Providing a Hastened Death or Medical Assistance in Dying (MAID): What Every Health Care Provider Should Know If They Receive A Request

Dr. Susan MacDonald
Dr. Chris Vadeboncoeur
Sharon Baxter
June 2016
Conflict of Interest

- **Susan MacDonald:**
  - Member of the Provincial PAD committee and practice subcommittee
  - Member of the CPSNL Board of Directors and co-writer of PAD policy
  - Palliative Care Physician at Eastern Health
  - Associate Professor of medicine and Family Medicine
  - Current Past President of the Canadian Society of Palliative Care Physicians
  - No financial gain from any of these positions

- **Sharon Baxter:**
  - Executive Director of the Canadian Hospice Palliative Care Association. No financial gain around this issue.

- **Chris Vadeboncoeur:**
  - Pediatrician, Palliative Care Team, Children’s Hospital of Eastern Ontario, Ottawa; Member of Physician Assisted Dying Committee, Canadian Hospice Palliative Care Association; Member of Working Group on Physician Assisted Dying, Canadian Society for Palliative Care Physicians; Member, Quality End of Life Coalition of Canada; No financial gain from any of these positions
Outline/Objectives

• Introduction
• Discuss the reasons patients make this request
• Review a brief history of what has happened up to now
• Discuss the new (draft) Bill on Hastened Death
• Review the new policy on MAID and outline possible responses health care providers make to a request for a hastened death
• Discuss the adequate response to a request
• Identify what needs to be done
• What are the impacts to the hospice palliative care field
• Issues to pay attention to!
Why are palliative care professionals giving this talk?

- Palliative care does NOT include hastened death
  - Palliative care provides comfort throughout the natural process of dying
    - Hastened death will not be provided on many PCUs
- Likely most patients who request this service will have a terminal illness
- Important to create a service that DOES NO HARM:
  - Safe, skilled practitioners who provide the service with careful guidelines
  - Protection for clinicians who do not wish to participate
  - Protection for patients who wish to have this service
  - Protection for patients who don’t wish to have this service
Hastened Death

• Where a physician or nurse practitioner brings about the intentional death of a consenting patient that is earlier than when a natural death would occur.

• Two types:
  • Euthanasia: injected medication that causes the immediate or rapid death of the patient
  • Assisted suicide: the clinician provides a lethal dose of medication that the consenting patient takes themselves either immediately or at another time
What are we NOT talking about?

- Physicians often decide not to initiate an intervention or to withdraw an intervention not because they want to hasten a patient’s death, but because they believe the intervention would be futile.
- Withdrawing the intervention returns the patient to the natural course of illness:
  - E.g. Withdrawal of artificial respiration; Deciding not to initiate or continue with artificial nutrition.
  - “Care and comfort measures”—This is essentially the current practice of palliative care:
    - Intent is not to hasten death, but to provide comfort in the dying process.
    - This is not hastened death.
What is palliative care?

- Confusion
- Many common misperceptions, including health care workers
  - We kill patients
  - We willingly overdose patients with morphine
  - We take away their medications so they die
  - Patients are admitted to the palliative care unit and three days later they are dead
WHO Definition

• Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:
  • provides relief from pain and other distressing symptoms;
  • affirms life and regards dying as a normal process;
  • intends neither to hasten or postpone death;
  • integrates the psychological and spiritual aspects of patient care;
  • offers a support system to help patients live as actively as possible until death;
  • offers a support system to help the family cope during the patients illness and in their own bereavement;
  • uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
  • will enhance quality of life, and may also positively influence the course of illness;
How did we get in this position? (a quick review of history)

- 1993 Sue Rodriguez challenged s. 241 of the Criminal Code as infringing s. 7 of the Charter of Rights.
- Essentially she felt that she couldn’t commit suicide (which is her right) because she needed help (and helping a person commit suicide was illegal)
What happened next?

• In 1993 the Supreme Court of Canada rejected Sue Rodriguez’s challenge (5-4 decision)
• 20 years passed and until Feb. 6, 2015, physician assisted suicide remained a criminal offence under the Criminal Code of Canada
• Lee Carter challenged the supreme court again (ALS)
• A second challenge was successful (Carter Decision)
• Ruling: Physician assisted, grievous and irremediable condition, not necessarily terminal condition, adult
• Supreme court gave Canada 1 year to create legislation
• Three panels created to review the situation and make recommendations
Continued…

• Federal panel had extensive consultation with stakeholders but was disbanded by the new Liberal govt.
• A new parliamentary panel took the Federal panel’s work and reviewed, creating recommendations
• A provincial/territorial panel also created recommendations
• An extension has been given to create laws around this until June 6
• However, a patient may make application to the court for assisted suicide or euthanasia as of Feb 6
• Federal legislation is being created
• Provincial legislation will need to be created
• The health authorities will need to determine how this service will be created and provided in each province
The new bill...
The *Criminal Code* would be changed so that:

- Physicians, nurse practitioners (and those who help them) can provide assistance to die to eligible patients without the risk of being charged with assisted suicide or homicide.
- There will be safeguards to make sure those who ask for medical assistance in dying are eligible, can give informed consent and voluntarily request it.
- The foundation is for the creation of regulations to establish a process for monitoring and reporting.
- Will be both euthanasia and assisted suicide.
The proposed legislation and safeguards were carefully designed to:

- recognize individual choice of medically assisted death for adults who are suffering intolerably and for whom death is reasonably foreseeable;
- affirm the inherent and equal value of every person's life;
- avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled;
- protect vulnerable people from being encouraged to die in moments of weakness;
- re-affirm society's goals with regard to preventing suicide;
- encourage a consistent approach to medical assistance in dying across Canada.
Eligibility

- being an adult (at least 18 years old) who is mentally competent or capable to make health care decisions for themselves
- having a grievous and irremediable medical condition
- making a voluntary request for medical assistance in dying which does not result from external pressure;
- giving informed consent to receive medial assistance in dying
- being eligible for health services funded by a government in Canada
Safeguards

- A written request by the patient or another adult on the patient's behalf, and witnessed by two independent witnesses
- A physician or nurse practitioner would need to be of the opinion that the patient is eligible
- A second physician or nurse practitioner would need to provide a written opinion
- The first and second opinion need to be independent of each other and of the patient
- Mandatory reflection period (15 days) between the day the written request was signed and the day medical assistance in dying was provided
- A patient could rescind their request at any time; and
- Immediately before providing medical assistance in dying, the patient has the opportunity to withdraw their request
But many questions remain

• What about patients with a chronic illness that may not have a natural death for years?
• How long will it take for the additional committee work to be made into law?
• Is there protection for organizations to opt out?
So who would be involved? (and who has guidelines created?)

- Physicians
- Nurses
- Social work
- Pharmacists
- Volunteers
- Other allied health
- Government departments
- College policy
- No policy
- No policy
- No policy
- -
- -
- -
What is happening in the medical colleges across Canada?

• All 10 Provincial Medical regulating bodies and one territorial body now have MAID guidelines in place and are detailed as follows...

• We won’t discuss the following province by province during the webinar but it is useful to know what your province is thinking about...
## Provincial Overview

<table>
<thead>
<tr>
<th></th>
<th>BC</th>
<th>AB</th>
<th>SK</th>
<th>MN</th>
<th>ON</th>
<th>QC</th>
<th>NB</th>
<th>NS</th>
<th>NL</th>
<th>PEI</th>
<th>YT</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Physicians</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1+</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Elig for Health Care</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Advance requests</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Time period (days)</td>
<td>15</td>
<td>14</td>
<td>?</td>
<td>7</td>
<td>?</td>
<td>14</td>
<td></td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written/witnessed</td>
<td>Y/1</td>
<td>Y/2</td>
<td>Y/?</td>
<td>Y/?</td>
<td>Y/1+MD</td>
<td>Y/?</td>
<td></td>
<td></td>
<td></td>
<td>Y/1</td>
<td>Y/2</td>
</tr>
<tr>
<td>Referral (transfer of care) if unwilling</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>18</td>
<td>18</td>
<td></td>
<td>16</td>
<td>19</td>
<td>19</td>
<td>18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Newfoundland

- Requires two physicians
- Creates templates for documentation
- Requires physicians to help patient find the services requested if they are not willing to provide it
- Suggests CMPA contact
Alberta

• The college notes that legal precedent recognizes mature minors as adults in their ability to consent but recommends "a careful and conservative approach" to mature minors.
• Where capacity is unclear or where a person is suffering from depression or other mental illness, a psychiatric or psychological consult is required.

Saskatchewan

• Attending doctor must ensure the patient has consistently expressed a desire for MAID "over a reasonable period of time," the length of which is dependent on the patient's condition.
• Patient must fill out a prescribed form confirming informed consent to receive MAID.
Manitoba

- Independent psychiatric assessment required where a patient does not have a terminal illness (prognosis of less than six months) or is not suffering from a "catastrophic and irreversible physical injury" or intractable physical pain or an advanced state of irreversible, significantly impaired function or imminent decline to that state. The assessment must rule out a treatable psychiatric disorder that is impairing patient's ability to tolerate suffering or assess treatment options.

Ontario

- An unspecified waiting period is required, length depending on the patient's condition.
Quebec*

- A patient must be covered by provincial health care, be of "full age" and capable of giving consent, be at the end of life, suffering from a serious and incurable illness, in an advanced state of irreversible decline and experiencing constant and unbearable physical or psychological suffering which can't be relieved in a manner acceptable to the patient.

*Note: The Quebec provincial law on assisted dying was drafted before the Supreme Court ruling and took effect on December 10, 2015.
New Brunswick

- Patient must meet criteria set out by the Supreme Court, which is further defined as suffering from a grievous illness for which there is no cure and which will eventually cause death.
- Patients with progressive illnesses who are also suffering from "intractable depression" are not automatically ineligible but doctors should proceed with "extraordinary caution" in such cases.
- Administering physician should obtain additional medical opinions as deemed appropriate to confirm prognosis, alternative options, and patient's capacity to make a free, fully informed choice.
Prince Edward Island

• Doctor must ensure patient has repeatedly expressed a desire for MAID "over a reasonable period of time," which may vary depending on patient's condition.

Yukon

• If a physician believes the patient suffers from psychiatric or psychological disorder or depression that could impair capacity to make an informed choice, the patient must be referred for assessment.
Statement from CMPA

Bill C-14 not passed on June 6 but may come into force at a later date. What does this mean for CMPA members in the meantime?

- legislation is in effect in Québec
- expects to receive inquiries from members regarding obligations
- identify potential medical-legal risks based upon individual scenarios
- expects it will be necessary in many cases to retain legal counsel to assist those faced with requests in navigating a patient’s eligibility to receive MAID, to ensure that the necessary safeguards are met, and that the medical assistance is carried out in a way that minimizes medical-legal risks
- endeavour to assist members in a way that does not impede patient access to MAID, while ensuring that physicians are aware of their potential medical-legal risks.
Statement from CNA

Supportive of Bill C-14

Committed to work with federal/provincial/territorial nursing partners to develop a national nursing framework on MAID, in parallel with improved palliative and end-of-life care.
Statement from CMA

Support Bill C-14

-provided input on the key issues of respecting the personal convictions of health care providers, the need to develop an end-of-life care coordination system, the need for a consistent, pan-Canadian framework and the need for clear safeguards to the provision of medical assistance in dying.

-Principles-based Recommendations for a Canadian Approach to Assisted Dying guided by a set of ten foundational principles

-caution and careful study of complex issues (mature minors, mental health conditions, advance care directives
Statement from CPA

- Recognizes role of pharmacists and provides protection against criminal liability related to MAID (though not for conscientious objection including declining to refer to another pharmacist)
- Requires physician or nurse practitioner to inform the pharmacist on intended use of medication

Concern raised:

- Critical for Health Canada to ensure that whatever drugs are recommended, are available and accessible to patients and their health teams
No such guidelines yet for other clinicians

- Nursing, Pharmacy and Social Work, do not, as of yet have guidelines in place
- There is no protection from legal action in the Carter Decision for allied health (unless the new Bill passes)
- There are no guidelines present for what goes on the death certificate
- The medication used for hastened death has not been approved by health Canada for this purpose (off label)
- Hastened death has not been determined to be an insurable service (no model for payment)
What to do when you receive a request

- Requests for Hastened death can be divided into two types:
  - Cry for help
  - Truly wishing to die
Help me

• Cry for Help
  • Patient is suffering
  • Gauging your reaction and whether you will listen and address their suffering
  • Not truly interested in ending their life at this point in time
• Truly wishing to die
  • Rarer but still present
  • Has generally thought a great deal about this before raising the topic
A cry for help

• This is often missed or avoided by physicians and allied health
• Frequently raised as statements like: “this is hard, maybe I’d be better off dead”, “I wish this was over”, “you wouldn’t let a dog suffer like this”, etc.
• Sometimes we don’t even hear this (when we are focused on something else, when we don’t like to deal with this sort of topic, when we’re too busy)
• The clinician’s response should be:
  • What makes you think that?
  • Can you tell me more?
  • That sounds like you’re really suffering...
  • How could I help you with this?
Truly wishing to die

• With the changes in the law, the public are aware that they have the option to request a hastened death
• All physicians who are approached by a patient requesting a hastened death MUST respond by:
  • Having a fulsome discussion
  • Outlining the various options for care and symptom management, including hastened death
  • Thoroughly document the discussion and possible next steps
• Regardless of whether you have personal issues with this topic you must:
  • Refer to a MD or agency that provides hastened death
  • Not abandon or end the therapeutic relationship with the patient for this reason
If we miss it...

• We risk alienating a patient
• We trivialize their suffering
• We miss the opportunity to really help them
• We risk a complaint
What needs to be done

• Regulatory bodies
  • Nursing, pharmacy and social work to create policy and guidelines

• Provincial Government
  • Create legislation
  • Determine who pays
  • Revise the death certificate
  • Provide $ support for this service

• Health authorities
  • Create guidelines for practice
  • Determine who will work on this service
  • Create a supportive safe atmosphere
  • Provide training
  • Create forms for documentation
What effects on the hospice palliative care community

• We say that HPC doesn’t hasten death but do we allow this procedure to happen on site.
• If we don’t allow this on site what are the procedures to transfer the patient, to where and is that patient-centred care.
• What do we do if we want to abstain and what do we do if a colleague is willing to engage in MAID?
• Do we confuse Canadians with the difference between HPC and MAID. What can we do to clarify what we do? How do we make the difference about advance care planning clearer?
• How do we provide the best care possible and then what do we do when our patient ask for hastened death?
• What are we going to do with the court challenges that we know we be started over this issue.
• How do we make a muddy situation clearer? Let’s continue to talk
Issues for us to think about....

- Who pays for the medications either for euthanasia or assisted suicide?
- What happens with the concept of Mature Minors (those under the current age of 18)
- What about those who wish to die at home?
  - Who attends them? What if things go wrong? Do they go to hospital? And die in the emergency room?
  - What about the ambulance and who pays these costs?
- What goes on the death certificate? The underlying cause of death i.e. cancer and how do we track the hastened deaths?
  - Use NL as an example
  - Need to be consistent across the country so we can evaluate over time
Questions?