

# Bringing Up Medical Assistance in Dying (MAiD) As a Clinical Care Option

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## **Canadian Association of MAiD Assessors and Providers (CAMAP)**

The Canadian Association of MAiD Assessors and Providers (CAMAP) is the unique association of professionals involved in the delivery of medical assistance in dying (MAiD) care in Canada. Founded in 2016, the mission is to support MAiD professionals in their work, educate the health care community about MAiD, and provide leadership on determining standards and guidelines in MAiD practice. CAMAP members strive to achieve the highest level of care for our patients and to model this care for a national and international audience. CAMAP works with governments in Canada at all levels, provincial medical and nursing regulatory bodies, national medical and nursing colleges, national professional groups, medical and nursing colleagues, and national organizations supporting MAiD.

### **Process**

The Bringing up MAiD guidance document working group consisted of experienced MAiD assessors & providers, an ethicist and MAiD coordinator. Work began by reviewing the previous “Bringing up MAiD” guidance document produced and published by CAMAP. The original guidance document was published before Bill C-7, necessitating an update.

The working group started by developing an outline of issues that were felt pertinent to current MAiD practice. All sections were reviewed by members of the working group for feedback and worked into a cohesive document.

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## Summary

The Canadian Association of MAiD Assessors and Providers (CAMAP) provides this guidance for physicians and nurse practitioners on how to bring up MAiD as a clinical care option. The question of whether, and if so how, other allied healthcare professionals may bring up MAiD is discussed. The goal is to support equitable access to information about MAiD for all patients across Canada, while also respecting the conscientious beliefs of health-care professionals and fostering collaborative approaches that prioritize patient well-being.

Each province and territory has its own regulatory guidance, and some employers have additional standards or guidelines outlining the scope and responsibilities of health professionals in their respective regions. These CAMAP guidelines can be used in collaboration with those documents to ensure best practice.

There is no provision in the law that prevents healthcare professionals from initiating a discussion about MAiD or from responding to patient questions about it. Health-care professionals may have a professional obligation to respond accurately and compassionately to patient inquiries about MAiD.

Only physicians and nurse practitioners who are directly involved in care planning and consent processes should consider whether they have a professional duty to initiate discussions about care options that may relieve suffering, including MAiD, when a patient may be eligible. These discussions must include the full range of available treatments, such as palliative care, comfort-focused measures, and, when appropriate MAiD. The timing of such discussions should be guided by clinical judgement and the individual patient's circumstances, considering their values, beliefs and goals of care.

As with all medical interventions, clinicians and other health-care professionals must not discuss MAiD with the intention of inducing, persuading, or convincing a patient to request it. The aim is to inform, not to influence.

Holding a conscientious objection to MAiD does not remove these professional responsibilities. Instead, it activates alternative duties to disclose the objection to the patient and to arrange for referral, transfer of care, or connection to a non-objecting clinician or another resource that can provide accurate information and facilitate access.

### Audience and recommendations

1. All healthcare professionals who care for patients with a grievous and irremediable illness, disease or disability (see Appendix 1), should have a basic understanding of the

eligibility criteria for MAiD. This knowledge is crucial not only to identify patients who may be eligible and could benefit from receiving accurate information, but also to avoid causing harm by bringing up MAiD with patients who clearly would not qualify, or at an inappropriate time.

2. Nurses and allied health-care professionals may appropriately engage in conversation about MAiD within the context of a therapeutic relationship. While they may not typically initiate treatment discussion, they are expected to respond when patients ask questions or express interest.
3. This document is intended to guide physicians and nurse practitioners in meeting their professional obligation to bring up MAiD as a care option when it is medically relevant and a patient is likely eligible and it meets their values and goals of care. Full disclosure of all treatment options is necessary to meet informed consent standards and to respect patient autonomy. Clinical judgment and sensitivity to the individual patient's context will determine when, or whether, the option of MAiD should be discussed.
4. Healthcare professionals who conscientiously object to MAiD should be familiar with their professional responsibilities and obligations. These guidelines propose a reasonable compromise that protects patient access to care while respecting personal moral or religious beliefs.
5. No health-care professional should be prevented from discussing MAiD as a health care option when it is legally permitted and professionally appropriate to do so. This applies equally in organizations that do not permit MAiD assessments and/or provision on site. In such situations, professionals are encouraged to seek guidance from their regulatory bodies and indemnity organizations to ensure they can meet their ethical obligation to patients.
6. CAMAP recommends that regulatory authorities, indemnity associations & health authorities provide consistent and clear communication to support professionals in their responsibilities to discuss MAiD as a clinical care option. National consistency, modelled on The College of Physicians and Surgeons of Ontario's referral policy (which has withstood legal and constitutional scrutiny) would help standardize practice across Canada and promote fairness, transparency and patient-centered care.

## MAiD Legislation and Bringing Up MAiD

It remains a criminal offence to counsel a person to die by suicide. Under the *Criminal Code* (see Appendix 2), “to counsel” means to provide information with the aim of inducing, persuading, or convincing a person to die by suicide.

From a clinical perspective, however, the term “to counsel” carries a different meaning. Within a therapeutic relationship, to counsel means to inform, explore and discuss - not to persuade. In everyday clinical use, such as in nursing or psychological care, counselling refers to communication, information sharing, active listening, patient education and emotional support. These actions fall squarely within the accepted scope of ethical practice when responding to patients who express a desire to die.<sup>1,2</sup>

It is important to recognize that the clinical and legal meanings of the word “counsel” are distinct. The clinical meaning of the word has no bearing on its legal definition. Therefore, as long as a health-care professional does not intend to induce or persuade a patient to request MAiD, it is entirely lawful to provide information, initiate discussion, and educate patients about MAiD as part of comprehensive care.

Nonetheless, healthcare professionals are advised to take a risk-based approach. The risk of misunderstanding or perceived influence may increase if a clinician raises MAiD systematically or indiscriminately, without regard for the patient’s individual context, clinical condition, or expressed needs.

To minimize any risk of undue influence, clinicians should remain aware of the inherent power imbalance within the clinician-patient relationship. When discussing MAiD it should be made explicit that MAiD is one of several possible options, and that the clinician’s role is to inform - not to recommend or promote - a particular course of action.

Similarly, when a conscientiously objecting clinician discusses the topic of MAiD or discloses their personal objection, they should clearly state that their objection is moral or personal in nature, and not a clinical recommendation against MAiD. This distinction ensures transparency, maintains trust, and protects both patient autonomy and clinician integrity.

Understanding this legal distinction lays the foundation for discussing free and informed consent in clinical settings.

## Free and Informed Consent

For consent to be legitimate, it requires that consent be voluntary, that the patient have capacity to consent, and that the patient be properly informed.<sup>3</sup>

With respect to voluntary consent, a patient can only choose among options that are acceptable to them—those aligned with their needs, preferences, and goals. It is therefore essential that they be offered the full range of medically appropriate options, including palliative care and MAiD where indicated. Without access to the complete spectrum of choices, a person may be unable to select what is best for themselves or to decline what they find unacceptable. For instance, if a patient is offered only the withdrawal of life-sustaining treatment, without being informed about palliative care or MAiD, can their consent truly be considered voluntary?

For a patient to be properly informed, they must be told about the material risks and potential benefits of the proposed treatment, as well as all reasonable alternatives. This includes clear information about the nature of each option and the other possible courses of action. The patient must receive the information that a reasonable person in similar circumstances would need in order to make an informed decision, and must have the opportunity to ask questions and receive satisfactory answers. Ensuring this understanding is the responsibility of clinicians and generally falls outside the scope of other healthcare professionals.

If a patient has the capacity to make their own health-care decisions, appears to have a serious and incurable illness, disease, or disability, and is in an advanced state of irreversible decline in capability, clinicians should consider whether MAiD ought to be discussed as part of an informed-consent conversation and a full discussion of available alternatives. If a patient does not meet the legal eligibility criteria, MAiD should not be offered as a treatment option. When eligibility (including capacity) is uncertain, MAiD may be introduced with the clear understanding that eligibility would need to be formally assessed. If a clinician has a conscientious objection to raising MAiD, they have an additional duty to discuss their objection and to ensure the patient understands and appreciates the full range of clinical care options.

It is important to note that there are exceptions to when MAiD should be included as an option. MAiD should not be raised if it is clearly clinically inappropriate—for example, when a patient is not capable of providing consent. Some have suggested that clinicians may not need to disclose MAiD if they *know* the patient objects to it. However, great caution should be used when deciding not to mention a legally available service.

First, patients' views can change. A person who once opposed MAiD when healthy, may reconsider after facing a grievous and irremediable medical condition. Second, health-care professionals may make incorrect assumptions about a patient's beliefs or preferences—for

example, assuming a patient might object because they belong to a faith community, even though some individuals of strong faith have chosen MAiD.

An individualized approach is always best. Clinicians should avoid making assumptions that might limit the information a patient receives about available options, and should confirm the patient's actual views about MAiD if these have not been explicitly stated.

## Ethical Considerations

### **Patient Autonomy**

Health-care professionals are guided by widely accepted ethical principles in their care and communication with patients. These include respect for patient autonomy (honouring a patient's wishes), beneficence (acting to do good), and non-maleficence (avoiding harm). These principles are set out in the *Canadian Medical Association (CMA) and Canadian Nurses Association (CNA) Codes of Ethics*.

The principle of respect for patient autonomy is central to determining whether, when, and how health-care professionals should raise MAiD as a clinical care option. To respect autonomy, clinicians must ensure patients are informed about all medically effective and legally available treatments, even when these may conflict with the clinician's personal values. This allows patients to make their own considered choices among treatment options—including provision, withholding, or withdrawal of treatment—and to provide informed consent, based on their values, beliefs and goals of care.

### **The Clinician's Gatekeeper Role and Obligation**

By meeting the consent requirements outlined above, clinicians fulfill their professional obligations as part of their inherent role as gatekeepers to the health-care system. Clinicians possess specialized knowledge of illness, disease, disability, treatment options, and available supports, and they are responsible for helping patients understand their choices for care, comfort, and cure.

Patients, by contrast, rarely have the same level of medical knowledge. They may not know which options exist, which are suitable for their circumstances, or how to access them. The same applies to patients with grievous and irremediable conditions who may qualify for MAiD. They cannot be expected to know whether they are eligible for MAiD<sup>4</sup> or how to initiate an assessment.

At the point in life when a person might qualify for MAiD—facing advanced decline, loss of capability, or intolerable suffering—they are often particularly vulnerable. They may experience barriers to accessing care or information, such as reduced mobility, limited independence or resources (including internet or phone access), communication challenges (loss of speech, hearing, or vision), dependence on caregivers, loss of privacy or autonomy, and distressing physical or psychological symptoms like fatigue, frailty, or anxiety.

Without timely and accurate information about their treatment options, patients may be unable to access MAiD before losing decision-making capacity, may suffer longer than necessary, or may have an end-of-life experience that is inconsistent with their values. Failing to provide information about MAiD to an eligible patient can cause harm—to the patient and their family—by limiting their choices.

Some clinicians expect patients to initiate conversations about intolerable suffering as a signal to discuss MAiD, but patients may not do so, especially in highly medicalized environments focused primarily on physical symptoms. Fear of “slippery slope” implications can also make clinicians reluctant to discuss MAiD with patients who have disabilities, out of concern that doing so could appear to devalue their lives. However, understanding a patient’s cultural background, spiritual beliefs, psychosocial experience, social context, and personal wishes is essential for designing a care plan that truly reflects their values and priorities.

### **Non-Maleficence - Avoiding Harm**

Health-care professionals may worry that raising MAiD too early or inappropriately could result in a complaint to their regulatory body. Such complaints are assessed against professional standards, not the personal views of patients or families. However, not disclosing MAiD can also lead to complaints—especially if a patient later learns they were eligible but not informed.

Given the therapeutic benefits of MAiD availability, including its association with increased palliative care involvement and reduced existential distress, failing to mention MAiD can represent a missed therapeutic opportunity.<sup>5,6</sup> Avoiding the topic can also prolong unwanted suffering and deny patients the chance to consider all options for relief and dignity.

### **Institutional Conscientious Objection**

Health-care professionals who work in settings where MAiD is restricted or unsupported face additional challenges. Nonetheless, they retain a professional duty to uphold patient autonomy and ensure informed consent. The existence of MAiD as a legal treatment option cannot be withheld.

Clinicians have an ongoing duty of care to provide safe, continuous, and non-discriminatory care, even when institutional policies create tension with professional obligations. They should be fully aware of their organization’s MAiD policies and the risks associated with deviating from

them. When institutional restrictions prevent clinicians from fulfilling their ethical duties, it is advisable to seek guidance from regulatory bodies or professional indemnity organizations to navigate these conflicts appropriately.

## How to Bring Up MAiD

There is no completely risk-free way to bring up the topic of MAiD. A respectful, trusting relationship between the patient and clinician, and sufficient time for such sensitive conversations, are essential. Patients for whom MAiD may be a potential option should be given opportunities to discuss their prognosis, values, and preferences for care before illness progression reduces their ability to participate meaningfully in these discussions.

In a therapeutic relationship, understanding the patient's values, beliefs, goals of care, fears, and sources of strength, as well as any previously expressed wishes, greatly reduces the risk of harm when introducing MAiD. If these areas have not yet been explored, the *Serious Illness Conversation Guide* is a well-tested, structured tool that can help clinicians initiate early and effective discussions with patients facing life-limiting illness.<sup>7</sup> While the guide does not specifically address MAiD, it supports understanding of the patient's priorities and values—insight that can help determine whether discussing MAiD would be appropriate.

Open-ended questions can also support these conversations. For example: “Is there anything about your spiritual or cultural beliefs you'd like to share that might help us care for you better?”

Such questions help clinicians approach the topic with humility and sensitivity. Palliative care colleagues are often skilled in initiating end-of-life discussions and can serve as valuable team members or mentors in these conversations. Numerous publications and frameworks are available to support clinicians in discussing end-of-life issues.<sup>8,9,10,11,12,13,14</sup>

Prior advance care planning conversations may also offer clues about whether a patient would want to discuss MAiD, though it is important to remember that patients' views may evolve over time. MAiD should always be raised gently and with permission, for example: “Some people in your situation might want to discuss Medical Assistance in Dying. Is that something you would like to discuss?”

The timing of these conversations should be guided by the **clinical context**, the patient's condition, and the quality of the therapeutic relationship.

## Patient Responses to MAiD Discussions

Research examining patient perspectives on MAiD conversations offers reassurance about the safety and value of these discussions. Evidence shows that discussing the wish to hasten death is not distressing to most patients with advanced illness. In one study, 94.8% of advanced cancer patients reported that discussing the topic was not upsetting, and 79.3% felt it was important for clinicians to proactively ask about and discuss this issue, whether or not they personally had such a wish.<sup>15</sup>

Similar findings have been reported in other populations. In a study of people living with ALS, half said they could imagine requesting assisted dying, and two-thirds had shared their wish with relatives. None had spoken about it with a physician, yet half said they would have liked to.<sup>16</sup> Likewise, individuals with Huntington's disease have reported a lack of open discussion about assisted dying with their health-care providers.<sup>17</sup>

These findings suggest that patients often appreciate honest, compassionate conversations about end-of-life options and may welcome clinicians taking the initiative to explore their values and wishes.

## Ethical Tensions

To explore the ethical tensions involved in bringing up MAiD, it is helpful to refer to the Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act*, 1982 (see Appendix 3).

As discussed earlier, clinicians serve as gatekeepers to the health-care system. In certain circumstances, they have a professional obligation—grounded in respect for patient autonomy and the requirements of informed consent—to bring up MAiD as a potential clinical care option. This discussion must occur within broader goals-of-care conversations, such as those concerning palliative care, long-term care, or the cessation or withdrawal of active treatment, when the patient has a grievous and irremediable medical condition.

In such cases, the clinician's duty to the patient may directly conflict with their personal moral or religious beliefs, creating a genuine ethical tension.

### Conscientious Objection

As the Government of Canada has stated: "Not all health-care providers will be comfortable with medical assistance in dying. The federal practice may not be consistent with a provider's beliefs

and values. The federal legislation does not force any person to provide or to help provide medical assistance in dying.”<sup>18</sup>

It is important to distinguish between **providing** MAiD (administering or prescribing the medication), **helping to provide** (e.g., performing assessments), and the **professional obligation** to support patient autonomy through the provision of information or referral.<sup>19</sup>

While some professionals with conscientious objections may perceive even the act of providing information or referral as “helping,” courts have not found the duty to inform to be an unconstitutional violation of conscience.<sup>20</sup> Strong ethical arguments also exist to minimize moral complicity while still protecting patient rights.

The *Canadian Medical Association (CMA) Code of Ethics and Professionalism* emphasizes the physician’s primary obligations: to promote the patient’s well-being, act in their best interests, and take all reasonable steps to respect their autonomy.<sup>21</sup> It recognizes the inherent vulnerability of patients—even those who are active participants in their care—and reinforces the physician’s duty of loyalty and non-abandonment. Physicians must always acknowledge and respond to a patient’s medical concerns and disclose when their personal moral commitments may influence clinical recommendations. Similarly, the *Canadian Nurses Association (CNA) Code of Ethics* reflects these same principles of patient-centred, ethical care, including respect, safety, and the duty to ensure continuity of care.

## **The Conventional Compromise**

To help reconcile the ethical conflicts that may arise when a clinician objects to a particular practice, Harvard philosopher Professor Dan Brock proposed the Conventional Compromise.<sup>22</sup> This model seeks a practical balance between respecting the moral integrity of the clinician and upholding the rights of patients and society. It recognizes that neither the rights of physicians nor those of patients are absolute; limitations on each may be justified when carefully weighed.

Under this approach, a clinician may conscientiously object to providing a particular service or intervention only if three conditions are met:

1. The clinician informs the patient about the service or intervention if it is medically relevant;
2. The clinician refers the patient to another professional who is willing and able to provide it; and
3. The referral does not impose an unreasonable burden on the patient.

In this framework, the responsibility for managing the objection lies with the clinician, not the patient. Abandoning a patient or creating barriers to care is ethically unacceptable. It would also

be inequitable to privilege the clinician's freedom of religion or conscience over the patient's right to security of the person and freedom of conscience under the *Charter*.

Patients should never have to choose between accessing a potential treatment and preserving an existing therapeutic relationship. This is especially true when social or economic factors limit access to alternative providers. Institutions and clinicians are encouraged to structure their practice environments to accommodate reasonable compromises that safeguard both patient and provider rights.

Most provincial and territorial regulatory bodies have established policies or standards addressing conscientious objection. In a 2018 court challenge (upheld in 2019), the *College of Physicians and Surgeons of Ontario (CPSO)* policy requiring effective referral was upheld.<sup>23,24</sup> The courts determined that the balance of competing rights favoured patient dignity and autonomy over a physician's objection to refer.

### **Duty to Refer**

Regulatory standards across Canada generally require clinicians to ensure that patient access to lawful medical services is not obstructed. The duty to refer includes both informing the patient of the clinician's non-participation and doing so in a manner that minimizes distress. Patients have the right to discuss their condition and all available treatment options, including those to which the clinician objects, with another professional who does not share the same objection.

Clinicians should make it clear that their objection is moral or personal, not clinical. If a patient is unaware that a procedure exists or is legal, the objecting clinician still has a legal and ethical obligation to provide that basic information.

Conscientious objection by other health-care professionals, such as nurses, follows the same principles. Nurses must ensure patient safety, avoid abandonment, and withdraw only once alternative care has been secured. The *Canadian Nurses Association (CNA) Code of Ethics* explicitly requires nurses to take all reasonable steps to maintain the quality and continuity of care, including a safe and respectful transfer to another provider.<sup>25</sup>

A clinician with a conscientious objection continues to have a duty of care to provide safe, continuous, and non-discriminatory care. Under the *Conventional Compromise*, this may include mentioning MAiD as a possible treatment option when clinically relevant, disclosing their own moral objection, and ensuring the patient's care is transferred appropriately. This approach minimizes moral complicity while maintaining the patient's access to information and choice.

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# Appendix 1

## **Grievous and Irremediable**

Definition (from An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) S.C. 2016, c. 3, Assented to 2016-06-17:

### **241.2 (2): Grievous and irremediable medical condition**

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

## Appendix 2

### **MAiD legislation**

The Canadian MAiD law (*An Act to amend the Criminal Code and make related amendments to other Acts [medical assistance in dying]* commonly known as C-14) came into force in June 2016. It states:

**Section 241 of the Act is replaced by the following:**

#### **Counselling or aiding suicide**

(1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

(a) Counsels a person to die by suicide or abets a person in dying by suicide; or (b) Aids a person to die by suicide.

#### **Exemption for medical assistance in dying**

(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.

#### **Exemption for person aiding practitioner**

(3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

#### **Exemption for pharmacist**

(4) No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

#### **Exemption for person aiding patient**

(5) No person commits an offence under paragraph (1)(b) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying in accordance with section 241.2.

#### **Clarification**

(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.

#### **Counselling, aiding, and abetting jurisprudence**

“Counselling” for the purposes of s.241(1) “concerns speech that, assessed objectively, aims to induce, persuade or convince a person to commit suicide.” *R. v. Morin* 2014 QCCQ 1609. “The actus reus of aiding or abetting is doing (or, in some circumstances, omitting to do) something that assists or encourages the perpetrator to commit the offence. While it is common to speak of aiding and abetting together, the two concepts are distinct, and liability can flow from either one.

Broadly speaking, “[t]o aid under s.21(1)(b) means to assist or help the actor. ...To abet within the meaning of s. 21(1)(c) includes encouraging, instigating, promoting or procuring the crime to be committed”: *R v Greyeyes*, 1997 CanLII 313 (SCC), [1997] 2 SCR 825, at para 26.” *R. v. Briscoe*, 2010 SCC 13 at para 14.

## Appendix 3

*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11

### **Rights and freedoms in Canada**

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Fundamental freedoms

2. Everyone has the following fundamental freedoms: (a) freedom of conscience and religion...

[...]

### **Legal Rights**

7. Everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

### **Equality before and under law and equal protection and benefit of law**

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.