



AHS CLINICAL ETHICS SERVICE

MEDICAL ASSISTANCE IN DYING:

Values-Based Self-Assessment Tool for Health Care Providers
(including Physicians)

FEBRUARY 2017

Introduction

The term ‘medical assistance in dying’ means either the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or 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.¹

The consideration and provision of medical assistance in dying can be broken down into five phases, as described below, including the pre-contemplative, contemplative, determination, action, and post-death phases.

The purpose of this self-assessment tool is to:

1. Support individuals to clarify or deepen their understanding of their own ethical perspective on medical assistance in dying;
2. Provide individuals with a language with which they can better convey their perspective to others; and
3. Enable individuals to further understand other perspectives

It is important to note that, regardless of the legal status of medical assistance in dying, no health care provider is compelled to provide medical assistance in dying. Health care providers who feel uncertainty in terms of the role they may or may not play should refer to the advice of their Regulatory Colleges for guidance on how to proceed.

Instructions:

STEP 1:

REVIEW THE PHASES OF A PROCESS THAT MAY LEAD TO MEDICAL ASSISTANCE IN DYING

STEP 2:

REVIEW THE VALUE STATEMENTS (TABLE 1) AND CHECK EACH THAT RESONATES WITH YOUR PERSPECTIVE

STEP 3:

DETERMINE WHICH OF THE GENERAL VIEWS MOST ALIGNS WITH YOUR SELECTED VALUE STATEMENTS AT THIS TIME

STEP 4:

CONSIDER THE PRACTICAL IMPLICATIONS OF YOUR PERSPECTIVE FOR YOUR INVOLVEMENT WITH MEDICAL ASSISTANCE IN DYING

¹ Legislative Background: Medical Assistance in Dying (Bill C-14), Government of Canada, 2016. p.7

Step 1. Phases

Begin by reviewing these phases.²

Phases which may lead to a medically assisted death and health care provider roles:



² The phases are described in more detail in the Clinical Guide for Medical Assistance in Dying

Step 2. Values

Review the values statements in Table 1 and put a check mark next to the ones that you think are *most important* and best characterize your thoughts about medical assistance in dying. You may find that your perspective resonates with one part of a values statement but not another. This is to be expected. If you find this taking place, consider why you are having different responses in this way.

Table 1.
Values that motivate perspectives on medical assistance in dying

Primary Value Theme	Values Statements	Check those that resonate <i>most</i> with your perspective
1. Respect for Limits of Human Authority	A human being does not have the authority to take another human being's life, no matter what the circumstances.	<input type="checkbox"/>
2. Respect for the Divine	The decision to end life sits with a higher being/power (God, Allah, the Creator, etc.) and so humans should not interfere with this greater plan.	<input type="checkbox"/>
3. Sanctity of Life	Life is sacred; therefore, we should never actively end another person's life.	<input type="checkbox"/>
4. Minimizing Suffering	It is important that we minimize suffering for our patients. Access to medical assistance in dying for eligible patients is an option that can relieve physical pain, and emotional, and existential/spiritual suffering (including loss of control, meaning in life, and fear of the death) through the choice to die.	<input type="checkbox"/>
5. Respecting Patient Wishes (Autonomy)	In certain circumstances, patients should be able to control the mode and timing of their deaths.	<input type="checkbox"/>
6. Promoting Fairness/Justice	Medical assistance in dying enables equal access to the choice to end one's life. Able-bodied individuals may be able to end their own lives without assistance, whereas those with diminished abilities may not be able to do so. Further, those who have the financial means, the capacity to plan and navigate systems, and supportive relationships can currently seek medical assistance in dying internationally, whereas those without these resources cannot.	<input type="checkbox"/>
7. Preserving Dignity	People who are suffering from incurable or terminal conditions may wish to avoid living in states that they perceive to lack dignity or want to be remembered in particular ways (e.g. independent, vibrant) and so should have control over the timing of their death.	<input type="checkbox"/>
8. Prolonging Life	Without access to medical assistance in dying, patients who have degenerative conditions may act to end their lives sooner than they might otherwise choose while they still have the physical capacity to do so.	<input type="checkbox"/>

Primary Value Theme	Values Statements	Check those that resonate <i>most</i> with your perspective
9. Care over the entire span of life, including death	Medical professionals are obliged to develop skills and deliver care over the complete span of life, including death. The care, attention, and energy that so often goes in to prolonging life should be matched by efforts toward ensuring that patients receive expert and compassionate care at the end of their lives	<input type="checkbox"/>
10. Commitment to Life-Saving Approaches	The availability of medical assistance in dying could lead to a devaluing of life within medicine which could result in a more cavalier attitude among physicians about hastening death, putting others at risk.	<input type="checkbox"/>
11. Protection of the Vulnerable	The availability of medical assistance in dying could lead to greater pressure on vulnerable others (sick, elderly, disabled) to choose medical assistance in dying.	<input type="checkbox"/>
12. Matching Care to Patient Need	It is important that excellent health care, including palliative care, is available to all patients suffering with challenging chronic symptoms or who are nearing the end of life. The availability of medical assistance in dying may lead to fewer efforts to address treatable conditions or to find other services or approaches that can meet our patients' needs.	<input type="checkbox"/>
13. Preserving Trust	It is important that people trust that the health system and their health care providers will work to look after their needs. Knowing that medical assistance in dying is provided within the health system could lead to people mistrusting health care which could result in some people not seeking the help that they need. It could also damage therapeutic relationships between patients and health care providers.	<input type="checkbox"/>
14. Preserving Health Care Provider Well-Being	It is important to me that I preserve my emotional/ spiritual/ psychological wellbeing and I am concerned about the potential personal impact of supporting patients to receive a medically assisted death.	<input type="checkbox"/>
15. Accountability and Organizational Support	It is important for me that I understand the process. I need to know more about how MAID will be provided, and specifically what my role would be and how I would be supported by the organization in discharging this role before I get more involved.	<input type="checkbox"/>
16 a. Preserving Harmonious Relationships	It is important for me to retain a positive image and have harmony with others. I do not want to be stigmatized or challenged by colleagues or friends/family/neighbours/members of my faith community, which may occur if I become involved in medical assistance in dying.	<input type="checkbox"/>
16 b. Preserving Harmonious Relationships	It is important for me to retain a positive image and have harmony with others. I do not want to be stigmatized or challenged by colleagues or friends/family/neighbours/members of my faith community, which may occur if I do <u>not</u> become involved in medical assistance in dying.	<input type="checkbox"/>

Step 3. Perspectives

Keeping the values that you selected in the table above in mind, review the following perspectives and choose which one best reflects your perspective on medical assistance in dying. You may find that your views align with components of different perspectives. That is ok. The important thing is to pay attention to what you understand your beliefs to be and why.

Table 2. Perspectives

PERSPECTIVE 1. Ethically object to Medical Assistance in Dying in principle

People who hold this perspective may ethically object to medical assistance in dying on the grounds that it represents (for conscience or religious beliefs) an overstepping of human authority or a failure to appropriately respect the sanctity of life (the values described in rows 1-3). Those who take this position may also have concerns about the potential effects caused by allowing medically assisted death (values described in rows 10-13). However, **due to having principled concerns** about the practice, those who hold this perspective are unlikely to change their views as more information about the processes and impacts of medical assistance in dying emerge. Similarly, those who take this position may hold some of the values listed in the rows 4-9, but do not take them to be so compelling as to override the views articulated in rows 1-3.

PERSPECTIVE 2. Ethically object to Medical Assistance in Dying on conditional grounds

People who hold this perspective ethically object to medical assistance in dying based on **concerns about the consequences** the practice may have for health care professions, health systems, accessibility of services for patients/clients, and the safety and vulnerability of particular groups (elderly/very ill/disabled). This perspective may be motivated by existing evidence about consequences of access to medical assistance in dying from other jurisdictions or about anticipated consequences of introducing medical assistance in dying in the Canadian context. Others may believe that enabling medical assistance in dying places us on a "slippery slope" where lifting the prohibition against offering assistance in dying under certain circumstances will lead to this prohibition (formally or informally) weakening in other circumstances. For example, that medical assistance in dying would be provided to those who do not meet specific eligibility criteria or that specific sectors of the population may feel added pressure to seek out an assisted death. Some people who hold this perspective may change their views about the permissibility of medical assistance in dying if, over time, the outcomes of concern do not come to pass in Canada. Others may see that the threat of negative consequences is constant, and will always have ethical reservations about the availability of medical assistance in dying.

PERSPECTIVE 3.

Not assisting with Medical Assistance in Dying based on inadequate information, practical or personal concerns

People who hold this perspective may choose not to be involved in medical assistance in dying for practical rather than ethical reasons (the values described in rows 14-16). Those who take this position may believe that there is too little information available about how medical assistance in dying will be provided and how it may affect those involved. Others may be concerned about the potential personal or professional consequences of their involvement in medical assistance in dying. It is possible to hold the values that support access to the procedure (statements 4-9) but to choose not to become involved for practical considerations. As more information becomes available about how medical assistance in dying will be organized and delivered, those who hold this position may determine their involvement in medically assisted death based on other reasons. This may lead them to elect to become involved, or to remain uninvolved. There are some who may always wish to avoid the complexity of the issue and so will continue to choose not to be involved.



PERSPECTIVE 4.

Not ethically in support of the procedure, but able to assist with Medical Assistance in Dying in a limited fashion

Individuals with this perspective may ethically object to medical assistance in dying but may not perceive being involved in the preliminary phases as contrary to their moral stance. This view may resonate with those who know that their skilled engagement can offer significant relief and even hope. Such engagement offers benefit for patients and could improve the conditions that led to the initial request for assisted death, thus minimizing the need to follow through with an assisted death.



PERSPECTIVE 5.

Ethically in support of the procedure, but only able to assist with Medical Assistance in Dying in a limited fashion

Individuals with this perspective believe that medical assistance in dying is ethically acceptable but wish only to be involved in a limited fashion, either by participating in particular phases of the process, or by choosing to only provide medical assistance in dying to patients with whom they have an established therapeutic relationship. Individuals who hold this view may have practical concerns (as articulated in statements 14-16) but are not so compelled by these considerations so as to be completely uninvolved. Rather, this combination of concerns leads them to adopt a limited or moderate ability to be involved.



PERSPECTIVE 6.

Ethically accepting of Medical Assistance in Dying and willing to be involved as much as is needed

Individuals in this group believe that medical assistance in dying is ethically acceptable and are willing to support eligible patients to have access to the procedure. Importantly, those whose values are heavily represented by statements 4-9 may still believe that the values described in other parts of the table are important. On balance, however, they may find that the values articulated in statements 4-9 are more compelling.



Step 4. Implications

What to do:

It is likely that, in the course of discussions about medical assistance in dying, people will encounter others with whom they disagree. Regardless of the individual perspectives involved, it is important that any interactions related to medical assistance in dying occur kindly, respectfully, and without judgment.

PERSPECTIVES 1, 2, OR 3:

You have chosen not to participate in Medical Assistance in Dying at any stage beyond a preliminary interaction

Individuals who align with this view are not obligated to participate in any phase of medical assistance in dying beyond the pre-contemplative phase. Within the pre-contemplative phase, all health care providers who are approached by patients or families about medical assistance in dying must respond in a non-judgement manner, explore the issues with the patient to the degree that they can, and then direct the inquirer to additional appropriate information sources (their treating physician, Health Link, web resources). Regulatory Colleges can be accessed to determine whether there are other requirements pertinent to the provider's health discipline. Providers with this perspective should continue to offer regular care (unrelated to medical assistance in dying) as long as the patient requires and accepts this care.

PERSPECTIVES 4 OR 5:

Your underlying values suggest that you are morally aligned with some practices relating to medical assistance in dying so are able to provide assistance through some phases of medical assistance in dying or only with particular patients

Review AHS process maps (available on the AHS website) to determine where your values suggest you can participate. Consult your regulating College to confirm your duties and obligations. When necessary, tell your colleagues and superiors which phases and roles you are prepared to support and, if you are comfortable doing so, the reasons for this decision. If you are not, from a values perspective, able to participate in all phases of medical assistance in dying and are working with patients who are seeking a medically assisted death, it is important to clarify with them the parts of the process where you will and will not be involved. Take care to inform the patient who will be supporting their care when you will not be present.

PERSPECTIVE 6:

Your underlying values suggest that you are morally aligned with the provision of medical assistance in dying so are able to provide assistance through all phases of Medical Assistance in Dying

If there is an opportunity to do so, consider contacting your regulator or the appropriate AHS department to inform them of your ability to be involved through all phases of medical assistance in dying. Become familiar with the policies and processes for the provision of a medically assisted death and with the resources that are in place to enable this work.



For more information:

Companion Resources (available on website)

- *Summary of Ethical Issues Relating to Medical Assistance in Dying*
- *Healing the Divide: A Health Care Provider's Relational Approach to Medical Assistance in Dying Discourse*

Contacts:

- AHS Clinical Ethics Service: clinicaethics@ahs.ca
- Care Coordinating Team: maid.careteam@ahs.ca



Contact Us:
AHS Clinical Ethics Service
1-855-943-2821
clinicaethics@ahs.ca