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

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# 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….

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## Doctor-assisted dying bill restricted to adults facing 'foreseeable' death

**Strict limits include 18-year age requirement and mandatory 15-day 'reflection period'**

By Kathleen Harris, CBC News Posted: Apr 14, 2016 10:32 AM ET | Last Updated: Apr 14, 2016 2:51 PM ET

**Doctor-assisted death legislation** 3:09

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Doctor-assisted death will be restricted to mentally competent adults who have serious and incurable illness, disease or disability under new legislation tabled in Parliament today.

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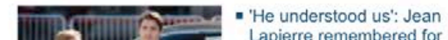

- 'He understood us': Jean Lapierre remembered for

# 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

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

# 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

**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?