Medical Assistance in Dying Policy Template

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

Updated: October 11, 2016

BACKGROUND

In January 2016, 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 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 policy template is intended for institutions that are participating in MAID and does not address institutional conscientious objection. The 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 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 version of the policy template is current as of **October 11, 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 Medical Assistance in Dying Policy, 3) the College of Nurses of Ontario Guidance on Nurses' Roles in Medical Assistance in Dying 4) Ontario College of Pharmacy Medical Assistance in Dying Guidance for Pharmacists & Pharmacy Technicians 5) The MOHLTC Medical Assistance in Dying Update: Stakeholder Presentation, week of July 18, 2016 6) The MOHLTC Medical Assistance in Dying Update: Stakeholder Question and Answer Resource, week of Aug. 1, 2016 and 7) the *Criminal Code* (as amended by Bill C-14).

Instructions for use:

The 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 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 policy template, 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 policy template. Prior versions of this policy template should be disregarded.

Summary of Changes to June 5th Version:

- Changed prior reference to Bill C-14 to the *Criminal Code* throughout template.
- Footnote 1 has been edited. The prior version has been deleted since the reference was specific to Local Health Integration Network integration decisions. Content regarding Long-Term Care Homes has been added.
- Footnote 2 has been edited to reference the conscience-related language contained in the *Criminal Code*.
- Definition of "Capacity" has optional language from the CPSO's MAID policy added.
- Definition of "Eligibility Criteria" has been revised to align with definitions from the *Criminal Code*: "capable" criterion has optional language included from MOHLTC resources pertaining to the potential role of the Consent and Capacity Board.
- Definitions of "Fidelity" and "Compassion" contained under the "Ethical Principles" definition have been enhanced.
- An additional definition of Independent has been added to clarify the requirements for witnessing the patient request.
- The definition of "Palliative Sedation Therapy" has been added.
- Deleted a portion of Footnote 3 that referenced *A.B. v. Canada* (Attorney General), 2016 ONSC 1912.
- Optional details regarding the MOHLTC clinical referral service have been added to the procedure section under 2b.
- Added steps to 3ci regarding informing patient that they have a grievous and irremediable condition and requirement to sign patient request form acknowledging that have been informed of said condition.
- Procedure step 5ai includes optional language from the CPSO's MAID policy defining "10 clear days."
- Procedure step 5aii contains new language regarding MAID and implications for organ and tissue donation.
- Procedure step 5aiii integrates new language providing notice to patient/family that completed MAID cases will require Coroner notification.
- Procedure step 5av has adopted the broader term of vascular access versus prior reference to one particular type, i.e. intravenous access.
- Procedure step 5avi contains information about the duty to inform the pharmacist regarding the intended use of the medication for MAID. Additionally, it contains optional language regarding drug coverage in the hospital and community settings.
- Procedure step 5aviii contains language to confirm the process for returning any unused medications following the MAID procedure.
- Procedure step 7b notes to consider including other potentially relevant individuals (e.g. cleaners, porters, interpreters) in the debrief.

- Links to the MOHLTC MAID Clinician Aid forms (A-C) have been added to the appendices.
- The FAQ in the appendices has been updated.
- The flow diagram in the appendices has been updated to align with policy template revisions.

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-policy-template.shtml.

MEDICAL ASSISTANCE IN DYING TEMPLATE

TABLE OF CONTENTS <insert hyperlinks>

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 therapy (see definition).>

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 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>.[2] Correspondingly, <organization's name> <supports/acknowledges> the <ability/right> of individual healthcare <practitioners/providers/professionals> that support

[1] Licensees of long-term care homes should refer to the licensees requirements and obligations within the *Long-Term Care Homes Act, 2007.*

[2] See preamble of Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying); see also *Criminal Code* "For greater clarity, nothing in this section compels an individual to provide or assist in providing medical assistance in dying" (s241.2(9)).

the provision of MAID to do so in accordance with the law and professional regulatory standards. Both participating and conscientiously objecting healthcare <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]. <"In the context of MAID, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of medication" (CPSO MAID Policy).**>**

<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 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:

- **Ontario Health Insurance Plan (OHIP) Eligible:** satisfies all OHIP eligibility requirements (but for the 90 day waiting period).
- **Adult:** <patient/client/resident>, as required by the *Criminal Code*, is eighteen years or older. <Note: the requirement that <patients/clients/residents> be at least 18 years or older departs from Ontario's *Health Care Consent Act* which does not specify an age of consent.>
- **Capable:** (see definition for capacity) <Patient/Client/Resident> must be capable to make decisions with respect to their health.
- **Grievous & Irremediable medical condition** (including an illness, disease or disability) that meets all of the following criteria:
  (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 (*Criminal Code* s241.2(2)(a)-(d)).
- **Voluntary:** <Patient/Client/Resident> has made an individual request for MAID that was not made due to external pressure.
- **Informed consent** (to MAID)**:** <Patient/Client/Resident> provides informed consent to receive MAID after having been informed of the options available to relieve their suffering, including palliative care.

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) an enduring commitment to support <patients/clients/residents> and families help people get through all facets surrounding MAID requests from inquiry to post-provision; (organizational-level) an ongoing commitment to support healthcare. <practitioners/providers/professionals> that support the provision of MAID and those that conscientiously object.
- **Compassion:** a deep, affective response to individual suffering and an appropriate response to relieve suffering.

Independent (Eligibility Assessment)**:** Per *Criminal Code*, 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/client/resident> making the request:

- **Beneficiary relationship:**
  (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
- **Professional relationship:** a mentor to them or responsible for supervising their work; or
- **Personal relationship:** connected in any way that would affect objectivity.

Independent (Witness for <Patient/Client/Resident> Request): Per *Criminal Code*, 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…;
(c) are directly involved in providing health care services…; or
(d) directly provide personal care to the person making the request.

Medical Assistance in Dying (MAID): 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 currently prescribe narcotics in Ontario.

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 (*Criminal Code* s.241.1(a)-(b)).[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 therapy, 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.>

Medical Practitioner: means a person who is entitled to practice medicine in the province of Ontario (*Criminal Code* s.241.1).

Most Responsible < 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.

Nurse Practitioner: means a registered nurse who, under Ontario law, is entitled to practice as a nurse practitioner and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat <patients/clients/residents> (*Criminal Code* s.241.1).

<Patient/Client/Resident: patient refers broadly to any inpatient or outpatient at an acute care organization. Client refers broadly to any individual receiving health services, 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]

[3] The *Criminal Code* outlines that the federal Minister of Health will establish guidelines in consultation with the provincial governments, on information included on death certificates which may include MAID and the qualifying condition that prompted the request.

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

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

<**Palliative Sedation Therapy:** is the continuous use of sedation until the <patient's/client's/resident's> death. It is an intervention to relieve suffering that is intolerable and refractory to the usual treatments for symptom management of the imminently dying <patient/client/resident> (Adapted from Sunnybrook's Palliative Care Unit Palliative Sedation Clinical Practice Guideline, 2015). >

<<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]

[5] See preamble of Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying); see also the *Criminal Code* "For greater clarity, nothing in this section compels an individual to provide or assist in providing medical assistance in dying" (s241.2(9)).

- <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 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> desire to die statement or an 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.>.

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

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.

<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 such 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. **<Note:** the MOHLTC has established a clinician referral support line to help Ontario clinicians to arrange for assessment referrals and consultation for <patients/clients/residents> requesting MAID. To access the service, call 1-844-243-5880.>

c. Preliminary considerations:

   i. Explore a <patient's/client's/resident's> motivation for expressing a desire to die statement or inquiring/requesting MAID. <See the Canadian Virtual Hospice's article: Assessing and managing a request for hastened death for support on how to facilitate this conversation. >

   ii. Have all other alternatives for care, e.g. palliative care, palliative sedation,

withdrawal of treatment, etc. and likely associated outcomes been explored with the <patient/client/resident>?

iii. How urgent is the patient's condition? For example, is the <patient's/client's/resident's> death or loss of capacity imminent?

iv. Have the perspectives of all appropriate individuals (with the <patient's/client's/resident's> consent) been involved?

v. If appropriate, make a referral to palliative care or other specialists to explore options for symptom management.

vi. Has input from ethics, legal, and/or spiritual care been considered?

vii. <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(b) below may be required. If the discussion reveals that the <patient/client/resident> is making a written request for MAID, the <medical or nurse practitioner > doing the assessment should confirm the content of the written request and explore the areas outlined in 3(b) with the <patient/client/resident>.

a. Confirm that <patient's/client's/resident's> written request meets *Criminal Code* documentation requirements, e.g. written request and independent witnesses, etc. See MOHLTC's <patient/client/resident> MAID request form available here.

b. Assess the <patient/client/resident> to see if eligibility criteria are met. See MOHLTC primary practitioner assessment form available here.

i. Confirm <patient's/client's/resident's> age and residency status, i.e. 18 years or older and eligible for OHIP.

ii. Confirm <patient's/client's/resident's> capacity. <Note: the CPSO recommends that physicians rely on recommended practices and procedures for capacity assessments.>

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. Has the <patient's/client's/resident's> request for MAID been made voluntarily without external pressure? (See definition for voluntary under eligibility criteria).

If not, other options should be explored.

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 #5 for a flow diagram of MAID).
   - Inform <patient/client/resident> that they have a grievous and irremediable condition.
   - Have the <patient/client/resident> sign and date the written request after being informed that the <patient/client/resident> has a grievous and irremediable condition. (See Appendix #2 for links to the MOHLTC Clinician Aids).

ii. If <patient/client/resident> is deemed ineligible for MAID, inform them of 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 3b 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 3b above). See the MOHLTC's secondary practitioner assessment form available here.

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/medical or nurse practitioner > 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 clear days 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>. <**Note:** the term "clear days" is defined as the number of days, from one day to another, excluding both the first and last day. Therefore, the MAID reflection period would begin on the day after the patient request is made and would end the day after the tenth day (CPSO MAID Policy, 2016).>

   ii. Identify appropriate <patient/client/resident> centred location where MAID will be provided, e.g., private room. <**Note:** if patient wishes to be an organ or tissue donor, this may affect the setting in which MAID can be provided in order to facilitate organ or tissue retrieval.>

   iii. <Medical or nurse practitioner> discloses to <patient/client/resident> that the Office of the Chief Coroner will investigate all MAID-related deaths. The extent of the coroner's investigation cannot be determined in

advance and may or may not include an autopsy (CPSO MAID Policy, 2016).

iv. 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. <Note: only physicians can currently prescribe narcotics in Ontario.>

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 healthcare <practitioners/providers/professionals> to participate in MAID>.

v. If vascular access (e.g. peripheral or central line) is required for <medical or nurse practitioner> administration, identify which healthcare <practitioner/provider/professional> is willing and available to insert the appropriate type of vascular access that will be used to administer the medication and that <practitioner/provider/professional> facilitating vascular access is aware of its intended use.

vi. Inform pharmacist at participating pharmacy that the medication is intended for the purpose of MAID. 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. <**Note:** MAID drug administered in the hospital setting will be covered by the global budget and for outpatient administration in the community, MAID drugs will be dispensed through a retail pharmacy at no charge. When a pharmacy receives and fills a prescription for MAID drugs, the pharmacy should submit an online claim to the MOHLTC through the Health Network System. Community providers should engage in discussions with relevant stakeholders, e.g. Calea (community supplier of medications and supplies to CCAC), to ensure that medications can be accessed in the community.>

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

viii. Confirm the process for returning any unused medications to the dispensing pharmacy.

ix. Conduct a case walk through with all interprofessional team member

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.

x. Educate <patient/client/resident> family members and any other persons that will be present what to expect during the <<medical or nurse practitioner> administration or self-administration > 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 MOHLTC's primary practitioner assessment form , secondary practitioner assessment form and patient request form. 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]

b. Debrief with interprofessional team members, and other relevant individuals (e.g. cleaners, porters, interpreters) as well as the 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 MAID policy 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] Under s. 10 of the *Coroners Act*, MAID deaths are required to be reported to the Office of the Chief Coroner, unless a court orders otherwise. The Coroner will be responsible for completing the death certificate. The Coroner is also required to complete a death investigation.

REFERENCES

TBA

RELATED <ORGANIZATION'S NAME> POLICIES/GUIDELINES

TBA

APPENDICES

1. MAID-IRG TOR
2. Links to MOHLTC's MAID Clinician Aids
3. Patient & Family FAQs
4. Illustrative Cases
5. Process Flow Map

ACKNOWLEDGEMENTS

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

APPENDICES

Appendix 1

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 2

Access most recent versions of voluntary MOHLTC clinician aids at the following Ministry webpage:
http://www.health.gov.on.ca/en/pro/programs/maid/

The clinician aid forms include the following:
Clinician Aid A: Patient Request for MAID
Clinician Aid B: Primary Practitioner MAID Eligibility Assessment
Clinician Aid C: Secondary Practitioner MAID Eligibility Assessment

Appendix 3

Medical Assistance in Dying

FAQ for Patients and Families

Peter Allatt, Bioethicist, Sinai Health System
3/10/2016

Assistance in Dying: FAQ for Patients and Families was developed to supplement discussion between patients, families and members of the healthcare team.
Assistance was provided by:

- Kevin Reel
- Sally Bean
- Philip Hebert
- Melanie de Wit
- Dianne Godkin
- Lauren Notini
- Andrea Frolic
- Many testers.

Testing continues with patients, family members and health care professionals.

Assistance in Dying: frequently asked questions

Introduction

This handout is about the personal decision to request "medical assistance in dying." Assistance in dying is intended for capable adults whose deaths are reasonably foreseeable.

1. 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.

Note 1: Ontario nurse practitioners are not currently permitted to prescribe controlled substances, some of which may be used in medical assistance in dying.

Note 2: Until further notice, oral medications are not widely available in Canada.

Note 3: Types of medication used for medical assistance in dying should be discussed with your doctor or nurse practitioner.

2. Who is eligible for Assisted Dying?

A person may be eligible for assisted dying if they meet **all** the following criteria:

a) Possess or are eligible for a provincial health card;
b) At least 18 years of age;
c) Capable of making decisions with respect to their health;
d) Have a grievous and irremediable medical condition (see below)'
e) Have made a voluntary request for assisted dying that, in particular, was not made as a result of external pressure, and;
f) Give informed consent to receive assisted dying after having been informed of the means that are available to relieve their suffering, including palliative care. [2]

[1] *Criminal Code* S. 241.1
http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014

3. What does capable mean?

A capable person has decision making capacity. You are able to:

- Understand the information that is relevant to making a decision about your health
  and
- Appreciate the reasonably foreseeable consequences of a decision or lack of decision.[3]

Your health care team assesses capacity by asking you questions.

4. What does it mean to give informed consent?

Before you request assistance in dying, you need to know about the options available to relieve suffering, including palliative care. Your health care team wants to make sure you have all the information you need to make this important decision.

Your team also wants to be certain that you are making this decision voluntarily -- that you are not being forced into it by someone.

Your consent is given in writing in front of two witnesses. This shows you are sure about your request. If you are unable to provide consent in writing, certain persons can sign on your behalf. (See questions #6 & #28 for more details).

5. Is there a waiting period?

Yes. Under normal circumstances there must be 10 days between the day you sign the request and the day you receive assistance in dying. This may be reduced if both the doctors/ nurse practitioners agree that death or loss of capacity to consent is near. Please ask your team for details on how this affects you. (See question #14 for details on doctor/nurse practitioner eligibility assessments).

6. Does my request need to be witnessed?

Yes, the request for assistance in dying must be signed and dated before **two** independent witnesses.

An independent witness

- is at least 18 years old
- understands the patient is requesting assisted dying
- will not benefit or does not believe they will benefit under the will or in any other way from the patient's death
- is not the owner or operator of a health facility in which the patient lives or is being treated
- is not providing health care services to the patient making the request

---

[2] *Criminal Code* S. 241.2 (1)
http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014
[3] Health Care Consent Act, 1996, S.O. 1996, c.2 Sched. A, s. 4(1).

- is not providing personal care to the patient making the request.

7. 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; 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.

8. What is enduring suffering?

Enduring suffering is physical or psychological pain or distress that has continued over time.

9. What is intolerable suffering?

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

10. How do I get started?

First, talk to your healthcare team about your concerns and your request. They will discuss all of your options with you. If you want to be formally assessed for assisted dying, you need to provide a request in writing, signed by two witnesses. This request should be given to your healthcare team. You can find the "Patient Request for Medical Assistance in Dying" form at http://www.health.gov.on.ca/en/pro/programs/maid/default.aspx

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

Patients choose when to stop treatment or when not to start treatment. These decisions, like assisted dying, are the personal decisions of each patient. Patients base these decisions on their values, beliefs and health care goals.

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 medical assistance in dying, the **patient's death is intended**. The cause of death is the medication given to the patient.

12. Is medical assistance in dying the same as assisted suicide?

Yes. Assisted dying includes both patient administered and doctor/nurse practitioner administered methods. In the past, the patient administered method was called assisted suicide.

13. Do I have to undergo treatment first?

No, you do not have to undergo any 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]

14. Does another doctor or nurse practitioner have to agree I meet the criteria?

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

15. Is there a right decision?

If you meet the criteria, this is a personal decision based on your values, beliefs and health care goals. You determine what is right or wrong for you.

16. What if I do not have a doctor or nurse practitioner?

If you do not have a doctor or nurse practitioner, you can contact health care connect:

https://www.ontario.ca/page/find-family-doctor-or-nurse-practitioner

or call **ServiceOntario, Infoline** 1-866-532-3161 TTY 1-800-387-5559. In Toronto, TTY 416-327-4282 Core hours : 8:30am - 5:00pm and ask how to join health care connect.

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

This varies. Some health care professionals will not be willing or able to help with medically assisted dying because it is not comfortable for them. It is a very personal choice for them, too. If they cannot help, you will be referred to someone who will.

18. Do I have to inform my family[5]?

[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.

It is usually a good idea to try to involve your family – getting assisted 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 health care team (e.g., social workers, spiritual care providers, occupational therapists, or others).

19. How long will the assessment take?

It depends how much time the doctors and nurse practitioners need to make sure that you meet the criteria. Please speak to your health care team if you have concerns.

20. Where can I have medical assistance in dying?

Medically assisted dying can be provided in hospital and at home. Your health care team will help you decide what is best for you.

21. Who can provide medical assistance in dying?

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

22. Can family provide medical assistance in dying?

Family can help you to complete forms and provide support during the process. Family cannot administer the medication that was prescribed by a doctor and intended to be administered by a doctor/nurse practitioner. However, if an eligible patient wishes to self-administer, and receives a prescription for self-administration, the family may assist at the patient's explicit request, for the purpose of helping the patient to self-administer.

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

Yes, you can have anyone you choose with you during the medical assistance in dying procedure. 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.

24. How long does the medical assistance in dying procedure take?

For doctor or nurse practitioner administration of medical assistance in dying, the procedure takes approximately 30 minutes to complete.

25. Can others make the decision for me?

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

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

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

27. Do I need to get court permission?

No. In Ontario, you do not need court permission to proceed. The decision is between you and your doctor or nurse practitioner.

28. 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.

Health care team members will confirm your wishes throughout the process.

29. What happens if I can't sign?

If you are not able to sign and date the request, another person may sign for you. This person must:

- be at least 18 years of age
- understand that the patient is requesting medical assistance in dying, and
- not know or believe they will benefit under the patient's will.

The signing must be done in your presence and under your direction.

30. What if I want to be an organ donor?

If you are considering medical assistance in dying and would like to be an organ and/or tissue donor please speak to your health care team or Trillium Gift of Life Network http://www.giftoflife.on.ca/en/ or 1-800-263-2833.

31. What if I have other questions?

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

Additional information can also be obtained from the:

College of Physicians and Surgeons of Ontario http://www.cpso.on.ca/

Ontario Ministry of Health and Long-Term Care
http://www.health.gov.on.ca/en/pro/programs/maid/default.aspx

Appendix 4

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

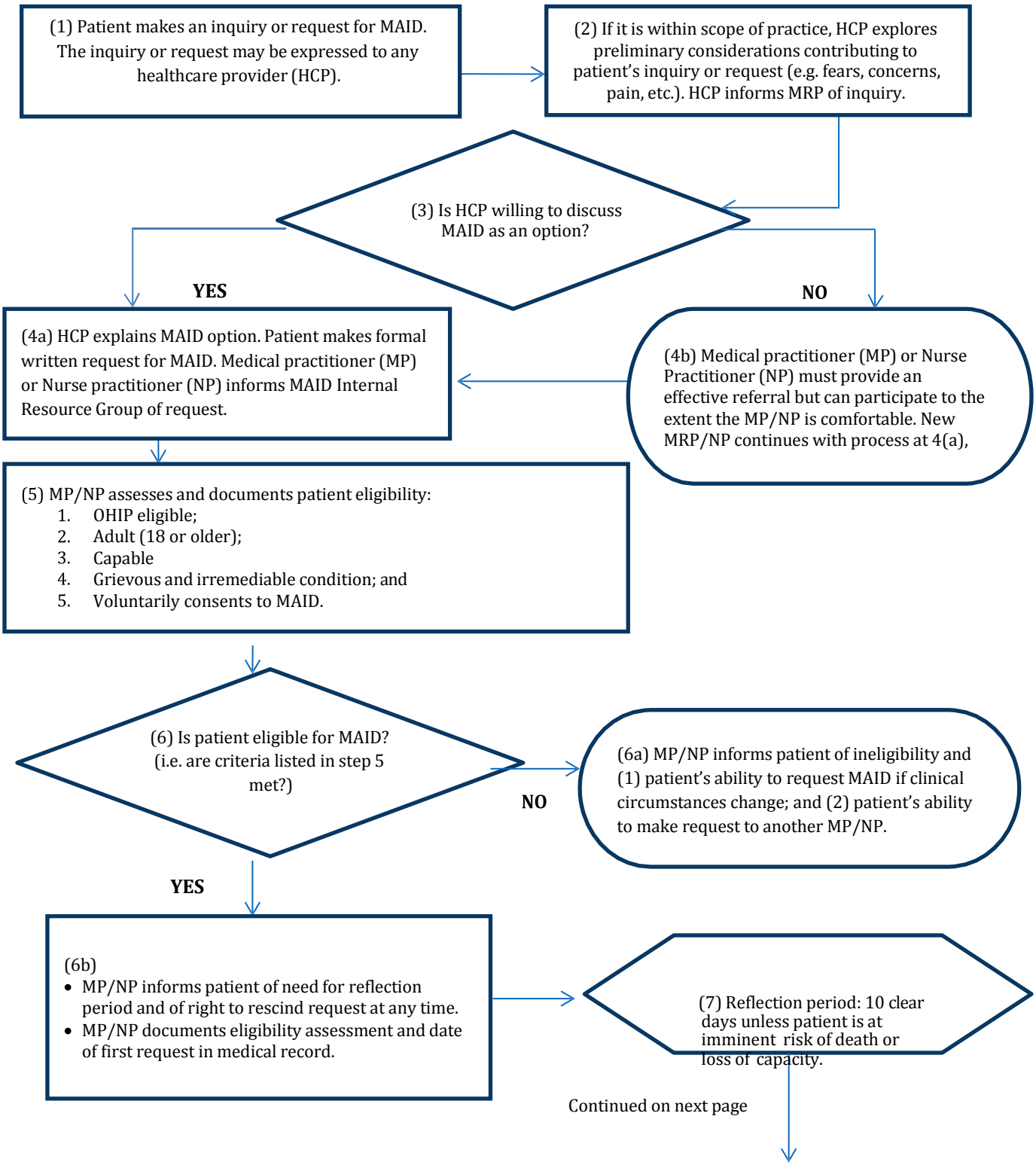
Individual in their late 40's and suffers from schizophrenia. Individual is on medications that help to stabilize but is a long-term heavy smoker and enjoys the socialization aspect of smoking. Due to heavy smoking, individual has developed moderate COPD and has no interest in smoking cessation. Individual 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?

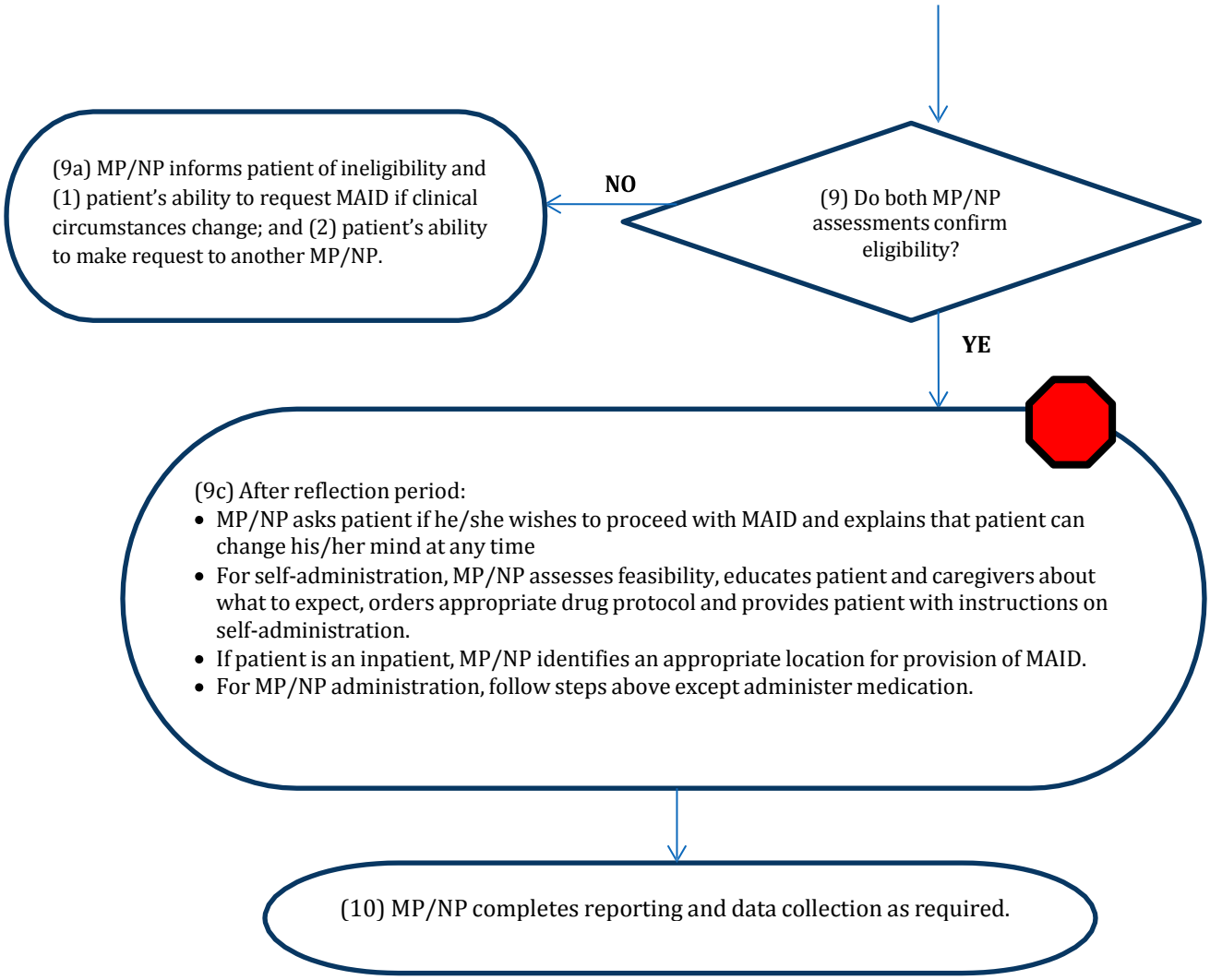
Appendix 5

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.



Continued on next page



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