CPF3100: Medical Assistance in Dying: Responding to Requests

Approved Date: July 13, 2016
Reviewed/Revised Date: October 11, 2017

1.0 Introduction

1.1 Description

The purpose of this policy is to provide a consistent ethical and compassionate approach, reflective of the *Health Ethics Guide* and Catholic teaching, when responding to a person in care within Providence Health Care ("PHC") who requests Medical Assistance in Dying, either through medically assisted suicide, where the patient is provided assistance in intentionally ending his or her own life, or voluntary euthanasia, where a physician directly administers a lethal dose of medication to end the patient's life. The procedure further outlines the steps for a safe and timely transfer of care for the patient to another facility in accordance with their wishes.

1.2 Scope

This policy applies to all PHC **Staff**, physicians, volunteers, students and any other persons acting on behalf of PHC and caring for PHC patients (to be referred to as "Personnel").

2.0 Policy

As a Catholic health care organization, PHC is committed to the inherent dignity of every human being throughout the entire continuum of life from conception to natural death. PHC has an institutional obligation as a Catholic health care provider to uphold the principles of Catholic moral teaching as set out in the Health Ethics Guide (3rd ed. 2012) approved by the Canadian Conference of Catholic Bishops (the Guide). Given the incompatibility of Catholic teaching with actions intended to terminate human life, PHC Personnel will not provide Medical Assistance in Dying.

PHC reaffirms its commitment to provide quality palliative/hospice and end-of-life care, promoting compassionate support for dying persons and their families, including:

1. Honouring patient/resident self-determination through the use of advance directives, advance care planning and/or options for care designation, including clear recognition of the role of substitute decision-makers;
2. Offering quality palliative/hospice and end-of-life care that addresses physical, psychological, social, and spiritual needs of persons who are dying and their families, and;
3. Delivering effective and timely pain and symptom management.

2.1 Principles

2.1.1 A request from a person in our care for Medical Assistance in Dying must be received in a compassionate and respectful manner.

2.1.2 The patient will be provided support in a non-judgmental way to ensure they are aware of all of the care options available to them, and they are provided with the appropriate physical, psychological and spiritual supports to help address the person's needs that may underlie their expressed request.

2.1.3 Personnel are morally and legally bound to work together with patients and families to resolve potential conflict around the goals of care and to find proactive solutions that respect the wishes of the patient and the integrity of all.

2.1.4 In response to a patient's informed request, the proactive solution may require a safe and timely transfer of care for the patient and their records to a non-objecting institution for continued exploratory discussion and assessment.

2.1.5 Our responsibility to provide care in accordance with the Guide also means that we must do so without abandoning those who may be impacted by such conscientious or professional decisions, or pressuring patients/residents and their families to justify their own beliefs.

2.1.6 In exceptional cases, formal assessment for MAiD eligibility may be done by an external provider through Vancouver Coastal Health at a PHC site. An exceptional case is one where the patient, in the opinion of the most responsible provider ("MRP"), is capable of making health care decisions, and has completed the Patient Request Form in order to explore eligibility for Medical Assistance in Dying, and meets at least one of the following criteria:

- The person in care is medically fragile to the extent that undergoing multiple transfers poses risk of serious harm or hastening death; or
- The person in care is receiving concurrent specialized treatment or comfort care measures that cannot be interrupted or interrupted without harm to the patient.

2.1.7 A formal assessment for MAiD at a PHC site as an exceptional case will only be done after the MRP or designate consults with Ethics, Risk Management or Medical Affairs.

2.2 Responsibilities

2.2.1 **All Staff (including Physicians)**
Maintain strict confidentiality concerning a request for Medical Assistance in Dying and any other aspect of a patient's personal information.

2.2.2 **Direct Care Staff**
Respond as able to patient's requests for information on Medical Assistance in Dying and inform the MRP of the request.

2.2.3 **Operations Leadership**
Ensure all staff are aware of this policy.

Consider impact of requests for Medical Assistance in Dying on care teams and provide support to staff as may be appropriate.

2.2.4 **All Physicians**

Ensure compliance with the College of Physicians and Surgeons of BC ("CPSBC") Standard concerning Medical Assistance in Dying.
Ensure the patients requesting Medical Assistance in Dying have had the opportunity to consider all alternative services which may alleviate their suffering.

2.2.5 **Most Responsible Provider**

Determine capacity of a patient requesting Medical Assistance in Dying.
Inform the Medical Assistance in Dying Response Lead of the request.
Arrange for a transfer of care for the capable patient to a non-objecting institution.

2.2.6 **Medical Assistance in Dying Response Lead**

Provide education to Staff on this Policy
Provide support to MRP and Staff responding to a request for Medical Assistance in Dying
Liaise with Vancouver Coastal Health ("VCH") and other healthcare stakeholders for transfer of care to a non-objecting facility when necessary.

2.3 Compliance

Staff who have concerns about care provided in relation to this policy are asked to contact Risk Management for follow-up.

3.0 Procedure

1. If a patient makes a request to any of his or her providers for Medical Assistance in Dying, this matter will be brought to the attention of the MRP.

2. The MRP, using the resources of the interdisciplinary team, will explore with the patient their concerns with the current situation and prognosis, and ensure the patient is made aware of all possible standard end-of-life care and treatment options, including adjustments to the current treatment plan, and palliative and comfort care.

    a. If the patient accepts these services, they will be provided to every extent possible.
    b. If, despite the offer or provision of these treatments and interventions, the patient determines that his or her needs and concerns have not been adequately met, and remains interested in Medical Assistance in Dying, the MRP will consider whether there is any indication that the patient is incapable of making a decision concerning Medical Assistance in Dying.
    c. If the MRP determines the patient to be incapable of decision-making regarding health care in general, the request for Medical Assistance in Dying will not be pursued. Subsequent decisions about health care will be made either by a substitute decision maker, and/or with the aid of an advance directive if one exists.
    d. If the patient requests a second opinion regarding his or her capacity, this will be provided.

3. If there is no concern about the patient's decisional capability, the MRP or designate will liaise with the MAiD Response Lead to initiate a transfer of care to a non-objecting centre/ setting through

VCH at assisteddying@vch.ca **or by phone at 604-613-5885 or 1-844-550-5556** for continued exploratory discussion and assessment.

4. Patients may be transferred to another facility of their choice in accordance with their wishes at any time if there is an admitting provider willing to assume care.

5. In an exceptional case, in consultation with the MRP or designate, the MAiD Response Lead should contact Ethics Services at ethics@providencehealth.bc.ca , or alternatively Risk Management or Medical Affairs.

6. If at any time the patient abandons interest in Medical Assistance in Dying, and seeks to return to PHC for care, re-engagement with PHC services will be expedited. If it is the wish of the patient to return to PHC during a waiting time, PHC will accept the patient back if appropriate to their ongoing care needs.

4.0 Guidelines for arranging transfer

1. Arrange for transfer as soon as possible in the event of a request for continued exploratory discussion and assessment for Medical Assistance in Dying.

2. In collaboration with the MAiD Response Lead, determine if patient is stable enough for a non-medical transport (for full criteria see Appendix A: "Non-Medical Transport Algorithm"):

   a. 24 hours of stable baseline vital signs
   b. No decreased LOC
   c. No new or uncontrolled arrhythmia
   d. No ischemic chest pain
   e. No respiratory distress

3. Suggested modes of non-medical transport include private vehicle, taxi, Handy Dart (if previously registered) and Hospital Transfers/SNT. Any cost for transfer should be covered by the Program.

4. Patients who do not meet the requirement for non-medical transport will require ambulance transfer.

5. The BC Patient Transfer Network ("PTN") is responsible for the planning and coordination of all inter-facility patient transfers via ambulance. PTN can be reached at 604-215-5911. It is important to communicate to PTN that the request is for transfer of a patient for an assessment of Medical Assistance in Dying, and not for an appointment.

6. BC Ambulance Service (BCEHS) is not able to guarantee a specific pick-up time, even with advance notice. This needs to be factored into any care planning around patient pain and symptom management, and communicated to the patient and family.

7. There is no BCEHS charge for an inter-facility transfer from acute care. There **is** a BCEHS charge for an inter-facility transfer from residential care. The cost of transfer is to be covered by the Program.

5.0 References

BC College of Social Workers Practice Guidance: Medical Assistance in Dying, March 2017

Covenant Health Policy– Responding to Requests for Medical Assistance in Dying, September 12, 2017

College of Pharmacists of BC: Guidelines on Medical Assistance in Dying,

College of Physicians and Surgeons of BC Professional Standards and Guidelines – Medical Assistance in Dying, April 2017

College of Registered Nurses of BC Practice Resources, Medical Assistance in Dying, May 2017

Health Ethics Guide 3rd Ed. Catholic Health Alliance, 2012

5.1 Related Tools, Forms and Guidelines

- None

5.2 Related Policies

- CPF0100: Abuse
- CPF2600: Advance Care Planning
- CPF0500: Consent to Health Care
- CPF1100: Options for Care

5.3 Definitions

Advance Care Planning is the process of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions.

Advance Directive provides written consent to (or refusal of) health care to a health care provider in advance of a decision being required about that care. Advance directives must be written, signed by a capable adult, and be witnessed by two witnesses (or one witness who is a lawyer or notary public). Advance Directives are considered to be legally binding in British Columbia.

Medical Assistance in Dying is used to describe the assistance provided to a person with the aim of intentionally ending his/her life, as well as voluntary euthanasia, where a legally recognized health professional directly administers a lethal dose of medication (or equivalent) in accordance with the wishes of the patient.

Medical Assistance in Dying Response Lead ("MAiD Response Lead") means the individual tasked with providing practical and psychosocial guidance and education to PHC Staff. The MAiD Response Lead also liaises with VCH and other healthcare stakeholders to facilitate a transfer of care to a non-objecting institution when necessary.

Most Responsible Provider (MRP) means the attending physician or nurse practitioner who has the overall responsibility for the management and coordination of care of the patient or resident at any given time.

Options for Care – PHC policy CPF1100 sets out four "Options for Care" in the event of a serious illness or sudden collapse during admission in a PHC facility. "Options for Care" provides a framework for patients/residents and their families to decide their treatment or care preferences during a current admission or episode of care.

Patient For the sake of readability, reference is made to the "patient" throughout this document. Unless otherwise directed, any reference to "patient" should be interpreted to mean patient, client and/or resident.

Staff means all employees (including management and leadership), medical staff (including physicians, midwives, dentists, and nurses), residents, fellows and trainees, health care professionals, students, volunteers, contractors, researchers and other service providers engaged by PHC.

Substitute Decision Maker If a decision is made that an adult is incapable of making a consent decision, consent must be obtained from a properly executed Advance Directive or from someone on the patient's behalf. The person making decisions on behalf of a patient is called a "substitute decision maker".

5.4 Keywords

Assisted suicide, death, euthanasia, (MAID), Medical Assistance in Dying, PAD, suicide

5.5 Appendix

A. Non-medical Transport Algorithm

Appendix A: Non-medical Transport Algorithm