



TITLE

**MEDICAL ASSISTANCE IN DYING**

SCOPE

Provincial

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**NOTE:** The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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## OBJECTIVE

- To facilitate a consistent, compassionate, **patient-centred** approach when responding to an **adult patient's** request for **medical assistance in dying**.

## POLICY STATEMENTS

This policy addresses the following activities associated with medical assistance in dying:

- a) responding to inquiries;
- b) assessing whether a patient meets the mandatory requirements while ensuring that safeguards are observed, and the provision of medical assistance in dying by either:
  - (i) the administering by the **most responsible health practitioner** (for the purpose of this policy, the most responsible health practitioner is a Physician or Nurse Practitioner) of a substance to a patient, at that patient's request, that causes that patient's death; or
  - (ii) the prescribing or providing by the most responsible health practitioner of a substance to a patient, at that patient's request, for self-administration of the substance that causes that patient's death; and
- c) reporting requirements after the patient's death.

Alberta Health Services (AHS) respects a patient's right to make informed health care decisions, including the right to consent to or decline specific health care interventions. Only adult patients who have the **capacity** to provide **informed consent** may be eligible for medical assistance in dying.

AHS shall support patients and **families** by providing clear and accurate information about medical assistance in dying.

AHS shall respect individual **health care providers'** rights to decline participation in medical assistance in dying, while ensuring that patients' care needs are met.

## APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

## ELEMENTS

### 1. Key Foundations of the Provision of Medical Assistance in Dying

- 1.1 Patient autonomy: Patients with capacity will be able to make their own decisions about their own lives and bodies based on their own preferences, values, and beliefs.
- 1.2 Equitable access: Patients who make a request for medical assistance in dying, who meet the mandatory requirements and when all the safeguards have been addressed, should have timely and reasonable access to this service. Consistent with other AHS services and program areas, reasonable access means that medical assistance in dying services may not be available at all **AHS settings**.
- 1.3 Respect for moral conscience: Health care providers may follow their beliefs and values when deciding whether or not to participate in medical assistance in dying.
- 1.4 Respect and dignity: Patients and their families shall be cared for by health care providers with open-mindedness, respect, compassion, and a thoughtful regard for their dignity and unique lived experience, including cultural elements that are important to the patient.
- 1.5 Health care provider qualifications: Health care providers participating in medical assistance in dying must have the requisite knowledge, care and skill, and be acting within their scope of practice, supported by all applicable laws, practice standards, bylaws, AHS policies, and other applicable requirements.
- 1.6 Duty to provide care: Patients shall not be abandoned or denied appropriate health care because of their request for or participation in medical assistance in dying.

- 1.7 Criminal law application and protections: Changes to the *Criminal Code* (Canada) mean Physicians or Nurse Practitioners may provide medical assistance in dying and allow other health care providers to assist Physicians or Nurse Practitioners in their provision of this service for patients. Physicians, Nurse Practitioners, and other health care providers may provide patients with information about the lawful delivery of medical assistance in dying. The law also extends to protect those who are acting on a reasonable but mistaken belief about a fact that is an element of the mandatory requirements or the required safeguards in this policy.
- 1.8 Protection of vulnerable patients: Attention to the conditions and context generating vulnerability which might have an influence on a patient's request for medical assistance in dying must be part of AHS' comprehensive and ongoing multi-disciplinary patient care. AHS' multi-disciplinary patient care teams must be committed to protecting vulnerable patients from discrimination, coercion, exploitation, and undue influence.

## 2. Mandatory Requirements

- 2.1 Only adult patients that meet the following mandatory requirements, as determined by two (2) independent Physicians or Nurse Practitioners (see section 2.2 below), are eligible for medical assistance in dying.
- a) The patient is eligible for health services funded by a federal, provincial, or territorial government in Canada (existing waiting periods or minimum residency requirements do not apply).
- b) The patient has a grievous and irremediable medical condition. This means all of the following criteria are met:
- (i) they have a serious and incurable illness, disease, or disability;
  - (ii) they are in an advanced state of irreversible decline in capability;
  - (iii) that illness, disease, disability, or state of decline causes them enduring physical or psychological suffering that:
    - is intolerable to the patient; and
    - cannot be relieved under conditions or with treatment that the patient considers acceptable; and
  - (iv) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances. A specific prognosis as to the specific length of time remaining is not required.
- c) The patient has made a request for medical assistance in dying on the required form(s). This request must be voluntary.

- (i) If the patient requesting medical assistance in dying is unable to sign and date the request for medical assistance in dying on the required request form, another person – who is at least 18 years of age, who understands the nature of the request for medical assistance in dying, and who does not know or believe that they are a beneficiary under the will of the patient making the request or a recipient, in any way, of a financial or other material benefit resulting from that patient's death – may do so in the person's presence, on the person's behalf, and under the person's express direction.
- d) The patient has the capacity to provide informed consent for medical assistance in dying in accordance with the AHS *Consent to Treatment/Procedure(s)* Policy Suite.

**Note:** An **alternate decision-maker** cannot make a request for, or consent to, medical assistance in dying on behalf of a patient who lacks capacity.

- e) The patient has given express informed consent for the delivery of medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. The patient's express informed consent shall be obtained in writing on the appropriate AHS consent form unless use of the AHS form is impracticable or unreasonable.
- (i) If the patient is physically unable to provide express informed consent in writing:
- a blind or disabled patient's mark is recognized as a valid signature on the consent form; or
  - verbal or other express (e.g., blinking, grunting) informed consent is acceptable with at minimum, one (1) witness, and this consent shall be documented on the AHS consent form along with why the patient was physically unable to sign.
- (ii) This informed consent is separate and in advance of the informed consent required immediately prior to the provision of medical assistance in dying as per section 3.1 (g) below.

2.2 Physicians and Nurse Practitioners are independent if they:

- a) are not in a mentorship or supervisory relationship with each other;
- b) do not know or believe that they are a beneficiary under the will of the patient making the request or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; and

- c) do not know or believe that they are connected to the other Physician or Nurse Practitioner or to the patient making the request in any other way that would affect their objectivity.

### 3. Safeguards

- 3.1 The most responsible health practitioner must ensure all of the following safeguards are met before delivering medical assistance in dying.
- a) All of the mandatory requirements are met as per section 2 above.
- b) The request for medical assistance in dying shall be in writing, dated and signed by the patient after the patient was informed by a Physician or Nurse Practitioner that the patient has a grievous and irremediable medical condition.
- c) The request in section 3.1 (b) above is signed before two (2) independent witnesses who also sign and date the request.
- (i) Independent witnesses must be adults who understand the nature of the request for medical assistance in dying. They must not act as a witness if they:
- know or believe that they are a beneficiary under the will of the patient making the request or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death;
  - are an owner or operator of any health care facility at which the patient making the request is being treated or any facility in which that patient resides;
  - are directly involved in providing health care services to the patient making the request; or
  - directly provide personal care to the patient making the request.
- d) The patient was advised that they may withdraw their request at any time and in any manner.
- e) The providing Physician or Nurse Practitioner shall ensure that the second assessing Physician or Nurse Practitioner has provided a written opinion confirming that the patient meets all of the mandatory requirements (see section 2 above).
- f) At least 10 clear days have passed between when the request was signed by or on behalf of the patient and when medical assistance in dying is to be delivered, except if the most responsible health practitioner

and the other assessing Physician(s) or Nurse Practitioner(s) agree that either:

- (i) the patient's death, or
- (ii) the patient's loss of capacity to provide informed consent,

is imminent, then the most responsible health practitioner is to specify a shorter time period that they consider appropriate under the circumstances.

- g) Immediately before medical assistance in dying is provided, the patient shall be given an opportunity to withdraw their request. The most responsible health practitioner shall obtain the patient's informed consent for medical assistance in dying. The Physician or Nurse Practitioner shall document express informed consent by:
  - (i) having the patient re-sign the original AHS consent form (dated again, with one [1] witness), understanding that a blind or disabled patient's mark is recognized as a valid signature;
  - (ii) having the patient sign a new AHS consent form (dated, with one [1] witness), understanding that a blind or disabled patient's mark is recognized as a valid signature; or
  - (iii) documenting the patient's express verbal or other express (e.g., blinking, grunting) informed consent in front of at minimum, one (1) witness, with documentation that specifies the witness name(s) and date on the patient's **health record**.
- h) If the patient has difficulty communicating, all necessary measures shall be taken to provide information in such a manner that the patient will understand the information and communicate their decision.

#### 4. Alberta Health Services' Responsibilities in Medical Assistance in Dying

- 4.1 AHS has a responsibility to assist Albertans with reasonable access to medical assistance in dying, in safe and clinically appropriate AHS settings, which means environments where health services are delivered by, on behalf of, or in conjunction with AHS, including the patient's home.
- 4.2 AHS shall:
  - a) provide comprehensive multi-disciplinary care including non-Physician health care providers working within their scope of practice, to patients and families when the patient is exploring end-of-life decisions;
  - b) provide non-judgmental, comprehensive care without bias;

- c) provide timely and reasonable access to information about palliative and all end-of-life care options, including bereavement care;
  - d) honour health care providers' decisions regarding their participation in the provision of medical assistance in dying;
  - e) take reasonable steps to facilitate self-referrals, referrals of patients from Physicians or Nurse Practitioners who decline to participate in medical assistance in dying, and referrals from AHS-contracted service providers for those patients intending to access medical assistance in dying;
  - f) ensure patients may access medical assistance in dying in a timely and coordinated fashion;
  - g) accommodate requests for timely patient transfers from health care settings opting not to deliver medical assistance in dying to an appropriate AHS setting or other non-objecting setting;
  - h) ensure access to consultation services, including but not limited to, Clinical Ethics, legal services for staff, Spiritual Care, Social Work, and Addiction and Mental Health services, as needed;
  - i) ensure that if **concerns** about a patient's health care experience arise, the patient concerns resolution process shall be available in accordance with the *AHS Patient Concerns Resolution Policy Suite*; and
  - j) enable the reporting of information related to medical assistance in dying as required by the Office of the Chief Medical Examiner and/or the Medical Assistance in Dying Regulatory Review Committee.
- 4.3 AHS' Medical Assistance in Dying Care Coordination Service shall offer:
- a) support to patients/families by providing information and access to education and supports, and linkages to all end-of-life care options including medical assistance in dying, and grief and bereavement services; and
  - b) support to both AHS and non-AHS Physicians, Nurse Practitioners, and interdisciplinary health care team members in the coordination of care and services related to medical assistance in dying and all end-of-life care options, and provide linkages to education, resource materials, specialty consultation services, and grief and bereavement services.
- 4.4 AHS' procedures and processes shall support the Physicians' and Nurse Practitioners' ability to:
- a) support patients;
  - b) assess mandatory requirements and ensure safeguards are met;

- c) prescribe and/or administer the drugs recommended for use that intentionally bring about a patient's death by established drug lists and protocols developed and maintained in consultation with the Alberta College of Pharmacists;
  - d) comply with documentation requirements; and
  - e) comply with any legal and AHS reporting requirements.
- 4.5 AHS shall ensure that the care provided to the patient and family after death is provided in accordance with established organizational policies and processes.

## 5. Health Care Providers' Responsibilities in Medical Assistance in Dying

- 5.1 Prior to participation in any aspect of care related to medical assistance in dying, health care providers should inform themselves of the direction being provided by their respective regulatory bodies and must comply with that direction.
- 5.2 Health care providers should also inform themselves with information, support, and guidance provided by the Medical Assistance in Dying Care Coordination Service, referral services, and the patient self-referral process.
- 5.3 Health care providers who are not Physicians or Nurse Practitioners shall respond to medical assistance in dying inquiries in a timely and non-judgmental, comprehensive manner without bias and shall notify a patient's most responsible health practitioner.
- a) If the patient does not have a most responsible health care practitioner or if the patient does not wish for their most responsible health practitioner to learn of the request, then the health care provider shall notify the relevant Manager and the Medical Assistance in Dying Care Coordination Service in a timely manner.
  - b) Health care providers may share information about medical assistance in dying with patients.
- 5.4 Health care providers electing not to participate in medical assistance in dying for appropriate reasons, including reasons of conscience, are not required to participate.
- a) The health care provider shall inform their Manager if they are unwilling or unable to support the provision of either the patient's usual care or care specific to medical assistance in dying.
  - b) The Manager shall ensure another appropriate health care provider who is willing and able, assumes the objecting health care provider's role.
- 5.5 An AHS Pharmacist may only dispense drugs for medical assistance in dying consistent with the list of drugs developed and maintained with the assistance of



the Alberta College of Pharmacists and supported by any applicable practice standards or other governing documents, and must comply with any legal, regulatory body, and mandatory reporting obligations.

- 5.6 Health care providers shall ensure documentation in the patient's health record is in accordance with AHS policies and legislative requirements.

## 6. Physicians' and Nurse Practitioners' Responsibilities in Medical Assistance in Dying

- 6.1 Only appropriately qualified Physicians and Nurse Practitioners may determine requirements for and provide medical assistance in dying. Physicians providing assessments or provisions within AHS settings will require privileges to do so. Nurse practitioners are required to maintain their own competency as set out by regulatory bodies and AHS.
- 6.2 Prior to assessing a patient for medical assistance in dying, the Physicians and Nurse Practitioners involved should review and follow advice documents and Standards of Practice set out by their respective regulatory bodies regarding their participation in aspects of care related to medical assistance in dying and may consult with their insurers / protective associations.
- 6.3 Upon receiving the formal request for medical assistance in dying, the Physician and/or Nurse Practitioner involved shall advise the Medical Assistance in Dying Care Coordination Service of the request.
- 6.4 Physicians or Nurse Practitioners who elect not to participate in medical assistance in dying for appropriate reasons, including reasons of conscience, are not required to participate.
- a) Physicians or Nurse Practitioners who elect not to participate in medical assistance in dying, and have a patient who has requested medical assistance in dying, shall provide the patient's information to the Medical Assistance in Dying Care Coordination Service. The Medical Assistance in Dying Care Coordination Service shall provide the patient with information and resources to facilitate access to a Physician or Nurse Practitioner who is willing to provide medical assistance in dying services.
  - b) Physicians or Nurse Practitioners shall continue to provide required health care to the patient until that Physician's or Nurse Practitioner's services are no longer required or wanted by the patient or until another Physician or Nurse Practitioner has assumed responsibility for the patient.
- 6.5 Under no circumstances shall the responsibility for providing medical assistance in dying be delegated or transferred from one Physician or Nurse Practitioner to another Physician or Nurse Practitioner who:
- a) has not independently verified the patient's mandatory requirements and express informed consent for medical assistance in dying; or

- b) is receiving supervision or mentorship (e.g., trainee) from any Physician or Nurse Practitioner.
- 6.6 With the patient's express informed consent, the provision of medical assistance in dying may be observed for learning purposes.
- 6.7 Only Physicians and Nurse Practitioners shall prescribe the drugs for medical assistance in dying. The most responsible health practitioner shall inform the Pharmacist involved when a prescription is being prescribed or obtained for the purpose of delivering medical assistance in dying.
- 6.8 The most responsible health practitioner shall obtain informed express written (signed) consent for a treatment plan developed together with a patient.
- a) The treatment plan shall include either:
    - (i) patient self-administration of the drugs with the most responsible health practitioner present; or
    - (ii) administration of the drugs by the most responsible health practitioner.
  - b) In developing a treatment plan for a patient who opts for self-administration, the treatment plan should contemplate contingencies in the event the self-administration is unsuccessful and Physician administration becomes necessary.
- 6.9 The most responsible health practitioner shall review, affirm, and/or determine that the patient's **advance care planning** and **goals of care designation** has occurred as per the AHS *Advance Care Planning and Goals of Care Designation* Policy and Procedure.
- 6.10 Physicians and Nurse Practitioners shall ensure documentation in the patient's health record is in accordance with AHS policies and legislative requirements. This documentation shall include, but is not limited to, capacity assessment, mandatory requirements, goals of care designation, completed consent forms, and record of medication administration.
- 6.11 Physicians and Nurse Practitioners shall comply with any legal, federal or provincial government, regulatory body, and mandatory medical assistance in dying reporting requirements.

## DEFINITIONS

**Adult** means, for the purpose of this policy, a person aged 18 years and older and excludes mature minors.

**Advance care planning** means a process which encourages people to reflect and think about their values regarding clinically indicated future health care choices; explore medical information

that is relevant to their health concerns; communicate wishes and values to their loved ones, their alternate decision-maker and their health care team; and record those choices.

**Alberta Health Services (AHS) setting** means any environment where treatment/procedures and other health services are delivered by, on behalf of or in conjunction with, Alberta Health Services.

**Alternate decision-maker** means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta), an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta).

**Capacity** means the ability for the patient to (1) understand the nature, risks and benefits of the procedure and the consequences of consenting or refusing and (2) understand that this explanation applies them.

**Concern** means a written or verbal expression of dissatisfaction that may be related to:

- the provision of goods and services to a patient;
- a failure or refusal to provide goods and services to a patient; and
- terms and conditions under which goods and services are provided to a patient.

**Express consent** means direct, explicit agreement to undergo a treatment/procedure(s), given either verbally or non-verbally (e.g., blinking, grunting), or in writing (information on Consent can be found on the AHS external website by searching 'Consent to Treatment/Procedure').

**Family (-ies)** means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

**Goals of care designation** means a codified instruction that provides direction regarding general care intentions, specific health interventions, transfer decisions and locations of care, for a patient as established after consultation between the most responsible health practitioner, patient and when appropriate, alternate decision-maker.

**Goals of care designation order** means the documented order for the goals of care designation as written by the most responsible health practitioner (or designate).

**Health care provider** means a person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

**Health record** means the collection of all records documenting individually identifying health information in relation to a single person.

**Informed consent** means the agreement of a patient to the patient undergoing a treatment/procedure after being provided with the relevant information about the treatment/procedure(s), its risks and alternatives and the consequences.

**Medical assistance in dying** means:

- (a) the administering by a Physician or Nurse Practitioner of a substance to a patient, at their request, that causes their death; or
- (b) the prescribing or providing by a Physician or Nurse Practitioner of a substance to a patient, at their request, so that they may self-administer the substance and in doing so cause their own death.

**Most responsible health practitioner** means the health practitioner who has the responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Alberta Health Services to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice. For the purpose of this Policy, this may only be either a Physician or Nurse Practitioner.

**Patient** means, for the purposes of this policy, an adult who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients, and outpatients.

**REFERENCES**

- Alberta Health Services Governance Documents:
  - *Advance Care Planning and Goals of Care Designation Policy* (#HCS-38)
  - *Consent to Treatment/Procedure(s) Policy* (# PRR-01) and Procedures
  - *Management of Patient Concerns Involving a Member of the Medical Staff Guideline* (# PRR-02-02)
  - *Patient Concerns Resolution Policy* (#PRR-02)
- Non-Alberta Health Services Documents:
  - *Advice to the Profession – Medical Assistance in Dying*, June 2016, (College of Physicians and Surgeons of Alberta)
  - *An Act to amend the Criminal Code and to make related amendments to other Acts (Medical Assistance in Dying)*, June 17, 2016 (Government of Canada) *Carter v. Canada* (Attorney General), 2015 SCC 5, [2015] 1 S.C.R. 331 (Supreme Court of Canada)
  - *Criminal Code* (Canada)
  - *Medical Assistance in Dying Care Coordination Service Ministerial Order D2-2016*, June 2016 (Government of Alberta)
  - *Medical Assistance in Dying: Guidelines for Nurse Practitioners*, March 2017, CARNA
  - *Medical Assistance in Dying: Guidelines for Nurses in Alberta*, March 2017, CARNA
  - *Medical Assistance in Dying Standard of Practice*, June 2016 (College of Physicians and Surgeons of Alberta)

**VERSION HISTORY**

Date	Action Taken
June 7, 2016	Revised
June 27, 2016	Revised
August 17, 2016	Non-substantive change to 5.4 (a) and 3.1 (e)
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