Medical Assistance in Dying Draft Policy Template

University of Toronto Joint Centre for Bioethics (JCB)
MAID Implementation Task Force

Updated: June 5, 2016

BACKGROUND

In January 2015, the University of Toronto Joint Centre for Bioethics (JCB) commissioned a Task Force on Implementing Medical Assistance in Dying (MAID, previously referred to as physician-assisted death) to anticipate and respond to ethical issues related to the implementation of MAID in Canada. The JCB Task Force is co-chaired by Sally Bean (Director, Ethics Centre and Policy Advisor, Sunnybrook Health Sciences Centre) and Dr. Philip Hébert (Professor, University of Toronto, Department of Family and Community Medicine). The JCB Task Force is an interdisciplinary group of scholars, practitioners, regulators, and community members working in collaboration with local and provincial health system stakeholders, including the Ontario Hospital Association (OHA), Ontario Shores Centre for Mental Health Sciences, and others. Further information about the JCB Task Force is available here: http://jcb.utoronto.ca/news/physician-assisted-death-resources.shtml.

Purpose of this document:

The MAID Model Policy Template was developed as a resource for Ontario health institutions to aid local planning to address and respond to patient inquiries or requests for medical assistance in dying. The draft policy template is intended for institutions that are participating in MAID and does not address institutional conscientious objection. The draft policy template seeks to operationalize the ethical principles of accountability, collaboration, dignity, equity, respect, transparency, fidelity and compassion.

Due to the evolving information surrounding MAID, this draft policy template is a *working document*. It will be updated iteratively as new legislative or regulatory information, including policy direction and resources from the Ontario Ministry of Health and Long Term Care (MOHLTC), is released. This resource contemplates the passage of Bill C-14 in the coming weeks, and is intended to support policy development in anticipation of Bill C-14 becoming law. This version of the model policy is current as of **June 5, 2016** and incorporates the following elements: 1) the Supreme Court of Canada's *Carter v. Canada* (Attorney General) ruling, 2) the College of Physicians and Surgeons of Ontario's Interim Guidance on Physician Assisted Dying, and 3) Proposed Federal legislation (Bill C-14) pertaining to MAID.

Instructions for use:

The draft policy template is designed for local adaptation. Text that appears in <blue font> between arrows is either optional language or indicating that the language should be tailored by relevant stakeholders within their local context, e.g., institutional, non-institutional, community, urban or rural. Throughout the document, the term Medical Assistance in Dying (MAID) will be used.

Disclaimer:

The draft policy template does NOT constitute legal advice. Health institutions, physicians, and other health practitioners should seek independent legal review and advice and discuss with professional colleges and insurers prior to implementation. The drafters of the model policy, their employers, and agents do not assume any liability, loss, damage, effects, or injury for damages arising from the use, adaptation or implementation of this model policy template. Prior versions of this policy should be disregarded.

JCB MAID IMPLEMENTATION TASK FORCE MEMBERS

For the current list of JCB MAID Implementation Task Force Members please visit: http://jcb.utoronto.ca/news/maid-draft-policy-template.shtml.

DRAFT MEDICAL ASSISTANCE IN DYING TEMPLATE

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POLICY STATEMENT <i.e. Background/Purpose/Scope/Introduction>

Scope

This policy applies to addressing patient inquiries or requests for Medical Assistance in Dying (MAID) (see definition) wherever an inquiry or request may arise within the <patient's/client's/resident's> healthcare journey. <(Refer to Definitions section for terms that appear in bold-face)>.

This policy does not apply to situations other than MAID and is separate and distinct from withholding or withdrawing treatment, palliative care (see definition) and palliative sedation.

Policy Statement

<Organization's name> recognizes the provision of MAID to a <patient/client/resident> meeting **eligibility criteria** (see definition) as a legal option within a participating[1] publicly funded <hospital, community health organization, chronic care institutions, etc.> that is participating in MAID. <To support implementation of MAID, <organization's name> will use an ethical framework to support medical and administrative decision-making. See Appendix TBA <Insert reference to organization's applicable ethical decision-making framework>.

<<Organization's name> <supports/acknowledges> the <ability/right> of individual healthcare <practitioners/providers/professionals> to **conscientiously object** (see definition) to participating in the provision of MAID in accordance with any requirements outlined in law, professional regulatory standards, <and employment/organization's requirements>. Correspondingly, <organization's name> <supports/acknowledges> the <ability/right> of individual healthcare <practitioners/providers/professionals> that support the provision of MAID to do so in accordance with the law and professional regulatory standards. Both participating and conscientiously objecting healthcare

[1] See *Local Health System Integration Act* S.O. 2006, s28,(2).

<practitioners/providers/professionals> must be treated in accordance with <Organization's name> <Code of Conduct/Respect Policy/Harassment Policy/Healthy Workplace Policy, etc.)>>

DEFINITIONS

<Canadian Medical Protective Association (CMPA): A mutual defense organization for physicians who practice in Canada. Its mission is to protect a member's integrity by providing services including legal defense, indemnification, risk management, educational programs and general advice.>

Capacity: A person is capable of making a particular decision if the individual is both 1) able to understand the information that is relevant to making that decision [the cognitive element] and 2) able to appreciate the reasonably foreseeable consequences of that decision or lack of decision [the ability to exercise reasonable insight and judgment].

<Care Coordinator: a professional regulated under the *Regulated Health Professions Act* or the *Social Work and Social Service Work Act* that manages home and community clients to ensure receipt of appropriate information, health care and support services. Additionally, provides a tailored, comprehensive assessment of client needs, develops the service plan, and determines available resources. >

Conscientious Objection: When an individual healthcare <practitioner/provider/professional>, due to matters of personal conscience, elects not to participate in MAID. The level of comfort and support an individual <practitioner/provider/professional> may or may not be willing to provide will likely vary in scope. For example, individual healthcare <practitioners/providers/professionals> may be comfortable supporting a range of activities such as having an exploratory discussion with the patient or providing a second medical opinion but are not willing to prescribe or administer, while other individual healthcare <practitioners/providers/professionals> may wish to limit their involvement in MAID to the full extent permitted by their professional regulatory colleges <or organization/employers>.

Consent: to provide informed consent to a <medication/service,> the following four requirements must be met: individual consenting must be capable (see definition for capacity); the decision must be informed (i.e., risks, benefits, side effects, alternatives, and consequences of not having treatment provided); made voluntarily (i.e., not obtained through misrepresentation or fraud); and be treatment specific (i.e., information provided relates to treatment being proposed). **Note**: **Neither substitute decision-maker consent nor advance consent (via an advance directive or living will) for MAID is permitted**.

Eligibility Criteria:

- **Competent** (i.e., capable) see definition for capacity. <Patient/Client/Resident> must be capable throughout process from request to completion.
- **Adult:** <patient/client/resident>, as required by Bill C-14, is eighteen years or older.
- **Grievous & Irremediable medical condition** (including an illness, disease or disability) that meets all of the following requirements:
  (a) a serious and incurable illness, disease or disability; and
  (b) 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; and
  (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining (Bill C-14).
- **Intolerable suffering:** 'subjective criteria that is assessed from the individual's perspective' (CPSO Interim Guidance on PAD; Carter v. Canada (Attorney General). "The <medical or nurse practitioner> must be satisfied that the <patient's/client's/resident's> condition causes them enduring physical and/or psychological suffering that is intolerable to the <patient/client/resident>. This may be demonstrated, in part, by communication by the <patient/client/resident> of a sincere desire to pursue MAID or through a dialogue with the <patient/client/resident> about their personal experience managing their condition" (CPSO Interim Guidance on PAD).
- **Clearly consents to termination of life:** 'The <medical or nurse practitioner> must be satisfied, on reasonable grounds, that the <patient's/client's/resident's> decision to undergo MAID has been made freely, without coercion or undue influence from family members, healthcare providers or others. The <patient/client/resident> must have a clear intention to end his/her own life after due consideration. The <patient/client/resident> must have requested MAID him/herself, thoughtfully and in a free and informed manner' (CPSO Interim Guidance on PAD).

Ethical Principles**: Eight high-level principles developed by Joint Centre for Bioethics Medical Assistance in Dying Task Force members to help guide decision-making around implementing MAID.**

- **Accountability:** Mechanisms exist to ensure that decision makers are responsible for their actions; all have an obligation to account for, and be able to explain one's actions
- **Collaboration:** Partnering with relevant stakeholders in a respectful and accountable manner such that each individual and entity understands their associated role and accountabilities.
- **Dignity:** The state or quality of being worthy of honour and respect of both humans and society. It belongs to every human by virtue of being human and to society as a

product of the interactions between and amongst individuals, collectives and societies.

- **Equity:** It suggests that like cases are treated similarly and dissimilar cases treated in a manner that reflects the dissimilarities; and is characterized by the 'absence of avoidable or remediable differences among groups of people regardless of social, economic, demographic or geographic definition' (WHO).
- **Respect:** Recognition of the individual's right to make individual choices according to their values and beliefs (within shared legal parameters). The collective endeavours of individuals may also deserve respect, though perhaps of a different degree than the level of respect afforded to individuals.
- **Transparency:** The quality of acting in a way that ensures that the processes by which decisions are made are open to scrutiny, and the associated rationales are publicly accessible.
- **Fidelity:** (interpersonal-level) commitment to help people get through all facets surrounding requests, provision of MAID and the aftermath; (organizational-level) commitment on behalf of the organization to follow through and be supportive to both staff members and physicians that support the provision of MAID and those that conscientiously object.
- **Compassion:** response to individual suffering.

Independent (Eligibility Assessment)**:** Per proposed Bill C-14, an objective assessment provided by a medical or nurse practitioner who is not in any of the following relationships with the other <medical or nurse practitioner> assessing the patient or the <patient/client/resident> making the request:

- **Financial relationship:**
  - **Beneficiary:** (do not know or believe that they are) a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
  - **Business:** in a business relationship with the other practitioner, e.g. part of a partnership or practice model in which profits and losses are shared; or
- **Professional relationship:** a mentor to them or responsible for supervising their work; or
- **Personal relationship:** connected in any way that would affect objectivity.

Medical Assistance in Dying (MAID): Per Bill C-14, the administering by a <medical or nurse practitioner> of a substance to a <patient/client/resident>, at their request, that causes their death; or the prescribing[2] or providing by a <medical or nurse practitioner> of a

[2] Note: only physicians can prescribe narcotics. Ontario law would have to be amended to accommodate nurse practitioner prescribing for MAID.

substance to a <patient/client/resident>, at their request, so that they may self-administer the substance and in doing so cause their own death.[3]

<The intent for the treatment to result in the <patient's/client's/resident's> death is unique in MAID. This intent to result in the <patient's/client's/resident's> death distinguishes it from other options such as palliative care, palliative sedation, withholding or withdrawing treatment, or refusing treatment because death is not intended but may incidentally occur due to the <patient's/client's/resident's> underlying condition.>

Most Responsible <Physician/Nurse or Medical Practitioner> (MRP): The <medical or nurse practitioner> who <admits a patient/client/resident and> is accountable for the medical management of that <patient/client/resident> and thus plays a key role throughout the decision-making process and provision of care. The MRP may or may not be the <medical or nurse practitioner> that facilitates MAID for an eligible patient but may be an initial point of contact to receive an inquiry or request for MAID.

<Patient/Client/Resident: (acute care) patient refers broadly to any inpatient or outpatient at an acute care organization. Client refers broadly to any individual receiving health services, e.g. from a community care provider or mental health facility. Resident refers to any individual that has been admitted to and living in a long-term care home. Resident might also refer to an individual living in a retirement home, hospice, etc.>

Internal Resource Group (IRG): An interprofessional group comprised of individuals internal to <organization's name> that is responsible for the administrative oversight of the provision of MAID. <**Note:** It is important that any prospective review is distinct and separate from retrospective oversight to ensure independence.>

- **<Oversight activities** may include the following: leading development of clinical and administrative processes to implement MAID, supporting staff to meet their professional obligations when a <patient/client/resident> makes an inquiry or request for MAID, reviewing documentation of a <patient's/client's/resident's> MAID eligibility assessment, or retrospective review of documentation for quality improvement purposes. See Appendix #TBD for MAID-IRG Terms of Reference. >[4]

Palliative Care: aims to provide comfort and dignity for the <patient/client/resident> living with the illness, as well as the best quality of life for the <patient/client/resident> and family. An important objective of palliative care is relief of pain and other symptoms. Palliative care meets not only physical needs, but also psychological, social, cultural, emotional and spiritual needs of each <patient/client/resident> and family. Palliative care may be the main focus of

[3] *A.B. v. Canada* (Attorney General), 2016 ONSC 1912. Cause of death for reporting to the Coroner will be addressed by Provincial law. Note that per the A.B case (March 2016, Ont. Sup Ct), for reporting to the Coroner, the "cause of death" is determined to be the underlying medical condition and not assisted death.

[4] Note: the scope of activities for the IRG, e.g. confirming eligibility, may pose risk or liability concerns to the institution.

care when a cure for the illness is no longer possible. (Definition adapted from the Canadian Hospice Palliative Care Association, 2016).

<<Patient Access/Conscientious Objection Infrastructure>: a confidential <institution-based >system maintained by <members or a delegate of the Internal Resource Group> that <both/either> identifies <practitioners/providers/professionals> not willing to participate in MAID <and/or> <practitioners/providers/professionals> that are willing to participate in MAID,to facilitate timely access to MAID.>

POLICY

The policy's overarching premises are the following:

- <Organization's name> acknowledges an ethical obligation to respond to a <patient's/client's/resident's> inquiry or request for MAID whenever it may occur within the <patient's/client's/resident's> healthcare journey.
- <Organization's name> supports <patient/person/patient & family> centred care and acknowledges the right of eligible <patients/clients/residents> to choose MAID as one option.
- When a <patient/client/resident> makes an inquiry or request for MAID, assistance in dying is only one among several possible options that may be explored with the <patient/client/resident>.
- <Organization's name> <supports/acknowledges> the <ability/right> of individual healthcare <practitioners/providers/professionals> to **conscientiously object** (see definition) to the provision of MAID in accordance with any requirements outlined in law, their professional regulatory standards <and employment/organization's requirements>. <Reference any resources available to healthcare practitioners that wish to conscientiously object, e.g. CPSO, CNO, CPhO, etc.>.[5]
- <Organization's name> recognizes that healthcare <practitioners/providers/professionals> conscientious objection may vary in degree and points of time. For example, a healthcare <practitioner/provider/professional >may feel comfortable counselling a patient or assessing eligibility but object to prescribing or administering medication.
- <Organization's name, has x <**patient access/conscientious objection infrastructure** (see definition, specify relevant infrastructure details) in place to support healthcare practitioners to support MAID to the extent they are comfortable.>
- Although the emphasis in MAID is on the role of the <medical or nurse practitioner or **Most Responsible Physician/Practitioner** (MRP) (see definition), given the

[5] Reference Bill C-14 if approved legislation includes a conscience clause.

interprofessional reality of current healthcare practice, the support of other healthcare <practitioners/providers/professionals> is essential.

- The **ethical principles** (see definition) of accountability, collaboration, dignity, equity, respect, transparency, fidelity, and compassion inform deliberations for inquiries/requests for MAID.
- <Patient's/Client's/Resident's> that are deemed ineligible for MAID will continue to receive appropriate and high-quality care that meets their needs.
- <Organization's name> is committed to providing ongoing education and support to both healthcare <practitioners/providers/professionals> that support the provision of MAID as well as those that conscientiously object.

Procedure

1) **<Identify relevant <patient/client/resident> MAID access pathways.[6]** Identify which of the different pathways through which a <patient/client/resident> may access MAID are applicable to the practice setting (e.g. inpatient requesting provision in hospital; inpatient requesting provision in community; outpatient requesting provision in hospital; outpatient requesting provision in community; long-term care resident requesting provision in long-term care home; community client requesting provision in community; palliative care patient requesting provision in palliative care facility; or primary care patient requesting provision in community, etc.). In light of MAID access pathway, confirm drug availability in relevant pharmacy.>

2) **Process for notifying appropriate persons to initiate an exploratory discussion in response to a <patient/client/resident> inquiry or request for MAID.** Discussion of MAID is initiated when a <patient/client/resident> makes an inquiry or request for MAID to any member of their <interprofessional healthcare team, etc.>.

   a. **<Identify appropriate persons to facilitate exploratory discussion**. For example, If the request is made to someone other than the **Most Responsible Physician/Practitioner** (MRP) (see definition), the healthcare <practitioner/provider/professional > receiving the inquiry or request should communicate to the <patient/client/resident> that <their MRP, a member of their interprofessional healthcare team, etc.> will be notified to have a follow up discussion with the <patient/client/resident>. If the MRP is not the individual having the follow up discussion, the <MRP > should be informed that the <patient's/client's/resident's> has made an inquiry or request.> **MAID Internal Resource Group** (MAID-IRG)(see definition) may be contacted via < # or @> to discuss this process.

[6] Note: patient care pathways are considered in the appendices and will be developed in the future.

<OR>

<In some cases, the healthcare <practitioner/provider/professional > receiving the inquiry or request may feel unprepared to have a conversation or conscientiously object to informing the <MRP or an appropriate person to have the conversation>. In some cases, the person must notify their <supervisor or delegate> that the <patient/client/resident is making an inquiry or request for MAID. Where possible, advance disclosure of intent to conscientiously object should be communicated to the <supervisor or delegate> so that advance disclosure to <patients/clients/residents> might be possible and another healthcare <practitioner/provider/professional > might be identified from the outset. The <Organization's name> > **MAID Internal Resource Group** (MAID-IRG)(see definition) may be contacted via < # or @> to discuss this process.

b. If the <MRP or appropriate person receiving the request> conscientiously objects to having an exploratory discussion with the patient (of available options, potentially including MAID), the <MRP/physician > must refer the patient to an appropriate physician or agency (in accordance with CPSO Interim Guidance on PAD policy). <Organization's name> **MAID Internal Resource Group** (MAID-IRG)(see definition) may be contacted via < # or @> to discuss this process.

c. Preliminary considerations:

   i. Explore a <patient's/client's/resident's> motivation for inquiring/requesting MAID. **See Appendix # TBA** for support on how to facilitate this conversation.
   ii. Have all other alternatives for care (that are acceptable to the<patient/client/resident>) been explored?
   iii. Has the <patient/client/resident> been informed of alternatives for care and likely associated outcomes?
   iv. How urgent is the patient's condition? For example, is the <patient's/client's/resident's> death or loss of capacity imminent?
   v. Have the perspectives of all appropriate individuals (with the <patient's/client's/resident's> consent) been involved?
   vi. If appropriate, make a referral to palliative care or other specialists to explore options for symptom management.
   vii. Has input from ethics, legal, and/or spiritual care been considered?
   viii. <Provide <patient/client/resident> with MAID FAQ document> (See Appendix # TBA MAID FAQ).

3) **Responding to a <patient/client/resident> inquiry or request for MAID.** The <MRP or healthcare <practitioners/providers/professionals> > communicates with the <patient/client/resident> to clarify if the discussion with the <patient/client/resident> constitutes an inquiry for additional information or a

request for MAID. If the discussion is merely a request for information, not all steps outlined in 3(a) below may be required. If the discussion reveals that the patient is making a request for MAID, the <medical or nurse practitioner > doing the assessment should explore the following areas with the <patient/client/resident>:

a. Assess the <patient/client/resident>to see if eligibility criteria are met. (See Appendix # **TBA** eligibility checklist).

   i. Confirm <patient's/client's/resident's> age and residency status, i.e. 18 years or older and eligibility for the Ontario Health Insurance Program.

   ii. Confirm <patient's/client's/resident's> capacity. (Add information regarding resources or where to seek additional support).

   iii. Does the <patient/client/resident> have a **grievous and irremediable medical condition** (including an illness, disease or disability; see definition under eligibility criteria)? Confirm that all of the following grievous and irremediable medical condition requirements are met:
      - condition is serious and incurable; and
      - <patient/client/resident> is in an advanced state of irreversible decline in capability; and
      - condition or state of decline causes enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions acceptable to the <patient/client/resident>; and
      - natural death has become reasonably foreseeable, taking into account all medical circumstances.

   If not, other options should be explored.

   iv. Is the <patient/client/resident> experiencing **intolerable suffering** (see definition under eligibility criteria)?

   If not, other options should be explored.

   v. Has the <patient's/client's/resident's> request for MAID been made freely, without coercion or undue influence from family members, healthcare providers or others? (See definition for clearly consent to termination of life).

   If not, other options should be explored.

b. Confirm that <patient/client/resident> request meets Bill C-14 documentation requirements, e.g. written request and independent witnesses, etc. See appendix #TBA for documentation requirements.

c. Determine and communicate to <patient/client/resident> if <medical or nurse practitioner > assesses that the individual is eligible or ineligible for MAID.

i. If <patient/client/resident> is deemed eligible for MAID, inform them of MAID process involved, particularly of their ability to decline MAID at any point. (See Appendix # for a process flow or overview of MAID, **TBA**).

ii. If <patient/client/resident> is deemed ineligible for MAID, inform them of alternative options and option to consult another <medical or nurse practitioner> to reassess eligibility. <The medical or nurse practitioner should reasonably assist in identifying another medical or nurse practitioner to do the assessment.>

4) **Clarifying** <patient/client/resident> **eligibility determination.**

a. If <patient/client/resident> meets the eligibility criteria (outlined in 3a above), the < medical or nurse practitioner > refers to an **independent** (see definition) <medical or nurse practitioner> not previously involved in the care of the <patient/client/resident> for a second assessment of the <patient's/client's/resident's> eligibility. If it is unclear if medical practitioner meets the independence requirement, consult the **Canadian Medical Protective Association** (see definition). <Nurse practitioners may consult <organization's name> Chief Nursing Officer, general counsel, risk manager, or the CNO's Practice Advisory for guidance.>

b. Independent <medical or nurse practitioner> assesses the <patient's/client's/resident's> eligibility (criteria outlined in 3a above).

c. If <patient/client/resident> deemed eligible, explore available options for <medical or nurse practitioner> administration versus patient self-administration

d. Explore <patient's/client's/resident's> preference and options for the setting for MAID, <e.g. identify who patient would like to be in room during provision and options for a holistic experience, e.g. music, pets, etc.>

e. If <patient/client/resident> does not meet the eligibility criteria, the <MRP or delegate> provides the <patient/client/resident> an explanation regarding their ineligibility.

i. <Patient/Client/Resident> is informed that they may consult another <medical or nurse practitioner> for an eligibility assessment. <The MRP/medical or nurse practitioner should reasonably assist in identifying another MRP/medical or nurse practitioner to do the assessment.>

ii. <MRP or delegate> repeats discussion of alternatives for care

5) **Planning for provision of MAID to an eligible person.**

a. Key planning considerations:

i. Confirming 10 calendar day reflection period is fulfilled (unless <patient's/client's/resident's> imminent death or loss of capacity can be confirmed by two independent <medical or nurse practitioners>.

ii. Identify appropriate <patient/client/resident> centred location where MAID will be provided, e.g., private room.

iii. Confirm details of <patient's/client's/resident's> holistic end of life care plan, e.g., who will be present and any additional comforts that may be incorporated such as music, reading, pet visitation, etc).

iii. Identify/confirm which <medical or nurse practitioners> is willing to prescribe or administer.

iv. Identify/confirm which interprofessional team members are willing to support provision of MAID to eligible <patient/client/resident>. <If in community, confirm with service provider organizations if the organization is willing or able to provide a <medical or nurse practitioner> to participate in MAID>.

v. If an IV is required, identify which healthcare <practitioner/provider/professional> is willing to insert the IV that will be used to administer the medication.

vi. Confirm that the identified pharmacy that will be filling the prescription has drug availability, an appropriate turnaround time, and can address any other potential impediments.

vii. Identify the medication protocol, including dosage, that will be used to for either <medical or nurse practitioner administration> or <patient/client/resident> self-administration.

viii. Conduct a case walk through with all interprofessional team members that will be participating in the administration by confirming eligibility criteria, confirming individual roles, and identifying the order and dosage of the medications that will be administered.

ix. Educate <patient/client/resident> family members and any other persons that will be present what to expect during the provision of MAID.

6) **Provision of MAID**

a. Before proceeding, confirm the following:

i. <Patient/Client/Resident> is capable and wishes to proceed with MAID.

ii. Required MAID and clinical documentation[7] has been completed. See Appendix #TBA. In particular, ensure patient capacity and consent has been documented.

7) **Post MAID Provision: ongoing support, monitoring, and follow up.**

a. Complete documentation and any necessary reporting requirements.[8] Additional details TBA.

b. Debrief with interprofessional team members and family regarding the MAID process and any opportunities for improving the process.

c. <IRG reviews completed documentation from a quality improvement perspective.>

d. <Identify resources that healthcare <practitioners/providers/professionals> may access to obtain additional support.

[7] Refer to CPSO's Interim Guidance on PAD documentation requirements section which also references the College's Medical Records Policy which establishes physicians' professional and legal obligations with respect to medical records.
[8] CPSO's Interim Guidance on PAD directs physicians to consult the Ontario Government for guidance on the completion of death certificates and any other reporting obligations for MAID.

REFERENCES

TBA

RELATED <ORGANIZATION'S NAME> POLICIES/GUIDELINES

TBA

APPENDICES (TBD) [9]

MAID-IRG TOR
Bill C-14 Formal MAID request
Bill C-14 documentation requirements
Patient & Family FAQs
Illustrative Cases
Process Flow Map
MAID access pathways (TBA)
Education guide for exploratory discussion (TBA)
Capacity assessment resources (TBA)
Patient eligibility checklist (TBA)

ACKNOWLEDGEMENTS

Select portions of this policy have been adapted from The Ottawa Hospital's MAID Policy and Trillium Health Partner's MAID Policy.

[9] To the extent that any of the appendices overlap or conflict with Ministry of Health and Long-Term Care issued MAID resources, the Ministry resources should be followed.

APPENDICES

Appendix # TBD

Template for MAID Internal Resource Group Terms of Reference

Purpose:

The purpose of the Medical Assistance in Dying (MAID) Internal Resource Group is to provide the administrative support and oversight of the provision of MAID in <Organization's name>.

<Oversight activities may include the following: leading development of clinical and administrative processes to implement MAID, developing educational resources to enhance knowledge understanding and awareness about MAID within <Organization's name>, supporting staff to meet their professional obligations when a <patient/client/resident> makes an inquiry or request for MAID, collaborating with relevant internal resources and with community partners, reviewing documentation of a <patient's/client's/resident's> MAID eligibility assessment, or retrospective review of documentation, tracking and reporting for quality improvement purposes.>[10]

Reporting Relationship:

The MAID IRG will report to <Senior Leadership Team/Quality of Care Committee of Board/ Management Committee, etc. at x# times per year.>

Membership:

The MAID IRG reflects interprofessional composition and is comprised of the following roles: <For example, Ethicist, Physician Leaders x2-3), Chief Nursing Executive, Chief Medical Executive, Professional Lead representatives from social work, nursing, pharmacy, spiritual care, patient/family advisor or representative, etc.> <Identify Chair or Co-chairs>.

Frequency of Meetings:

<Meetings will be scheduled as needed depending on the frequency of MAID requests but at a minimum, will meet quarterly.>

[10] Note: the scope of activities for the IRG may pose risk or liability concerns.

Quorum:

50% + 1

Review:

<The TOR should be reviewed annually or updated when required.>

Acknowledgement: This model Terms of Reference has been adapted from Hamilton Health Sciences' Physician-Assisted Dying Resource and Assessment Service Team Charter, McKenzie Health's Medical Assistance in Dying Resource Group Terms of Reference, and Toronto Central Community Care Access Centre's Internal Resource Task Force Terms of Reference.

Appendix # TBD

<Patient/Client/Resident> Formal Request for Medical Assistance in Dying

Under Authority of: ***An Act to amend the Criminal Code and to make related amendments to other Acts*** **(medical assistance in dying), 2016 (currently, Bill C-14)**

A. Request

i. I am formally requesting medical assistance in dying.

ii. I understand that my request for medical assistance in dying must be approved by two independent medical or nurse practitioners, who determine if I meet the eligibility criteria.

iii. I understand that at any time, and in any manner, I may withdraw my request.

Patient Name (printed)	Patient Signature	Date

B. If patient is unable to sign (print patient's name in A. and then complete remainder of B.)

i. I attest that this written statement represents the <patient's/client's/resident's> request for MAID and I am signing on the patient's behalf because the patient is physically unable to do so.

ii. I attest that I meet the criteria of an independent witness (below).

Name (printed)	Signature	Date

C. Independent witness

Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they:

a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;

b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;

c) are directly involved in providing health care services to the person making the request; or

d) directly provide personal care to the person making the request.

D. Witnesses

Witness 1

i. I attest that the patient has signed this document or if unable, that the document represents the <patient's/client's/resident's> request for MAID.

ii. I attest that I meet the criteria for an independent witness.

Name (printed)	Signature	Date

Witness 2

i. I attest that the patient has signed this document or if unable, that the document reflects the current wish of the patient.

ii. I attest that I meet the criteria for an independent witness.

Name (printed)	Signature	Date

Acknowledgement: This form was developed by JCB MAID Implementation Task Force Member, Rob Sibbald

Appendix # TBD

Required Documentation for Medical Assistance in Dying

Under Authority of: *An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying), 2016 (currently, Bill C-14)

A. Eligibility for medical assistance in dying

A person may receive medical assistance in dying only if they meet all of the following criteria:

a) they are eligible or, but for any applicable minimum period of residence or waiting period, would be eligible for health services funded by a government in Canada;
b) they are at least 18 years of age and capable of making decisions with respect to their health;
c) they have a grievous and irremediable medical condition;
d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
e) they give informed consent to receive medical assistance in dying.

B. Independence of Practitioners

The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the other opinion are independent if they:

a) are not in a business relationship with the other practitioner, a mentor to them or responsible for supervising their work;
b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

C. Assessments

First Assessment

i. I have assessed the patient named above and determined that they meet the above criteria.
ii. I am independent of the practitioner named in part B.
iii. I am a □ Medical Practitioner; □ Nurse Practitioner.

Name (printed)	Signature	Date of Assessment

Second Assessment

i. I have assessed the patient named above and determined that they meet the above criteria.
ii. I am independent of the practitioner named in part B.
iii. I am a □ Medical Practitioner; □ Nurse Practitioner.

Name (printed)	Signature	Date of Assessment

D. Day of Procedure

I attest to the following:

- □ I am a registered medical practitioner or nurse practitioner.
- □ At least 10 clear days have passed between the day on which the request was signed by the person and today or if not, it is because myself and the other practitioner referred to in **Part B** above are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent.
- □ The pharmacist who dispensed the medication was informed about the purpose for which the medication would be used.
- □ Immediately before providing the medical assistance in dying, the person listed in **Part A** above was given an opportunity to withdraw their request.
- □ The person listed in **Part A** above has given express consent to receive medical assistance in dying.
- □ Any other regulatory obligations provided by my College and/or the Province of Ontario have been complied with.

Name (printed)	Signature	Date

Acknowledgement: This form was developed by JCB MAID Implementation Task Force Member, Rob Sibbald

Medical Assistance in Dying

FAQ for Patients and Families

After June 6, 2016

Acknowledgement:

Peter Allatt, Bioethicist, Mount Sinai Health System

Assistance in Dying: FAQ for Patients and Families has been developed to supplement discussion between patients, family and members of the healthcare team.

Assistance was provided by:

- Kevin Reel
- Sally Bean
- Philip Hebert
- Melanie de Wit
- Numerous beta testers

Beta testing continues with patients, family members and health care professionals.

Assistance in Dying: frequently asked questions

After June 6, 2016

Introduction

This handout is about the personal decision to request "medical assistance in dying." Assistance in dying is intended for patients with a serious condition that causes long-term suffering.

What is "Medical Assistance in Dying"?[1]

Medical Assistance in Dying means:

(a) Administering by a doctor or nurse practitioner of a substance to a person, at their request, that causes their death;

or

(b) Prescribing or providing by a doctor 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.

Please note: Until further notice, there may be limitations on the prescription or provision of oral medications.

Who can provide Medical Assistance in Dying?

Any physician (medical doctor) and or nurse practitioner (licensed in the province) can provide assistance in dying.

Who is eligible for Medical Assistance in Dying?

A person qualifies for medical assistance in dying if they meet **all** the following criteria:

a) Are eligible for a health card
b) At least 18 years of age and capable of making decisions with respect to their health
c) Have a grievous and irremediable medical condition (see below)
d) Have made a voluntary request for medical assistance in dying that, was not made as a result of external pressure, and
e) Give informed consent to receive medical assistance in dying.[2]

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[1] Bill C-14. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). S. 241.1 http://www.parl.gc.ca/LegisInfo/BillDetails.aspx?Language=E&Mode=1&billId=8177165

[2] Bill C-14. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). S. 241.2 (1) http://www.parl.gc.ca/LegisInfo/BillDetails.aspx?Language=E&Mode=1&billId=8177165

What does competent mean?

A competent person has decision making capacity. This means you are able to:

- Understand the information that is relevant to making a decision about the treatment

and

- Appreciate the reasonably foreseeable consequences of a decision or lack of decision.[3]

Your healthcare team assesses capacity by asking you questions.

What does it mean to clearly consent?

You will need to make two separate requests for assistance in dying. At least one request must be in writing. This shows you are sure about your request. Your team wants to be certain that you are not being forced into this decision, and that you have all the information you need to make this decision.

Is there a waiting period between the two requests?

Yes. There must be at least 10 days between signing the written request and assistance in dying (unless both healthcare providers agree that death or loss of capacity to consent is imminent). These 10 days give you an opportunity to think about your request, and to be sure this is what you want. Please ask your team for details on how this affects you.

What does grievous and irremediable medical condition mean?

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;
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;
d) and
e) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

What is enduring suffering?

Enduring suffering is physical or psychological pain or distress that you have lived with for a long time.

What is intolerable suffering?

Intolerable suffering is physical or psychological pain or distress that you find unbearable.

How is assistance in dying different from stopping or not starting treatment?

Patients may choose to stop treatment or not to start treatment. These decisions, like assisted dying, are each patient's decisions to make. Patients base these decisions on their values, beliefs and healthcare goals.

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[3] *Health Care Consent Act*, 1996, S.O. 1996, c.2 Sched. A, s. 4(1).

The key difference is the intent of the decision. Patients who choose to stop treatment or not to start treatment intend to avoid treatment that will not provide a benefit or that is too difficult. Their intent is not necessarily to bring about their own death. If death happens, the cause of death will be their disease.

With assistance in dying, the patient's death is intended.

Is assistance in dying the same as assisted suicide?

They are similar. Assistance in dying includes both patient administered and physician administered methods. In the past, the patient administered method was called assisted suicide.

Do I have to undergo treatment first?

No, you do not have to undergo treatment (e.g., chemotherapy, surgery) you find unacceptable. The Supreme Court wrote that irremediable: "… does not require the patient to undertake treatments that are not acceptable to the individual."[4]

Is there a right decision?

This is a personal decision based on your values, beliefs and health care goals. You determine what is right or wrong for you.

Does my physician have to agree I meet the criteria?

You will be assessed by two (2) or more physicians or nurse practitioners. They will have to agree that you meet the criteria. If one or more feel you do not meet the criteria, you can ask to be assessed by another physician or nurse practitioner.

Can I expect my health care team to provide assistance in dying?

Maybe. Many healthcare professionals and some healthcare institutions will be unwilling to help with assisted dying because it is not comfortable for them or goes against an institution's faith-based mission. It is a very personal choice for them, too. If they cannot help, you will be connected to a person or resource that will.

Do I have to inform my family[5]?

It is usually a good idea to try to involve your family - getting medical assistance in dying may have a major impact on them. If it is difficult to talk with your family for any reason, you can ask for help from your healthcare team (e.g., social workers, spiritual care providers, occupational therapists, or others).

How long will the assessment take?

It depends how much time the physicians or nurse practitioners require to make sure that you meet the criteria. Please speak to your healthcare team if you have concerns.

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[4] *Carter v. Canada (Attorney General)* 2015 SCC 5, [2015] 1 S.C.R. 331.[127] http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do.

[5] Family is defined as anyone important to the patient.

Where can I have Assistance in Dying?

Assistance in dying can be provided in hospital and at home. Your healthcare team will help you to review the options and discuss what is best for you.

Can family provide assistance in dying?

Family can help you to complete forms and provide support to the physician or nurse practitioner during the process. [11]

Can I have family and friends with me when I die?

Yes, you can have anyone you choose with you during assisted dying. You should discuss this with them well in advance to make sure they are willing to be present. The health care team will help prepare you and them. They need to understand what they will see before they agree.

Can others make the decision for me?

No, only you can make the decision to request assistance in dying. If you are not capable, others cannot make the decision for you.

Can I write down my wishes in case I lose capacity?

No, you must be able to ask for assisted dying at the time. You cannot write your wishes for assistance in dying in an advance care plan (e.g., living will).

Do I need to get court permission?

Maybe. Until Bill C-14 is approved and takes effect or other clear legal authority eliminates the need for a court order, you might have to get court permission. You may need to consult a lawyer on this issue.

Can I change my mind?

Yes, you can change your mind at any time, for any reason. Simply tell a member of your health care team. If you change your mind, there will be no negative consequences; you will continue to receive high quality care. No one will think any less of you if you change your mind.

What happens if the patient can't sign?

If the patient requesting assistance in dying is not able to sign and date the request, another person (at least 18 years of age) who understands that the patient is requesting assistance in dying may do so in the patient's presence on their behalf.

What if I have other questions?

If you have other questions, please ask a member of your health care team.

Additional information can be obtained from the College of Physicians and Surgeons of Ontario.

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[11] *Bill C-14. An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying). S. 227(2) http://www.parl.gc.ca/LegisInfo/BillDetails.aspx?Language=E&Mode=1&billId=8177165.

Appendix # TBD

Illustrative Cases: (Will include cases indicating a clear yes, clear no, equivocal eligibility, concurrent mental health, etc.)

1. Terminal Illness with Concurrent Depression

Senior in their late 70's with terminal metastatic lung cancer requests MAID. Individual has been taking anti-depressants for five years since the death of spouse from cancer. Person witnessed spouse's agonizing death from cancer and wishes to avoid a similar fate including loss of dignity. Individual fears loss of capacity and a subsequent inability to access MAID. Individual's two adult children are in disagreement about whether their parent should access MAID: one is fully supportive and the other completely objects.

Illustrative Questions:

Has the individual's depression been well-managed? What is individual's current psychological status? Is the request for MAID predominantly precipitating from a depressed outlook/point-of-view about the future? If applicable, is the individual willing to try alternative treatments for depression? What is the patient's prognosis? Is loss of capacity imminent? What is the rationale for each child's different perspective on MAID? Is the individual concerned about the disagreement between the children? What role could the healthcare team play to help mediate the disagreement?

2. Non-terminal Condition

An individual in their late 70's is experiencing debilitating spinal stenosis and associated morbidity including inability to walk or use of hands. The individual is in constant pain despite best attempts at medical management. The individual is no longer able to participate in activities that were once meaningful. Although modifications to the individual's home have been made to make it more accessible, the individual feels hopeless about the future and does not want to live the remainder of life in this physical and emotional state. The individual makes an appointment with their family physician to discuss potential options, including MAID. (Note, case adapted from: Incardona N, Bean S, Reel K, Wagner F. An ethics-based analysis and recommendations for implementing physician-assisted dying in Canada. Toronto: Joint Centre for Bioethics, University of Toronto. February 3, 2016).

Illustrative Questions:

Does individual meet Bill C-14 grievous and irremediable requirements, e.g. is a natural death reasonably foreseeable? What activities do provide meaning to the individual's life? What is the individual's emotional state? Has the individual been screened for or is receiving treatment for depression? Is the potential depression primary or secondary to the chronic pain? Have all palliative symptom relief options that are acceptable to the patient been considered and attempted? How long has individual known the family physician? Will the family physician have a historical perspective of the patient's deterioration and suffering?

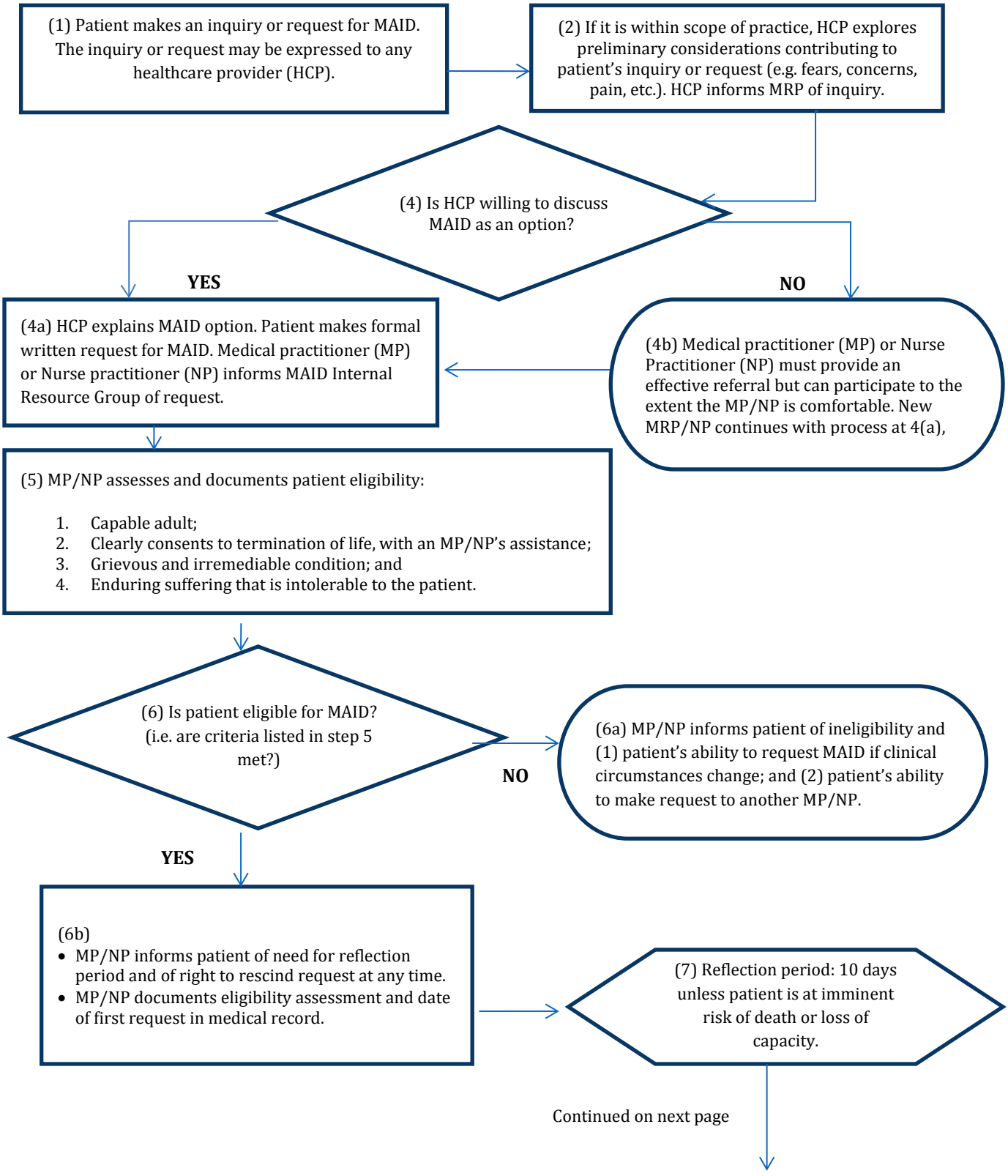
3. Chronic Disease and a Concurrent Mental Health Condition

Individual in their late 40's and suffers from schizophrenia. Individual is on medications that help to stabilize but is a long-term heavy smoker and enjoys the socialization aspect of smoking. Due to heavy smoking, individual has developed moderate COPD and has no interest in smoking cessation. Individual is on intermittent oxygen therapy and engages in unsafe practices, e.g. smoking while using the oxygen, despite repeated education on safe use. Although the individual could slow down the progression of COPD and prolong life, smoking cessation is refused. Due to repeated unsafe oxygen use practices, individual is getting evicted from public housing and is having difficulty finding an appropriate living environment. Individual is alienated from family and has no close friends, just a few acquaintances that the individual smokes with at the housing development. Otherwise, person is socially isolated. Individual fears a painful, inevitable death from COPD and requests MAID.

Illustrative Questions: Would this constitute a "serious and incurable disease" since individual refuses to stop smoking? Would individual consider a trial of potential harm reduction measures such as nicotine replacement therapy or vaping? Due to the psycho-social/social determinant factors (e.g. living situation/external pressures), is this truly a voluntary request? How soon after the housing issue arose did the individual request MAID? What alternative housing options or possibilities for reducing social isolation have been explored?

Flow Diagram for Assessing Patient Requests for Medical Assistance in Dying (MAID)

Note: This is only a high-level overview and should be supplemented by a detailed process.



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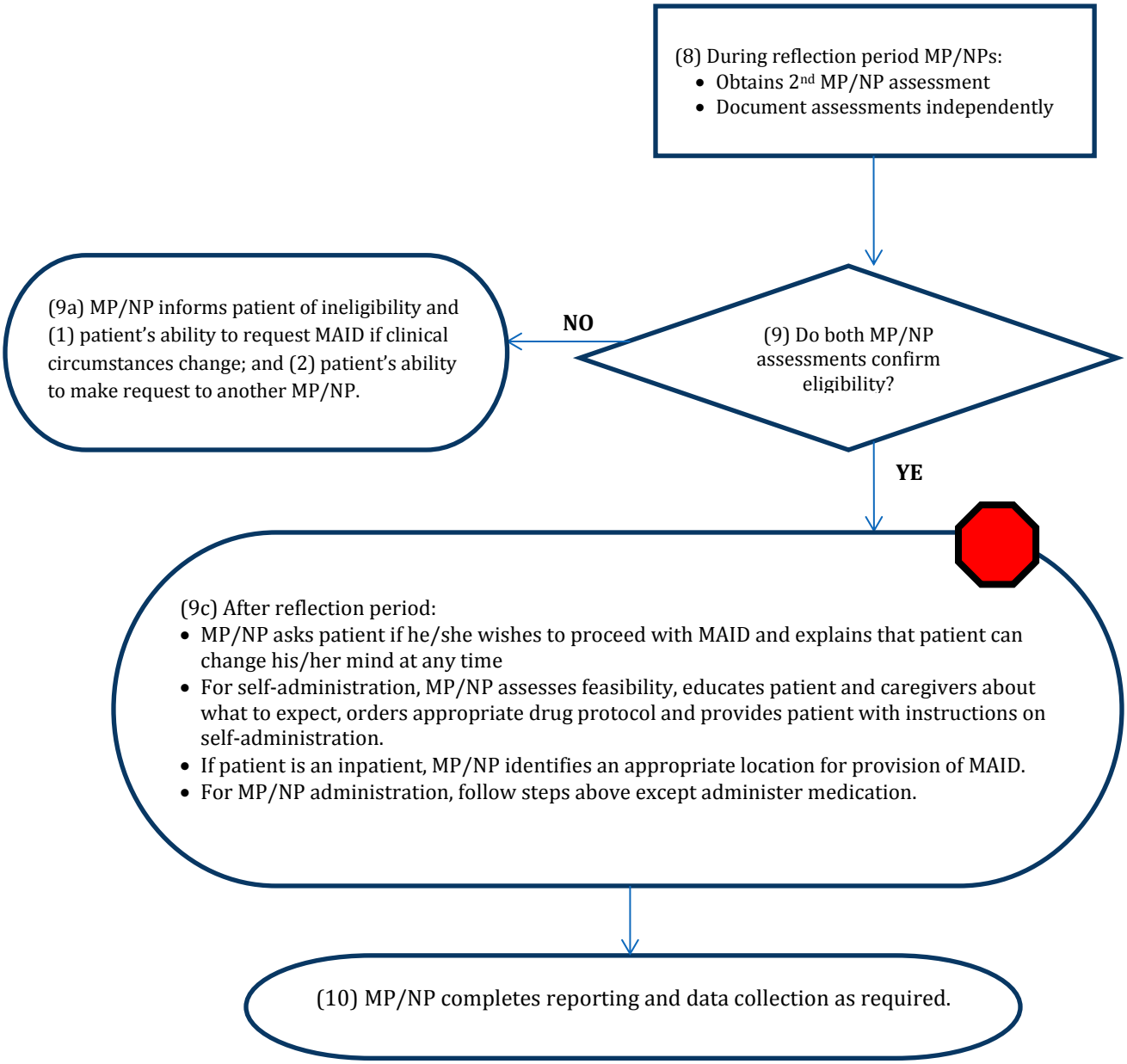

Acknowledgement: this flow chart was adapted from one created by
JCB MAID Implementation Task Force Member, Jonathan Breslin