Medical Assistance in Dying Policy

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Policy Statement

Scope

This policy applies to addressing resident inquiries or requests for Medical Assistance in Dying (MAID) (see definition) in a long-term care home (the "**Home**").

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

The Home recognizes the provision of MAID to a resident who meets the **eligibility criteria** (see definition) as a legal option within a publicly funded organization participating in MAID. The Home also supports the resident's right to choice and access to care and services to meet their needs.

The Home acknowledges the right of individual healthcare practitioners to **conscientiously object** (see definition) to participating in the provision of MAID in accordance with any requirements outlined in law, professional regulatory standards, and the Home's requirements.

Policy Statement (continued)

Residents should note that when physicians limit the health services they provide, including MAID, for reasons of conscience or religion, the College of Physicians and Surgeons of Ontario (CPSO) requires they provide residents with an "Effective referral" to a non-objecting physician, health care provider or agency in a reasonable accessible location and timely matter.

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].

Conscientious Objection: When an individual healthcare practitioner (medical practitioner, nurse practitioner, pharmacist or other individual supporting a resident who wishes to have MAID) due to matters of personal conscience, elects not to participate in MAID. The level of comfort and support an individual practitioner may or may not be willing to provide will likely vary in scope. For example, individual healthcare practitioners may be comfortable supporting a range of activities such as having an exploratory discussion with the resident or providing a second medical opinion but are not willing to prescribe or administer, while other individual healthcare practitioners may wish to limit their involvement in MAID to the full extent permitted by their professional regulatory colleges or the home with which they are affiliated (including as employees).

Consent: to provide informed consent to MAID, 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 for MAID is permitted**.

Referral: A Physician makes an effective referral when he or she takes positive action to ensure the resident is connected in a timely manner to another physician, health care provider, or agency who is non-objecting, accessible and available to the resident (see College of Physicians and Surgeons of Ontario Effective Referral Policy Act, https;//www.cpso.on.ca/Physicians/policies-guidance/Policies/Medical-Assistance-in-dying).

Eligibility Criteria:

- **Adult:** resident, as required by the amendments to the *Criminal Code* made with the coming into force of 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.

- **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 resident's condition causes them enduring physical and/or psychological suffering that is intolerable to the resident. This may be demonstrated, in part, by communication by the resident of a sincere desire to pursue MAID or through a dialogue with the 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 resident's decision to undergo MAID has been made freely, without coercion or undue influence from family members, healthcare providers or others. The resident must have a clear intention to end his/her own life after due consideration. The resident must have requested MAID him/herself, thoughtfully and in a free and informed manner (see CPSO Interim Guidance on PAD and other documents as updated).

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 and those that conscientiously object. MAID
- **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 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 resident, at their request, that causes their death; or the prescribing[1] or providing by a medical or nurse practitioner of a substance to a resident, at their request, so that they may self-administer the substance and in doing so cause their own death.[2]

[1] Note: Nurse practitioners do not currently have the scope of practice to prescribe narcotics (including the standard drugs currently used for MAID) under the *Controlled Drugs and Substances Act.* Ontario law would have to be amended to accommodate nurse practitioner prescribing for MAID. At the time of writing we do not believe an RN may administer the drugs. OANHSS will continue to monitor the role of nurse practitioners and RNs. If in doubt, consult the College of Nurses of Ontario (CNO).

The intent for the treatment to result in the resident's death is unique in MAID. This intent to result in the 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 resident's underlying condition.

Most Responsible Physician/Nurse or Medical Practitioner (MRP): The medical or nurse practitioner who is considered the resident's attending health practitioner (in most cases in long-term care, this will be the attending physician) is accountable for the medical management of that 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 resident but may be an initial point of contact to receive an inquiry or request for MAID.

Resident: Refers to any individual that has been admitted to and living in a long-term care home.

Internal Resource Group (IRG): An inter-professional group comprised of individuals internal to the Home 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 of MAID cases, to ensure independence. Long-term care homes will determine whether they wish to have such an internal committee, or what other oversight of MAID will be required, e.g. through another existing committee of the Home.

- 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 resident makes an inquiry or request for MAID, reviewing documentation of a resident's MAID eligibility assessment, or retrospective review of documentation for quality improvement purposes. [A MAID-IRG Terms of Reference document is available on the Joint Centre for Bioethics website][3]

Palliative Care: aims to provide comfort and dignity for the resident living with the illness, as well as the best quality of life for the 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 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).

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[2] 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.

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

Policy

The policy's overarching premises are the following:

- The Home acknowledges an ethical obligation to respond to a resident's inquiry or request for MAID whenever it may occur within the resident's healthcare journey.
- When a resident makes an inquiry or request for MAID, assistance in dying is only one among several possible options that may be explored with the resident.
- In addition to supporting palliative care services and other end-of-life care, the Home acknowledges the right of the resident who meets the eligibility criteria to choose MAID as an end-of-life option and that MAID will be available in the Home.
- The Home acknowledges the right of individual healthcare practitioners to **conscientiously object** (see definition) to the provision of MAID in accordance with any requirements outlined in law and their professional regulatory standards.
- The Home recognizes that healthcare practitioners' conscientious objection may vary in degree and points of time. For example, a healthcare practitioner may feel comfortable counselling a resident or assessing eligibility but object to prescribing or administering medication.

  Most Responsible Physician/Practitioner (MRP) (see definition) remains responsible, but given the inter-professional reality of current healthcare practice, the support of other healthcare practitioners is essential.
- The **ethical principles** (see definition) of accountability, collaboration, dignity, equity, respect, transparency, fidelity, and compassion inform deliberations for inquiries/requests for MAID.
- Resident's that are deemed ineligible for MAID will continue to receive appropriate and high quality care that meets their needs.
- The Home is committed to providing ongoing education and support to both healthcare practitioners that support the provision of MAID as well as those that conscientiously object.
- The Home allows external assessors on site to provide MAID assessment and provisions.

Procedure

1) ***Identify resident MAID access pathways.***
Identify which of the different pathways through which a resident may access MAID are applicable to the practice setting i.e., a long-term care resident requesting provision within the Home; confirm drug availability in relevant pharmacy.

2) ***Process for notifying appropriate persons to initiate an exploratory discussion in response to a resident inquiry or request for MAID.*** Discussion of MAID is initiated when a resident makes an inquiry or request for MAID to any member of their inter-professional healthcare team.

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 receiving the inquiry or request should communicate to the resident that their MRP will be notified to have a follow up discussion with the resident. If the MRP is not the individual having the follow up discussion, the MRP should be informed that the resident has made an inquiry or request. **MAID Internal Resource Group** (MAID-IRG) (see definition) may be contacted (or, an existing internal committee may assume any MAID-IRG functions).

b. If the identified person (e.g. MRP) conscientiously objects to having an exploratory discussion with the resident (of available options, potentially including MAID), the MRP must refer the resident to an appropriate physician or agency (in accordance with CPSO Interim Guidance on PAD policy).

c. **Preliminary considerations:**
   i. Explore a resident's motivation for inquiring/requesting MAID.
   ii. Have all other alternatives for care (that are acceptable to the resident) been explored?
   iii. Has the resident been informed of alternatives for care and likely associated outcomes?
   iv. How urgent is the resident's condition? For example, is the resident's death or loss of capacity imminent?
   v. Have the perspectives of all appropriate individuals (with the 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?

3) ***Responding to a resident*** **inquiry or request for MAID**. The MRP communicates with the resident to clarify if the discussion with the 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 resident is making a request for MAID, the medical or nurse practitioner doing the assessment should explore the following areas with the resident:

a. Assess the resident to see if eligibility criteria are met.

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

ii. Confirm resident's capacity.

iii. Does the 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
- 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 resident; and
- natural death has become reasonably foreseeable, taking into account all medical circumstances.

If not, other options should be explored.

iv. Is the resident experiencing intolerable suffering (see definition under eligibility criteria)?

If not, other options should be explored.

v. Has the 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 resident request meets Bill C-14 documentation requirements, e.g. written request and independent witnesses, etc.

c) Determine and communicate to resident if medical or nurse practitioner assesses that the individual is eligible or ineligible for MAID.

i. If resident is deemed eligible for MAID, inform them of MAID process involved, particularly of their ability to decline MAID at any point.
ii. If 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 resident eligibility determination.

a. If 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 resident for a second assessment of the resident's eligibility. If it is unclear if medical practitioner meets the independence requirement, medical practitioners should consult the **Canadian Medical Protective Association** (see definition). Nurse practitioners may consult the Home's Director of Care [or other applicable role].

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

c. If resident deemed eligible, explore available options for medical or nurse practitioner administration versus resident self- administration.

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

e. If resident does not meet the eligibility criteria, the MRP or delegate provides the resident an explanation regarding their ineligibility.
   i. 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 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 resident's imminent death or loss of capacity can be confirmed by two independent medical or nurse practitioners.
   ii. Identify appropriate resident centred location where MAID will be provided, e.g., private room.
   iii. Confirm details of 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 inter-professional team members are willing to support provision of MAID to eligible resident. If MAID will be performed on-site at the Home by external providers, document this.
   v. If an IV is required, identify which healthcare Practitioner 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 resident self-administration.
   viii. Conduct a case walk through with all inter-professional 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 resident and family members and any other persons who will be present what to expect during the provision of MAID.
   x. Ensure that confidentiality is maintained throughout the MAID process.

6) ***Provision of MAID***

a. Before proceeding, confirm the following:

i. Resident is capable and wishes to proceed with MAID.

ii. Required MAID and clinical documentation has been completed. In particular, ensure resident capacity and consent has been documented in accordance with the rules established with the enactment of Bill C-14 and the Home's requirements.

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

a. Complete documentation and any necessary reporting requirements.5

b. Debrief with inter-professional 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. [optional]

d. Identify resources that healthcare practitioners may access to obtain additional support.

e. Offer support and resources to family for bereavement.

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[4] 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.

[5] 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.

Schedule 1

Resident Formal Request for Medical Assistance in Dying

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.

Resident Name (printed) Resident Signature Date

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

i. I attest that this written statement represents the resident's request for MAID and I am signing on the resident's behalf because the resident 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 resident has signed this document or if unable, that the document represents the <resident'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 resident has signed this document or if unable, that the document reflects the current wish of the resident.
ii. I attest that I meet the criteria for an independent witness.

Name (printed) Signature Date

Schedule 2

Required Documentation for Medical Assistance in Dying

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 resident 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

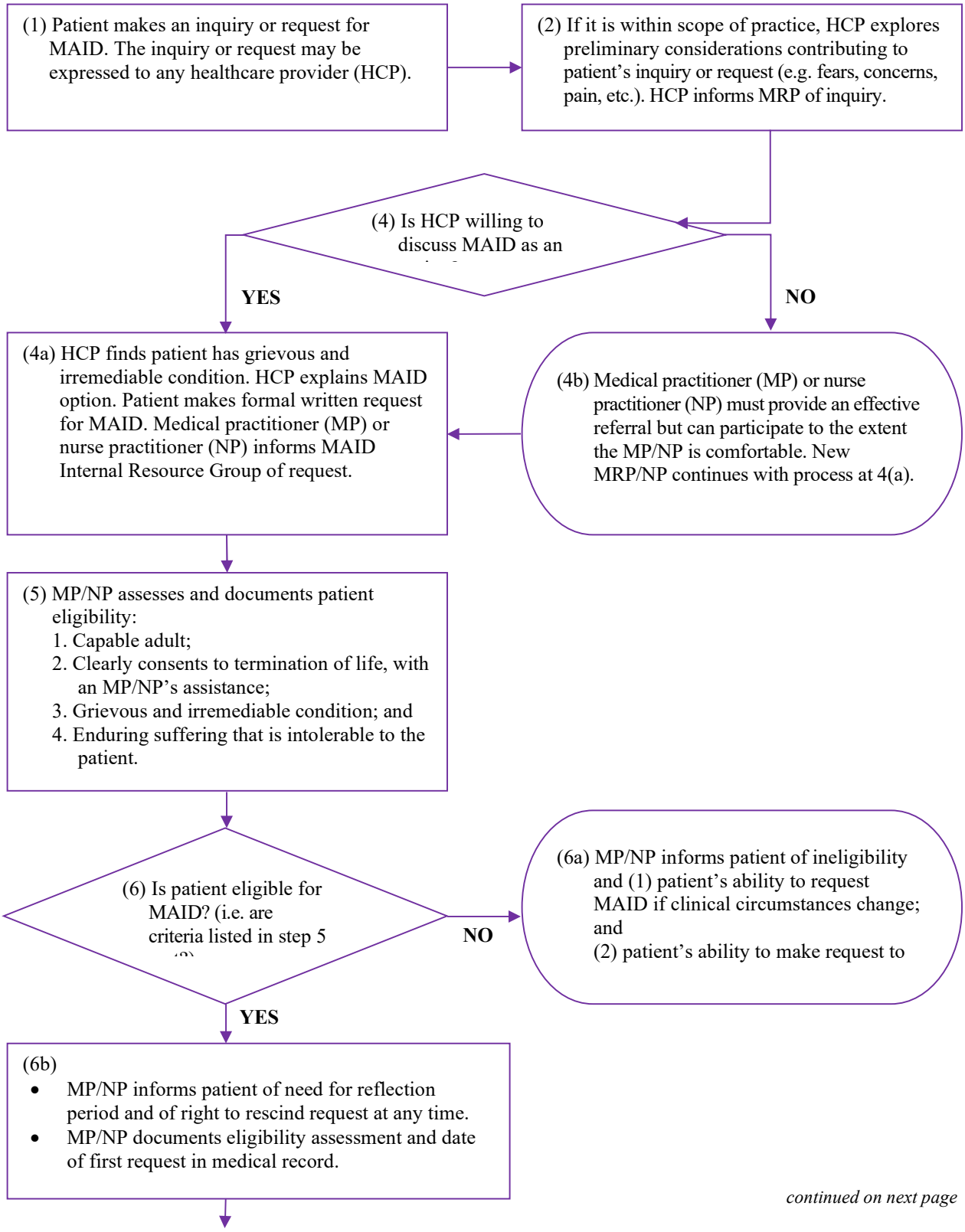
I attest to the following:

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

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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