframe. The CPDP or the CMQ will then assess the quality of the care provided. In addition, the physician must give notice to the Commission on End of Life Care within 10 days of administering the aid and send the Commission certain prescribed	irremediable medical condition.	the establishment of such a committee in Alberta, physicians are required to notify the CPSA when a death involves the assistance of a regulated member, and to provide all documents identified in the guidelines. The collection of this information will ensure appropriate procedures and documentation, to enhance the provision of professional services.	assisted death is a reportable death and a physician participating in a physician-assisted death must comply with the requirements of that Act.	*Inquiries Act*, and *The Vital Statistics Act* in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.	collect data on PAD, and advocates that a data collection mechanism form part of the federal and/or provincial legislative framework. Where PAD is provided, physicians are advised to consult the Ontario government for guidance on the completion of death certificates and any mandatory reporting obligations associated with PAD.	privacy, especially in a smaller jurisdiction. This does not preclude the collection of anonymized data. Regarding oversight for potential abuse or malpractice, death is always reviewable to the coroner. In addition it could be open to a family member to complain to the College regarding the approach a physician took with the matter.	function with respect to PAD. Also recommends that cause of death be the grievous and irremediable medical condition that qualified the patient to be eligible for PAD, PAD will be noted as the mechanism utilized. This reporting on the death certificate, in combination with other reporting requirements that may be established, will ensure that incidents of PAD can be readily captured and available to the Medical Examiner and the oversight	attending physician. The oversight body would review the documentation for compliance. Prov/Terr should ensure that legislation and/or regulations are in place to support investigations related to assisted dying by existing prov/terr systems. Pan-Canadian guidelines should be developed to clarify how to classify the cause on the death certificate.

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	information.							body.	

Regulatory Authorities	Documents on PAD
College of Physicians and Surgeons of British Columbia ("CPSBC")	Interim Guidance, *Physician-Assisted Dying*, approved January 22, 2016, https://www.cpsbc.ca/files/pdf/IG-Physician-assisted-Dying.pdf
College of Physicians and Surgeons of Alberta ("CPSA")	Advise to the Profession, *Physician-Assisted Death*, published December 2015, http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/
College of Physicians and Surgeons of Saskatchewan ("CPSS")	Policy, *Physician-Assisted Dying*, approved November 2015, https://www.cps.sk.ca/Documents/Legislation/Policies/POLICY%20-%20Physician-Assisted%20Dying.pdf
College of Physicians and Surgeons of Manitoba ("CPSM")	Schedule M attached to and forming part of By-Law No. 11 of the College, *Physician Assisted Death*, December 2015, http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/PAD/PADSchM.pdf
College of Physicians and Surgeons of Ontario ("CPSO")	*Interim Guidance on Physician-Assisted Death*, approved January 26, 2016, http://www.cpso.on.ca/CPSO/media/documents/Council/Council-Materials_Jan2016.pdf
College of Physicians and Surgeons of New Brunswick ("CPSNB")	Guidelines, *Assistance in Dying*, December 2015, http://www.cpsnb.org/english/Guidelines/AssistanceinDying.htm
College of Physicians and Surgeons of Nova Scotia ("CPSNS")	*Standard of Practice: Physician-Assisted Death*, January 13, 2016 (under consultation – not approved), http://www.cpsns.ns.ca/Portals/0/PDFpoliciesguidelines/DRAFT%20Standard%20of%20Practice%20-%20Physician-Assisted%20Death.pdf
Canadian Medical Association ("CMA")	Principles-Based Recommendations for a Canadian Approach to Assisted Dying, January 22, 2016, https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf
* Note that the government of the Northwest Territories is currently holding consultations on a legislative framework on PAD; the College of Physicians and Surgeons of Newfoundland and Labrador has prepared a draft standard of care on PAD and anticipates to have it finalized in March 2016	

Submissions of the CMPA to the Joint Parliamentary Committee on Physician Assisted Death