POLICY

Medical Assistance in Dying: Patient's Death is Reasonably Foreseeable

Status:	**Approved**
Approved by Council:	September 17, 2016
Amended:	November 2018 June 2021 September 2023
To be reviewed:	September 2028

BACKGROUND

Canadian legislation has established significantly different requirements for medical assistance in dying depending upon whether the patient's death is, or is not, reasonably foreseeable.

This document addresses the legal requirements and the expectations of the College for physicians dealing with a request for medical assistance in dying from a patient whose death **is** reasonably foreseeable.

A companion policy - *Medical Assistance in Dying – Patient's Death is Not Reasonably Foreseeable* addresses the legal requirements and the expectations of the College for physicians dealing with a request for medical assistance in dying from a patient whose death **is not** reasonably foreseeable.

On February 6, 2015, the Supreme Court of Canada struck down the law prohibiting medical assistance in dying.[1] The Canadian Government amended the Criminal Code provisions effective June 17, 2016.[2] The legislation was further amended effective March 17, 2021.[3] The legislation[4] contains a number of requirements that must exist for physicians or nurse practitioners to provide Medical Assistance in Dying. The most important of those are:

1) The patient must be eligible for health services funded by a government in Canada;
2) The patient must be at least 18 years of age and capable of making decisions with respect to their health;
3) The patient must have a grievous and irremediable medical condition;

[1] Carter v. Canada (Attorney General), 2015 SCC 5; https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html?resultIndex=1
[2] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent
[3] *An Act to amend the Criminal Code (medical assistance in dying)* https://parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent
[4] The *Criminal Code* sections 227 and 241 .1 https://laws-lois.justice.gc.ca/eng/acts/c-46/

4) The patient must have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure and was made after the patient was informed that they have a grievous and irremediable medical condition;
5) The patient must have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care;
6) Two practitioners (physicians or nurse practitioners) must confirm that the patient meets the criteria established in the legislation to receive medical assistance in dying.

The legislation states that a person has a grievous and irremediable medical condition only if they meet all of the following criteria:

1) They have a serious and incurable illness, disease, or disability;
2) They are in an advanced state of irreversible decline in capability; and
3) That illness, disease, disability or 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.

The legislation specifically excludes a mental illness as an illness, disease or disability that can qualify a person for Medical Assistance in Dying. It is anticipated that the legislation will remove this restriction effective March 17, 2024.

The amendments to the legislation which came into effect on March 17, 2021 provide for two forms of eligibility for Medical Assistance in Dying. That legislation made the following changes to the legislation if a patient's death is reasonably foreseeable:

The eligibility requirements for such patients is similar to the eligibility requirements prior to the change in legislation. The legislation makes the following changes for persons whose death is reasonably foreseeable:

a) Only one witness is required for the signature of the patient requesting medical assistance in dying (rather than the two previously required);
b) A patient can sign an advance directive that will allow medical assistance in dying to be provided if the patient loses capacity;
c) A patient who self-administers the medications to cause death can sign a document requesting that a physician or nurse practitioner be present at the self-administration and administer medications to cause death if the patient loses capacity to consent and death does not occur within a specified period;
d) There is no longer be a 10 day waiting period between determining that a patient is eligible for medical assistance in dying and the administration of medical assistance in dying.

The legislation contains a number of other provisions that provide protection to individuals involved in assisting patients to access medical assistance in dying. Among those are:

1) Protection for physicians and nurse practitioners who provide medical assistance in dying based upon a reasonable but mistaken belief that the patient qualified;
2) Protection for pharmacists and other health care workers who assist with medical assistance in dying;
3) Protection for individuals who provide information to patients about medical assistance in dying;
4) Protection for individuals who assist patients to self-administer medication that has been prescribed to them for the purpose of medical assistance in dying.

The College of Physicians and Surgeons of Saskatchewan has established this policy for the following purposes:

1) To provide information that will assist physicians and the public in understanding the criteria and procedural requirements that must be met regarding medical assistance in dying; and
2) To outline the specific legal requirements to participate in medical assistance in dying and to establish expectations of physicians who are involved with medical assistance in dying.

DEFINITIONS

Medical Assistance in Dying (MEDICAL ASSISTANCE IN DYING) is defined in s. 241.1 of the *Criminal Code* to mean:

1) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

2) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

FOUNDATIONAL PRINCIPLES

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

1) *Respect for patient autonomy*: Competent adults are free to make decisions about their bodily integrity. Given the finality of medical assistance in dying, significant safeguards and standards are appropriate to ensure that respect for patient autonomy is based upon carefully developed principles to ensure informed patient consent and consistency with the principles established by Canadian Law;

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

3) *Respect for physician values*: Within the bounds of existing standards of practice, and subject to the expectations in this document and the obligation to practise without discrimination as required by the CMA *Code of Ethics* and human rights legislation, physicians can follow their conscience when deciding whether or not to provide medical assistance in dying;

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

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

a) provide guidance to patients and the public about the requirements which patients must meet to access medical assistance in dying;

b) advise patients what they can expect from physicians if they are considering medical assistance in dying; and,

c) clearly express what is expected of physicians.

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

Accountability: Physicians participating in medical assistance in dying must ensure that they have appropriate technical competencies as well as the ability to assess decisional capacity, or the ability to consult with a colleague to assess capacity in more complex situations. Physicians who choose to assess eligibility for or provide MAID, must have sufficient training, experience, and qualifications to safely and competently do so in the circumstances of each case. Physicians must practise only within a scope for which they are appropriately trained, licensed and competent. Assessing patients for MAiD eligibility and providing MAiD are not within the usual scope of practice for physicians. The College strongly encourages any physician who assesses patients for MAiD eligibility or who provides MAiD to take MAiD training which includes training in capacity assessment, trauma-informed care, and cultural safety and humility;

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

1. CONSCIENTIOUS OBJECTION

A physician who declines to provide medical assistance in dying must not abandon a patient who makes this request; the physician has a duty to treat the patient with dignity and respect. The physician is expected to provide sufficient information and resources to enable the patient to make his/her own informed choice and access all options for care. This means arranging timely access to another physician or resources, or offering the patient information and advice about all the medical options available. Physicians must not provide false, misleading, intentionally confusing, coercive or materially incomplete information, and the physician's communication and behaviour must not be demeaning to the patient or to the patient's beliefs, lifestyle choices or values. The obligation to inform patients may be met by delegating this communication to another competent individual for whom the physician is responsible.

A physician who declines to provide medical assistance in dying must make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing medical assistance in dying to the patient when authorized by the patient to do so; and document the interactions and steps taken by the physician in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

A physician must continue to provide care and treatment not related to MAID if the person wishes to continue receiving care from the physician. A physician with an existing therapeutic relationship with a person requesting MAID (independent of the MAID request) must not discharge the person from their care on the grounds that a MAID request has been made or the person is also receiving services from a MAID team or centralized process.

2. REQUIREMENTS FOR ACCESS TO MEDICAL ASSISTANCE IN DYING – PATIENTS WHOSE DEATH IS REASONABLY FORESEEABLE

The Federal Legislation requirements are set out in the introductory section of this policy.

The College requires that:

A. Any physician who conducts an assessment for the purpose of determining if a patient is eligible for medical assistance in dying pursuant to these requirements must:
   1. have received approval from the Saskatchewan Health Authority or the College to perform assessments for the purpose of determining if a patient is eligible for medical assistance in dying; and,
   2. be satisfied that the patient seeking medical assistance in dying has a grievous and irremediable medical condition which the physician has verified by:
      a. a clinical diagnosis of the patient's medical condition; and
      b. a thorough clinical assessment of the patient which includes consideration of all relevant, current and reliable information about the patient's symptoms and the available medical treatments to cure the condition or alleviate the associated symptoms which make the condition grievous, including, where appropriate, consultation with another qualified physician;
   3. be fully informed of the current relevant clinical information about the patient and his/her condition;
   4. be qualified to render a diagnosis and opine on the patient's medical condition or be able to consult with another physician with relevant expertise for the limited purpose of confirming the diagnosis, prognosis or treatment options;
   5. use appropriate medical judgment and utilize a reasonable method of assessment;
   6. when assessing whether a patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable, ensure that:
      a. the unique circumstances and perspective of the patient, including his/her personal experiences and religious or moral beliefs and values have been seriously considered;
      b. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and
      c. treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous or, if the patient is terminal, palliative care interventions; and the patient adequately understands the:
         1. current and anticipated course of physical symptoms, ability to function and pain and suffering specific to that patient; and

2. effect that any progression of physical symptoms, further loss of function or increased pain may have on that specific patient; and
3. available treatments to manage the patient's symptoms or loss of function or to alleviate his/her pain or suffering.

d. the physician has responded to all reasonable questions from the patient regarding MAiD.

e. The physician has taken steps to be aware of the person's values and beliefs, and will ensure that the person's request for MAiD is unambiguous and enduring. They must ensure it is rationally considered during a period of stability, and not during a period of crisis. This may require serial assessments.

f. If the physician assesses a person's request for MAiD virtually or obtains consultations in relation to MAiD virtually, the physician will:

1. confirm the patient agrees with the assessment proceeding virtually;
2. determine that a valid conclusion can be drawn about the person's eligibility for MAID; and,
3. ensure that the assessment aligns with the provisions of other relevant College standards and policies.

B. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessment related to the patient's eligibility for medical assistance in dying.

3. PRACTICE STANDARDS RECOMMENDED BY THE MAID PRACTICE STANDARDS TASK FORCE ESTABLISHED BY HEALTH CANADA

The MAiD Practice Standards Task Force was convened by the government of Canada to establish a Model Practice Standard that could be adopted by regulatory bodies. The Model Standard states the following in relation to establishing whether a patient has a grievous and irremediable condition that eligibility.

The College requires that physicians comply with the following practice standards taken from the Model Practice Standard:

9.4 Grievous and irremediable medical condition

9.4.1 To find a person eligible for MAID, the provider and assessor must be of the opinion that the person has 'a grievous and irremediable medical condition.'

9.4.2 A person has a 'grievous and irremediable medical condition' if:

(a) they have a serious and incurable illness, disease, or disability;

(b) they are in an advanced state of irreversible decline in capability; and,

(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.

9.5 Serious and incurable illness, disease, or disability

9.5.1 To find a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person has a serious and incurable illness, disease, or disability.

9.5.2 'Incurable' means there are no reasonable treatments remaining where reasonable is determined by the clinician and person 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.

9.6 An advanced state of irreversible decline in capability

9.6.1 To find a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person is in an advanced state of irreversible decline in capability.

9.6.2 Capability refers to a person's functioning (physical, social, occupational, or other important areas), not the symptoms of their condition. Function refers to the ability to undertake those activities that are meaningful to the person.

9.7 Enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

9.7.1 To find that a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person's illness, disease, or disability or state of decline causes the person enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

9.7.2 For the purposes of forming the opinion that the suffering criterion for MAID is met, assessors and providers:

(a) must explore all dimensions of the person's suffering (physical, psychological, social, existential) and the means available to relieve them;

(b) must explore the consistency of the person's assessment of their suffering with the person's overall clinical presentation, expressed wishes over time, and life narrative;

(c) must be of the opinion that it is the person's illness, disease, or disability and/or state of decline in capability that is the cause of the person's suffering;

(d) must be of the opinion that the suffering is enduring; and

(e) must respect the subjectivity of suffering.

4. SPECIFIC REQUIREMENTS FOR ASSESSING MEDICAL DECISION MAKING CAPACITY

The College requires that:

A. Any physician who conducts an assessment of a patient for the purpose of determining if the patient is capable of making decisions with respect to their health pursuant to the federal requirements must:

1. be fully informed of the current relevant clinical information about the patient and his/her mental and physical condition;
2. be able to assess competence in the specific circumstances of the patient whose capacity is being assessed or be able to consult with another physician with relevant expertise for the limited purpose of assessing the patient's medical decision making capacity; and,
3. as capacity is fluid and may change over time, physicians must be alert to potential changes in a person's capacity. Where appropriate, assessors and providers should undertake serial assessments of a person's decision-making capacity.

B. When it is unclear whether the patient is competent to make a decision to request medical assistance in dying, a psychiatric/psychological consult is required to examine the patient's decision-making capacity (or limitations) in greater detail.

C. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessments of a patient's medical decision making capacity.

5. SPECIFIC REQUIREMENTS FOR OBTAINING INFORMED CONSENT

The Federal Legislation requirements are set out in the introductory section of this policy.

The College requires that:

A. Physicians who obtain informed consent for medical assistance in dying must have sufficient knowledge of the patient's condition and circumstances to ensure that:
   1. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and
   2. the treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous and/or palliative care interventions where the patient is terminal; and
   3. the patient is offered appropriate counseling resources; and
   4. the patient fully understands that:
      a. death is the intended result of the pharmaceutical agent(s); and
      b. the potential risks and complications associated with taking the pharmaceutical agent(s).

B. Each physician who obtains informed consent from the patient for medical assistance in dying must:
   1. have either conducted his/her own assessment or be fully informed of the assessments conducted by other physicians of the patient's medical condition and the patient's medical decision making capacity; and
   2. meet the legal requirements for informed consent, including informing the patient of:
      a. material information which a reasonable person in the patient's position would want to have about medical assistance in dying;
      b. the material risks associated with the provision/administration of the pharmaceutical agent(s) that will intentionally cause the patient's death; and

3. meet with the patient separate from family members or others who may influence the patient's decision at least once to confirm that his/her decision to terminate his/her life by medical assistance in dying is voluntary and that the patient has:
    a. made the request him/herself thoughtfully; and
    b. a clear and settled intention to end his/her own life by medical assistance in dying after due consideration;
    c. considered the extent to which the patient has involved or is willing to involve others such as family members, friends, other health care providers or spiritual advisors in making the decision or informing them of his/her decision; and
    d. made the decision freely and without coercion or undue influence from family members, health care providers or others.

C. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements for obtaining informed consent.

6. ADDITIONAL REQUIREMENTS OF THE FEDERAL LEGISLATION

The federal legislation also:

(a) requires that physicians who, in providing medical assistance in dying, prescribe or obtain a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose;

(b) requires physicians to comply with guidelines established for the completion of certificates of death for patients to whom medical assistance in dying is provided;

(c) creates criminal offences for knowingly failing to comply with the eligibility and safeguard requirements set out in criminal code and destroying documents with the intent to interfere with a patient's access to medical assistance in dying, the assessment of a request for medical assistance in dying or a person seeking an exemption related to medical assistance in dying;

(d) requires physicians to provide a written report in several circumstances related to Medical Assistance in Dying. The reporting requirements are set out under the heading **Reporting and Data Collection** in this policy. A physician who receives a written request for Medical Assistance in Dying is generally required to file a report with the Saskatchewan Health Authority.

7. ADMINISTERING MEDICAL ASSISTANCE IN DYING TO A PATIENT WHO HAS LOST THE CAPACITY TO CONSENT

The amendments to the legislation which came into effect on March 17, 2021 allow a patient to sign an agreement with the administering physician to provide medical assistance in dying if the patient loses capacity to consent.

The legislation states:

Final consent — waiver

(3. 2) For the purposes of subsection (3), the medical practitioner or nurse practitioner may administer a substance to a person to cause their death without meeting the requirement set out in paragraph (3) (h) if

(a) before the person loses the capacity to consent to receiving medical assistance in dying,

(i) they met all of the criteria set out in subsection (1) and all other safeguards set out in subsection (3) were met,

(ii) they entered into an arrangement in writing with the medical practitioner or nurse practitioner that the medical practitioner or nurse practitioner would administer a substance to cause their death on a specified day,

(iii) they were informed by the medical practitioner or nurse practitioner of the risk of losing the capacity to consent to receiving medical assistance in dying prior to the day specified in the arrangement, and

(iv) in the written arrangement, they consented to the administration by the medical practitioner or nurse practitioner of a substance to cause their death on or before the day specified in the arrangement if they lost their capacity to consent to receiving medical assistance in dying prior to that day;

(b) the person has lost the capacity to consent to receiving medical assistance in dying;

(c) the person does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration; and

(d) the substance is administered to the person in accordance with the terms of the arrangement.

For greater certainty

(3. 3) For greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes of paragraph (3. 2) (c).

Advance consent invalidated

(3. 4) Once a person demonstrates, by words, sounds or gestures, in accordance with subsection (3. 2), refusal to have the substance administered or resistance to its administration, medical assistance in dying can no longer be provided to them on the basis of the consent given by them under subparagraph (3. 2) (a) (iv).

8. ADMINISTERING MEDICAL ASSISTANCE IN DYING TO A PATIENT WHO SELF-ADMINISTERS BUT THE MEDICATIONS DO NOT CAUSE DEATH

The amendments to the legislation which came into effect on March 17, 2021 allow a patient who has chosen to self-administer the medications intended to cause death to sign an agreement with the prescribing physician to provide medical assistance in dying if death does not result and the patient loses capacity to consent.

The legislation states:

> **Advance consent — self-administration**
>
> **(3.5)** In the case of a person who loses the capacity to consent to receiving medical assistance in dying after self-administering a substance, provided to them under this section, so as to cause their own death, a medical practitioner or nurse practitioner may administer a substance to cause the death of that person if
>
> > **(a)** before the person loses the capacity to consent to receiving medical assistance in dying, they and the medical practitioner or nurse practitioner entered into an arrangement in writing providing that the medical practitioner or nurse practitioner would
> >
> > > **(i)** be present at the time the person self-administered the first substance, and
> > >
> > > **(ii)** administer a second substance to cause the person's death if, after self-administering the first substance, the person lost the capacity to consent to receiving medical assistance in dying and did not die within a specified period;
> >
> > **(b)** the person self-administers the first substance, does not die within the period specified in the arrangement and loses the capacity to consent to receiving medical assistance in dying; and
> >
> > **(c)** the second substance is administered to the person in accordance with the terms of the arrangement.

9. SPECIFIC REQUIREMENTS OF THE PRESCRIBING OR ADMINISTERING PHYSICIAN

In this section "administering physician" refers to a physician who administers pharmaceutical agent(s) for the purpose of terminating the patient's life.

In this section "prescribing physician" refers to a physician who prescribes pharmaceutical agent(s) for the purpose of patient self-administration to terminate the patient's life.

Both prescribing physicians and administering physicians are responsible for confirming that all of the requirements of this policy have been met before the pharmaceutical agent(s) that intentionally cause the patient's death can be provided or administered. There can be only one administering or prescribing physician for each patient.

In this section "self-administration", "administration by the patient" and similar terms include situations where pharmaceutical agent(s) are administered with the assistance of a non-physician at the direction of the patient.

The legislation requires that a physician must give the patient an opportunity to withdraw their request and must ensure that the patient gives express consent to receive medical assistance in dying immediately before providing the medical assistance in dying.

Accordingly, it is the College's view that a physician cannot prescribe medications for self-administration unless the physician will be personally present when the patient self-administers the medication to confirm the patient's consent to receiving medical assistance in dying.

A. The College requires that:

1. an administering physician must have the authorization of the Saskatchewan Health Authority to administer pharmaceutical agents to cause the death of patients where the pharmaceutical agent(s) are administered in a Saskatchewan Health Authority facility or the College if the pharmaceutical agents(s) are administered elsewhere;
2. a prescribing physician must have the authorization of the College to prescribe pharmaceutical agents to cause the death of patients;
3. an administering or prescribing physician must have appropriate knowledge and technical competency to provide/administer the pharmaceutical agent(s) in the appropriate form and/or dosage that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent;
4. a prescribing physician must have appropriate knowledge and technical competence to provide appropriate instructions to the patient as to how to administer the pharmaceutical agent(s) that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent in circumstances where the patient elects to self-administer the pharmaceutical agent(s);
5. an administering physician must be readily available to care for the patient at the time the pharmaceutical agent(s) that intentionally brings about the patient's death is administered by the administering physician or taken by the patient until the patient is dead; and
6. a prescribing physician must
    a. have a written agreement with the patient which states that:
        i. the physician will be present at the time the person self-administers the pharmaceutical agents that are intended to bring about the patient's death; and,
        ii. the physician will administer pharmaceutical agent(s) to cause the death of the patient by intravenous administration if the patient has lost the capacity to consent to receiving medical assistance in dying and does not die within a specified period;
    b. personally take possession of the pharmaceutical agents that are intended to bring about the patient's death;
    c. personally deliver the pharmaceutical agent(s) to the patient at the time and location that are mutually agreed to between the patient and the physician for self-administration of the pharmaceutical agent(s);
    d. be personally present at the time and location that are mutually agreed to between the patient and the physician for self-administration of the pharmaceutical agent(s);
    e. bring the necessary equipment and pharmaceutical agent(s) to cause the death of the patient by intravenous administration at the time and to the location mutually agreed to between the patient and the physician for self-administration of the pharmaceutical agent(s);
    f. administer pharmaceutical agents by intravenous administration to cause the death of the patient if the self-administration by the patient does not result in the patient's death, and if the patient is incapable of providing instructions, or the patient requests the physician to administer pharmaceutical agents causing death;
    g. remain at the patient's location until the patient's death.
7. A prescribing or administering physician must certify, in writing, that he/she is satisfied on reasonable grounds that all of the following requirements have been met:

a. The patient is at least 18 years of age;

b. The patient's medical decision making capacity to consent to receiving medication that will intentionally cause the patient's death has been established in accordance with the requirements of the *Criminal Code* and this policy;

c. All of the requirements of the *Criminal Code* and this policy in relation to assessing eligibility for medical assistance in dying and obtaining and documenting informed consent have been met; and

8. A prescribing or administering physician must ensure that the requirements of physicians set out in all relevant federal and provincial legislation, including the *Criminal Code* 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.

USE OF STANDARD FORMS

The Medical Assistance in Dying (MAiD) - Provincial Program established a working group with broad representation to provide recommendations for forms which could be used to assist physicians, nurse practitioners, pharmacists and other health professionals to comply with the legislation, including the reporting requirements which came into effect November 1, 2018.

The College expects that physicians who receive a written request for Medical Assistance in Dying, or who assess patients for eligibility for medical assistance in dying, or who administer or prescribe for medical assistance in dying will utilize the forms that have been developed and follow the protocols contained in those forms.

The Medical Assistance in Dying (MAiD) - Provincial Program may also establish an expectation that the Medical Certificate of Death should be completed by the administering physician.

If additional documentation is developed by the working group, it will be made available through the Medical Assistance in Dying (MAiD) - Provincial Program, the Saskatchewan Health Authority and/or the College of Physicians and Surgeons website.

REPORTING AND DATA COLLECTION

The Government of Canada adopted regulations which came into effect November 1, 2018. Those regulations require physicians to provide a written report in several circumstances related to Medical Assistance in Dying. A physician is required to report if the physician receives a written request for Medical Assistance in Dying and one of the following occurs:

(a) The physician provides Medical Assistance in Dying;

(b) The physician refers a patient to another practitioner or a care coordination service for Medical Assistance in Dying;

(c) The physician assesses a patient and determines the patient is not eligible for Medical Assistance in Dying;

(d) The physician becomes aware that the patient has withdrawn the request;

(e) The physician becomes aware that the patient has died from a cause other than Medical Assistance in Dying.

If a physician is required to report, that report is made to the Saskatchewan Health Authority. The Saskatchewan Health Authority, together with other stakeholders including the Government of Saskatchewan and the College, have approved forms for use by physicians to meet this reporting obligation.

Reporting forms can be Faxed to the Saskatchewan Health Authority at 1-833-837-9006