Medical Assistance in Dying: AHS Approach & Implementation

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  – None, either related or unrelated to this presentation
  – I am a contractor with AHS and this work was completed under the terms of my contracts
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Legislative & Regulatory Frameworks
Supreme Court Decision

• February 6, 2015, SCC ruled unanimously in *Carter v. Canada*
  – Sections 241(b) and 14 of the Criminal Code
    • Sections making it illegal for anyone to assist in, or cause the death of another person
  – SCC ruled these sections violate the constitutional rights of certain grievously and irremediably ill adult individuals
• Delayed implementation
Federal Legislation

• June 17, 2016: Federal legislation received Royal Assent
  – allowed physicians and Nurse Practitioners to provide medical assistance in dying
  – limited criteria as compared to *Carter*
  – Requires mandatory data reporting
Patient eligibility criteria:

- At least 18 years old and competent
- Has a grievous and irremediable medical condition, i.e.:
  - serious and incurable illness, disease or disability; and
  - advanced state of irreversible decline in capabilities; and
  - enduring physical or psychological suffering, caused by the medical condition, that is intolerable to the person; and
  - natural death has become reasonably foreseeable (precise proximity to death is not required)
- Voluntary request required
- Informed consent required
- Eligible for publicly funded health care services in Canada
Safeguards

– First Medical opinion confirming patient meets all criteria
– Second independent medical opinion confirming patient meets all criteria
– Request in writing (or by proxy if patient cannot write) before two independent witnesses
– Right to withdraw request at any time
– 10 clear day waiting period, unless death or loss of capacity is imminent
– Consent must be re-affirmed immediately before medical assistance in dying is provided (right to withdraw Consent)
Important Definitions

Medical assistance in dying means:

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

As defined in the Act
Alberta Approach
Regulatory Framework (GoA)

• Alberta Ministerial Directive
  – CPSA Standard of Practice
    • Identifies expectations for physicians
  – CARN A Standard of Practice
    • Identifies expectations for nurse practitioners
  – Medical Assistance in Dying Review Committee
    • Meeting regularly since December 2016
  – Care Coordination Service (AHS)
AHS Approach

- AHS Policy in place
  - Being updated. Feedback sought on the policy being incorporated
- Establishment of Care Coordination Service
- Publicly available website: [www.ahs.ca/MAID](http://www.ahs.ca/MAID)
- Ongoing process refinement and coordination as required with external partners
Care Coordination Service (AHS)

- Available to support patients, families, and care teams through the process:
  - Does not provision assisted death; acts as a central coordinating body
  - Access to resources, consultants, transfers, forms, information, colleagues, pharmacists
  - Avoids undue barriers to access for the patient while honoring right for a provider to not participate, without abandoning
  - Mechanism to also look for special conditions of vulnerability
Care Coordination Service

- Four nurse navigators, one in the south, two in Calgary/Central and one in the north
  - Jo Heggerud (Edmonton & North)
  - Lise Lalonde and Tanya Paquette (Calgary & Central)
  - Rachel McGean (South Zone)
- Link with designated operations and medical leads in each zone
- Accessed through maid.careteam@ahs.ca
- Accessed through Health Link (811)
Data

- As of June 30, 2017:
  - 789 Requests for Information
  - 259 formal requests for Assisted Death
  - 165 provisions (*now 197 as of August 31*)
  - Involve both MD’s and NP’s
  - About 2/3 facility based and 1/3 community based
  - All have selected IV route
Issues & Considerations
Ineligible Individuals

• Mature Minors
  – Issues of Vulnerability vs. Autonomy

• Loss of Capacity & use of Advance Directives
  – Issues of Vulnerability vs. Premature Death

• Mental Health
  – Issues of Safeguards vs. Discrimination
Expert Panels

• Struck to review these three groups
• Developing a report and making recommendations

• CCA:
  – Have also struck expert panels
  – Timeline by December 2018
  – Review but no recommendations
Data/Information

• Requirement to *understand* the phenomenon
  – Current data primarily focused on completed procedures
  – Need data on those who *don’t* proceed
• National work
  – CIHI
  – Health Canada
• Provincial Work
  – Review Committee
Capacity

• Assumed but with a high index of suspicion for loss
• Requirement to have capacity at set points in time
  – Includes time of signing form; assessments; consent immediately prior
  – Issue of pain control and impact of drugs on capacity
Practical Issues – 1

• Geography
  – Being addressed by Care Team
  – May include videoconferencing (for components)
  – Availability of providers for some roles an issue

• Faith-based Institutions
  – Negotiations around access
  – Some components are provided
  – Sometimes transfers are required
Practical Issues – 2

• Costs
  – Drugs
    • Covered in AHS facilities including acute care and long term care
    • Through Blue Cross for community or SL settings
  – Ambulance
    • Required for transfers
    • Being negotiated but not charged to patients
Practical Issues – 3

• Costs
  – Physician Billing
    • Existing codes
    • Overlay code
• Pensions/Life Insurance
  – Pensions not affected
  – Standard insurance suicide clauses may apply
Information and Resources
Documents

• Clinical Guide
• Placemat
• FAQ’s for Patients/Families
• FAQ’s for PCN Physicians
• Specific resources
  – “Let’s Talk About” Series
  – Patient Teaching Sheet
Clinical Guide: Rationale

• Structures thinking around medical assistance in dying
• Comprehensive identification of components required at different points in time
• Helpful to delineate what is and is not possible at various sites
### Contemplation Phase

**Patient/Family INQUIRY** to any of the following:
- Patient’s Most Responsible Health Practitioner
- Health Line 811 → Care Coordination Service
- AHS Staff Member → MRHP (MD or NP)
- AHS Care Coordination Service (CCS)
  - [MAID.CareTeam@ahs.ca](mailto:MAID.CareTeam@ahs.ca)

**Is MRHP (MD or NP) willing to be involved with:**
- providing information?
- assessment for eligibility?
- implementation?

**If MRHP willing:**
- Provide patient or family with information and discuss options
- Support connecting patient or family to CCS
- Review process
- Conduct an initial assessment of eligibility to identify any supports needed

**If MRHP not willing:**
- Provide patient with CCS contact information
- CCS contacts patient
- CCS identifies willing physicians and/or NPs for first and/or second assessment
- CCS identifies any supports needed

**At any point, the patient and/or family on behalf of the patient may raise a concern related to the process through the AHS Patient Relations Department, as per the AHS Patient Concerns Resolution Policy and Patient Concerns Resolution Process Procedure.**

**Patient makes decision to proceed**

### Determination Phase

**1st physician or NP completes assessment and charts in patient medical record, informs patient**
- Patient completes written and witnessed Record of Request for Medical Assistance in Dying Form
- Period of Reflection begins (10 clear days)

**2nd physician or NP completes assessment and charts in patient medical record**

**Patient Eligible**
- Patient advised eligible and wishes to proceed with MAID planning.

**Patient Not Eligible**
- Patient advised not eligible: MRHP or CCS to connect patient with other non-MAID services.

**Planning continues**
- Care Coordination Service [MAID.CareTeam@ahs.ca](mailto:MAID.CareTeam@ahs.ca) to help identify providing team:
  - Providing physician/NP (if different from MRHP)
  - Nursing support and/or IV initiation
  - Pharmacist
  - Other resources as identified (physician, nursing, social work, mental health, ethics, spiritual care)

**Patient makes decisions regarding:**
- Site (home, hospital)
- Route (IV, oral)
- Family and/or loved one’s to be present
- GCD status discussed and updated

**Team and Patient/Family Develop Plan**

### Action Phase

**Plan developed/consider the following:**
- Site
- Route
- Data/timeing
- Aftercare discussion/planning
- Other needs/wishes (e.g., Organ donation)

**TEAM Checklist (obtain checklists from CCS):**
- Medication
  - Protocol (IV or Oral)
  - Pharmacist to review consent form
  - Providing Practitioner to complete Alberta Blue Cross Special Authorization form for all non-facility events
- Medical Support
  - IV (MD or Nursing to initiate)
  - Other (e.g., Anesthesia support)
- Psychosocial-spiritual Support for:
  - Patient, family and loved ones
  - Team members (e.g., peer support)
  - End of Life Religious Protocols
- Administration
  - Ensure all necessary paperwork is completed
  - Process for final record/witness of patient consent to proceed

**PRE–ADMINISTRATION of Medication**
- Complete checklists
- Confirm patient consent/consent form completed and on site
- GCD completed and Green Sleeve on site
- Confirm patient knows they can rescind request

**POST–Administration of Medication**
- Providing physician or NP to complete the Providing Practitioner for Medical Assistance in Dying

**Care After**

### Care After Death Phase

**Care Coordination Service and/or providing physician or NP to identify supports for:**
- Family
- Implement aftercare plan
- Psychosocial-spiritual Support
- Grief and bereavement support coordinated
- Team members
  - Physician and/or NP
  - AHS Staff (e.g., Spiritual Care SW, AMH)
  - Others

**POST—Administration of Medication**
- Notify Medical Examiner and fax theProviding Practitioner form for Medical Assistance in Dying to the ME office asap.
- Care of the deceased resources on webpage
- Implementation of required End of Life Religious Protocols
- ME to arrange transport of body
- Return all unused medication to pharmacy
- Complete all required documentation and fax to CCS and ME as soon as possible
- Family to notify funeral home of Medical Examiner involvement

**Debrief and Learnings:**
- Engage use of AHS MAID Supportive Review Process/Offer involvement to all team members
- Consider inviting family to provide feedback prior to debrief
- Share learnings as appropriate with:
  - Family
  - MAID CCS and team
  - AHS leadership
  - Provincial MAID Leadership

See Comprehensive Clinical Guide for detailed processes at [www.AHS.ca/MAID](http://www.AHS.ca/MAID)
Learning Resources

• For NP’s and MD’s:
  – CMA Introductory Module
  – AHS Assisted Death Modules (accessed through MyLearningLink, CPSA and CARNA)

• Work was done on a capacity module
Learnings
Key Learnings

• Need for:
  – Leadership
  – Sensitivity to beliefs and perceptions
  – Collaborative creation and integration
  – Transparency
  – Anticipation as much as possible
  – Learning from experiences
Contact points and information

• E-mail:
  – MAID.careteam@ahs.ca

• Website with Resources:
  – www.ahs.ca/MAID
    • For patients, providers
    • Educational resources
    • Data
Project Contacts

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