

# **MEDICAL ASSISTANCE IN DYING IN ALBERTA TWO YEARS AFTER BILL C-14**

**PALLIATIVE AND END OF LIFE CARE  
IN CONTINUING CARE**

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# PRESENTER DISCLOSURE

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- **Faculty:** Douglas Faulder, M.D.
- **Relationships with commercial interests:**
  - None
- I am representing Alberta Health Services in a contracted leadership position

# LEARNING OBJECTIVES

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- To have an understanding of the legislative and ethical aspects of Medical Assistance in Dying
- Understand the Alberta model of access and provision of Medical Assistance in Dying
- Review the Alberta experience of Medical Assistance in Dying in the first 2 years and more of the Bill C-14 era

# OUTLINE

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- **Background**
- **Current Legislation on Medical Assistance in Dying**
- **The Alberta Model**
- **The Alberta Experience**
- **Challenges and Controversies**
- **Questions and Discussion**

## BACKGROUND – WHAT LED US HERE?

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Medical Assistance in Dying is the latest development on a path of increasing individual patient autonomy, a Western medical ethical philosophy.

- Suicide decriminalized in Canada in 1972, but aiding and abetting remain criminal acts.
- Canadian Charter of Rights and Freedoms, 1982.

## BACKGROUND— WHAT LED US HERE?

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- Right to Refuse life-sustaining treatment
  - Withholding or withdrawing life-sustaining treatment at a patient’s request

Developed in common law; reaffirmed in 1992 by SCC  
*Nancy B. v. Hotel-Dieu*

- Canadian Charter of Rights and Freedoms: Section 7 “right to life, liberty and security of person”
- In *Carter v. Canada*, referred to as a ‘conventionally ethical end-of-life practice’

## BACKGROUND— WHAT LED US HERE?

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- *1993 Rodriguez v. British Columbia*, seeking Assisted Suicide on basis of Charter Rights



# BACKGROUND— WHAT LED US HERE?

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- *2015 Carter v. Canada*





## BACKGROUND— WHAT LED US HERE?

June 2016 – Bill C-14, an Act to Amend the Criminal Code

- Recognizes personal autonomy and dignity
- Recognizes inherent and equal value of every life
- Specifies safeguards to protect vulnerable persons and guard against errors or abuse
- Sets out eligibility
- Encourages a consistent approach across Canada

## CURRENT LEGISLATION

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- *241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:*
  - *(a) they are 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;*

## CURRENT LEGISLATION

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- *241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:*
  - *(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 after having been informed of the means that are available to relieve their suffering, including palliative care.*

## CURRENT LEGISLATION

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- (2) A person has a ***grievous and irremediable*** medical condition only if they meet **all** of the following criteria:
  - (a) they have a serious and incurable illness, disease or disability;
  - And (b) they are 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;***

## CURRENT LEGISLATION

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- (2) A person has a ***grievous and irremediable*** medical condition only if they meet **all** of the following criteria:
  - 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.

## CURRENT LEGISLATION

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CPSA definition of ***Reasonably foreseeable***:

- Death is considered reasonably foreseeable when a physician can justifiably predict or expect death as an outcome of the patient's medical circumstances, considering the provision of medical treatments acceptable to the patient.

## CURRENT LEGISLATION - SAFEGUARDS

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- *(3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must*
  - *(a) be of the opinion that the person meets all of the criteria set out in subsection (1);*
  - *(b) ensure that the person's request for medical assistance in dying was*
    - *(i) made in writing and signed and dated by the person or by another person under subsection (4),*
    - *And (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;*
- *And further*

# THE ALBERTA MODEL

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## Alberta Health Services

- Planning starting Summer 2015 – strong leadership, extensive consultation
- Strong Provincial policies; a model of Zone based MAID Care Coordination Teams
- Nurse Navigator with Physician support
- To support patients and health care team members in all stages of Medical Assistance in Dying



# MAID CARE COORDINATION TEAMS

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- Created by Ministerial Mandate to AHS.
- Supporting patients, families and health care providers in all aspects of Medical Assistance in Dying, in and out of AHS, from the earliest inquiry for information only, through to post-death support to families and health care providers.
- Not directly involved in the assessment for, or provision of, Medical Assistance in Dying, as nurse or physician.
- A very functional model, responsive to patient and clinician needs.

# EZ/NZ MAID CARE COORDINATION TEAM

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- Core Team of Nurse Navigator, Medical Lead and Community Physicians
- Identified direct support – Ethicist, Psychiatrist, Geriatrician
- Indirect Support as needed

## First Steps

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- A patient asks about MAID?

## PATIENT JOURNEY

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If determined by the patient to continue, a formal **Record of Request** filled out and signed with 2 witnesses.

Navigator arranges 1<sup>st</sup> and 2<sup>nd</sup> Assessments for eligibility; and facilitates a providing physician/NP.

Ideally, one assessment by the patient's primary care provider and one by the Medical Assistance in Dying providing physician/NP, assuring independence.

# PATIENT JOURNEY

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- The Zone Nurse Navigator will contact the patient and arrange an interview, usually in person. Neutral position of Navigator.
- With the patients permission they will contact relevant care providers.
- Care needs identified and provided.
- Some basic screening for eligibility may be done. Questions answered to the extent that the patient desires.
- Follow-up left up to the patient.
- ❖ Patient may stop or pause at any point.

# PATIENT JOURNEY

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## Eligibility Assessment

- Likely 1 – 2 hours
- Grievous and irremediable suffering; reasonable and foreseeable death; capacity; voluntariness
- Physician/NP to complete required AHS form, and maintain own notes
- Physician should contact CMPA
- Maintains contact with Navigator

# PATIENT JOURNEY

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## Eligibility and/or Provisioning Assessment

- Likely 12 -18 hours total, Including providing MAID
- At least 2 visits with patient and family, 2 – 3 hours each
- All relevant information gathered
- Grievous and irremediable suffering; reasonable and foreseeable death; capacity; voluntariness
- Physician/NP to complete required AHS form, and maintain own notes
- Physician should contact CMPA

# PATIENT JOURNEY

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Planning, if eligibility confirmed, by Physician/Navigator:

- Ensure Advance Care Planning and affairs in order.
- Methods discussed and decided on (PO or IV). IV access assessed in both cases.
- Date and site confirmed. Nurse assistance arranged.
- Transport arranged.
- Care after death discussed and understood.



# PATIENT JOURNEY

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Day of MAID Provision: Navigator may/may not be present

- ❖ If capacity lost, process ceases.
- ❖ Patient may stop or pause at any step.
  
- Patient transported to site, if necessary.
- Physician/NP(only) is dispensed medication package.
- Physician/NP on site, with assisting nurse.
- Capacity re-confirmed.
- IV started with consent.
- Process re-explained to patient, and family.

# PATIENT JOURNEY

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Day of MAID Provision:

- Patient given all the time necessary.
- Final arrangements and goodbyes.
- Final consent.
- IV Medication Administration
  - Benzodiazepine
  - Local Anesthetic
  - Coma inducing agent
  - Neuromuscular blocker

All recorded on AHS Providing Practitioner MAID Form.

# PATIENT JOURNEY

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Day of MAID Provision:

❖ After death

- Pronouncement of death
- Notification of Medical Examiner
- Package faxed to ME.
- Body released to Funeral Home

# Post - Death

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- Physician and Navigator
  - Family contact & Bereavement support
  - Every event is offered a Supportive Review – lead by an Ethicist typically
- Medical Examiner
  - Review of Unnatural Death as per provincial Legislation
  - Completion of Medical Certificate of Death

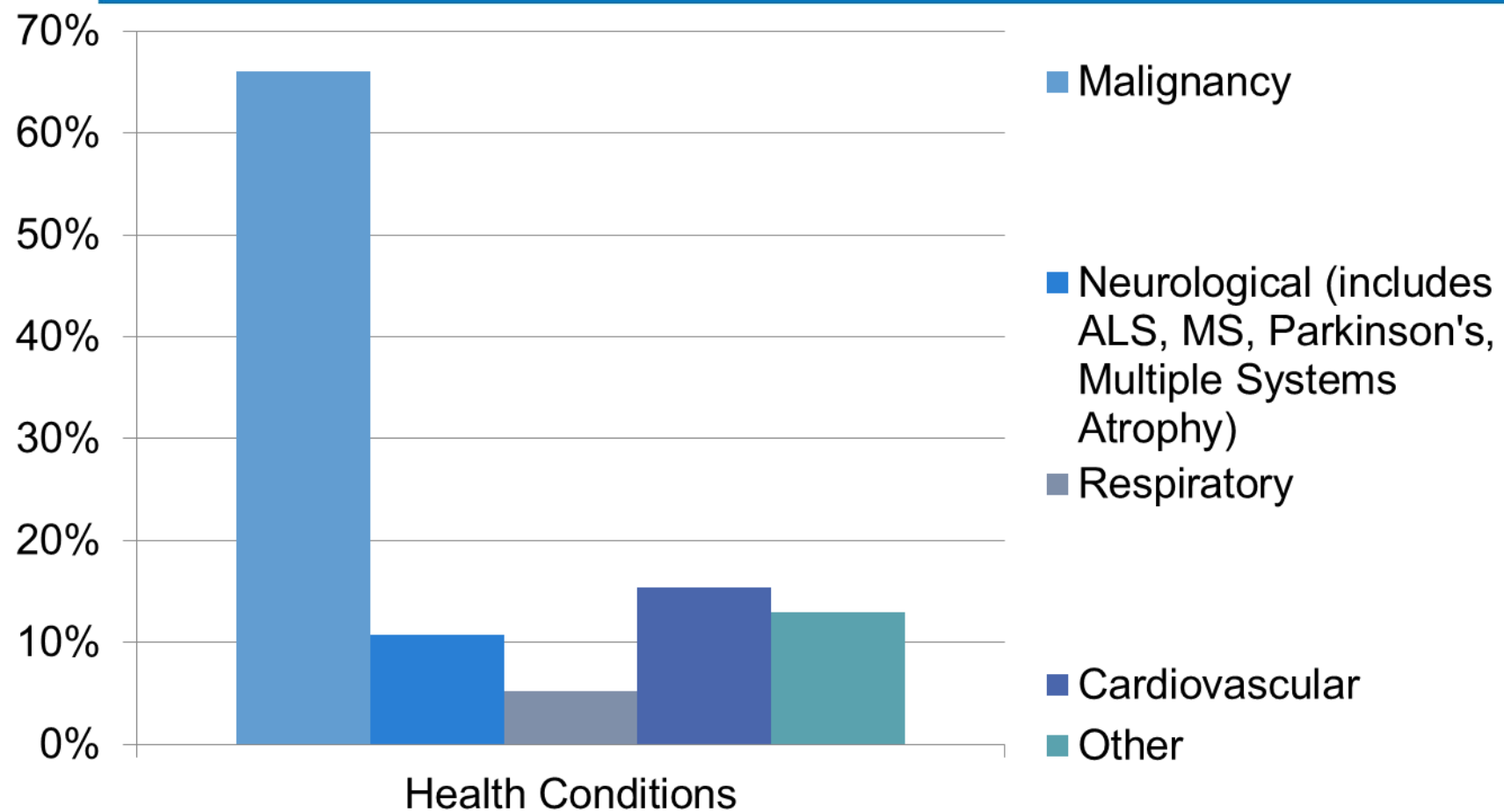
# THE ALBERTA EXPERIENCE TO DATE

## Medical Assistance in Dying Activities

Zone	Total	Facility	Community
South	61		
Calgary	183		
Central	44		
Edmonton	197		
North	32		
<b>TOTAL</b>	<b>517</b>	<b>326</b>	<b>191</b>

\*data is cumulative beginning June 17, 2016

# THE ALBERTA EXPERIENCE TO DATE



# CHALLENGES & CONTROVERSIES

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- Faith-Based Organizations
- Palliative Care
- Complexity and Multimorbidity
- Tissue and Organ donation
- Bill C-14 Directed Issues

# FAITH-BASED ORGANIZATIONS

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- Individual conscientious objection is recognized, but what about organizational conscientious objection?
- Applies to Acute Care (Covenant) and Long-Term Care (Covenant, Good Shepherd Society, Salem Manor, St. Michaels)
- 76 patients provided MAID were transferred from faith-based sites, to home or AHS site.
- Covenant policy clear, process less so. Addressed on a case-by-case basis.



# PALLIATIVE CARE

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## *International Association for Hospice and Palliative Care* Position Statement 2017



*IAHPC believes that no country or state should consider the legalization of euthanasia or PAS until it ensures universal access to palliative care services and to appropriate medications, including opioids for pain and dyspnea.*



*In countries and states where euthanasia and/or PAS are legal, IAHPC agrees that palliative care units should not be responsible for overseeing or administering these practices.*



*The law or policies should include provisions so that any health professional who objects must be allowed to deny participating.*

# PALLIATIVE CARE

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## ***Canadian Hospice Palliative Care Association***

No updated policy statement since June 2016

*“Euthanasia, physician assisted dying, medical aid in dying or assisted suicide are not considered a part of the practice of hospice palliative care.”*

- Advocacy – **“Let’s Talk About Hospice Palliative Care First”**

# LET'S TALK ABOUT HOSPICE PALLIATIVE CARE **FIRST**



DECISIONS



RESPECT



QUALITY



END OF LIFE

Euthanasia? Assisted Suicide? Hospice Palliative Care?  
There are some facts you should consider.

Visit [www.chpca.net/hpcffirst](http://www.chpca.net/hpcffirst) for more information.



# Palliative Care Matters<sup>•</sup>

Fostering Change in Canadian Health Care

CONFERENCE BOARD OF CANADA REPORT MAY 2017

## EXECUTIVE SUMMARY

# Palliative Care Matters: Fostering Change in Canadian Health Care

### At a Glance

- Palliative Care Matters is an initiative championed by Covenant Health in partnership with 13 national health-related organizations to ensure all Canadians with life-limiting illnesses have timely access to high-quality palliative care.
- The initiative adapts an innovative consensus development model to foster a conversation between the public, researchers, and health system leaders.
- This report brings the consensus statement and recommendations developed through the initiative forward to key stakeholders.
- Continued collaboration and sharing between governments and other stakeholders is needed to take the next steps in achieving the vision of the initiative.

# Palliative Care Matters: Fostering Change in Canadian Health Care

- The Canada Health Act be amended to include integrated, palliative home care with portable universal access and support for patients and caregivers, customized to patients' medical and psycho-social needs;
- The federal government provide substantial and sustained funding for the development of a national strategy, including capacity building, standards development and monitoring, and research;
- Every physician in Canada be able to provide basic palliative care and that accrediting and licensing bodies and professional colleges ensure competencies are taught and tested; and
- A wide-spread public awareness campaign about palliative care support the implementation of a national palliative care strategy

# COMPLEXITY AND MULTIMORBIDITY

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- More complex scenarios
- Elderly patients with complexity, multimorbidity and frailty
- Suffering without a reasonably foreseeable death
- A “Reasonably Foreseeable Death” in the totality of the patient

# TISSUE AND ORGAN DONATION

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- Evolving



## BILL C-14 - REQUIRED REVIEW TOPICS

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- ADVANCED DIRECTIVES
  - If a loss of capacity after a request accepted
  - After a diagnosis
  - Prior to any diagnosis
- MATURE MINORS
- MENTAL HEALTH
  
- AHS has had Expert Panels on these subjects and made submissions.

# THANK YOU!

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## Your questions?

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