HANDLE WITH CARE
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A Risk Management Newsletter For the Health Care Protection Program Members

Medical Assistance in Dying

2017 is an important year in Canadian history. Not only does it mark the 150th anniversary since Confederation, it also marks the first full year that medically assisted death has been legal in Canada.

This newsletter presents articles reflecting the changes to the legal landscape, the current challenges facing clinicians, and what future changes can be anticipated.

Article Summary

Director's Message

Dear Readers;

With the Supreme Court decision of *Carter* and the enactment of Bill C-14, the legal landscape of healthcare in Canada changed making it legal in Canada for individuals to request and receive a substance intended to end their life, subject to certain parameters. This change has impacted almost every organization providing healthcare and every practitioner of healthcare. Difficult conversations are occurring with colleagues, patients, and families.

Handle with Care has taken the unusual step of releasing an entire newsletter devoted to this single topic. The following articles present information on the legal changes that occurred to allow Medical Assistance in Dying (MAiD) in Canada, the current environment for those providing MAiD, and a glimpse toward what the future may hold.

I would like to take this opportunity to remind our clients that coverage under the Health Care Protection Program (HCPP) remains in force regardless of whether a client entity has decided to provide MAiD or not. The Health Team consultants are sensitive to the many diverse business models of our clients and respect the decisions being made on this multi-dimensional issue. As always, we are here to answer any questions you may have regarding how your HCPP coverage will respond and to provide general risk management advice.

We recognize that further changes to the law, enacted regulations and judicial decisions will impact how MAiD is delivered in our province and across the country. HCPP will continue to monitor all such changes, and from time to time will publish further updates.

Kindest Regards,

Sharon White
Director, Health Care Protection Program

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MEDICAL ASSISTANCE IN DYING: THE CHANGING MEDICAL-LEGAL LANDSCAPE

"This issue is not one of life or death. The issue is what kind of death, an agonized or peaceful one.
Shall we meet death in personal integrity or in personal disintegration?
Should there be a moral or demoralized end to mortal life?"

Fletcher, J. (1954). *Morals and Medicine*. Princeton, NJ: Princeton University Press at 754.

BACKGROUND: *Carter* 2015 and *Carter 2016*

Historically, medical assistance in dying ("MAiD") was prohibited in Canada pursuant to sections 14 and 241(b) of the *Criminal Code*. However, on February 6, 2015, the Supreme Court of Canada (the "SCC") in *Carter v. Canada (Attorney General)*, 2015 SCC 5 ("*Carter* 2015") declared those provisions of the *Criminal Code* prohibiting assisted suicide invalid to the extent that they prohibit physician-assisted dying for a competent adult:

1. who clearly consents to the termination of his or her life;

2. who has a grievous and irremediable medical condition which is causing the individual enduring, intolerable suffering; and

3. whose suffering could not be alleviated by any treatment acceptable to him or her.

In order to give the federal government and provincial and territorial legislatures an opportunity to formulate a legislative response to *Carter 2015,* the SCC suspended its declaration of invalidity for a period of twelve months. Quebec's legislature was the first to respond in December of 2015 when it enacted the *Act respecting end-of-life care*, which specifies the criteria to qualify for medical assistance in death in that province, as well as specific requirements for institutions and professionals providing end-of-life care in Quebec. To date, no other provincial legislature has enacted comprehensive legislation specifically governing MAiD.

On January 15, 2016, the SCC extended the suspension of its declaration of invalidity for a further four months at Parliament's request (see *Carter v. Canada (Attorney General)*, 2016 SCC 4 ("*Carter 2016*").To diminish any harm to persons seeking a physician-assisted death arising from the extension, the Court stated that individuals who sought access to MAiD were required to apply to the superior court in their jurisdiction for judicial authorization.

PATIENT PERSPECTIVES: The Changing Landscape

"I am not suffering from anxiety or depression or fear of death. I would like to pass away peacefully and am hoping to have a physician-assisted death soon. I do not wish to have continued suffering and to die of this illness by choking. I feel that my time has come to go in peace"

Ms. S, *Re HS*, at para 15.

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On February 29, 2016, Ms. S, an Alberta woman in the final stages of ALS, became the first person in Canada to obtain a physician-assisted death (see: *HS (Re)*, 2016 ABQB 121; "*Re HS*").

Four days prior to her death – on February 25, 2016 – Ms. S applied to the Alberta Court of the Queen's Bench and successfully obtained an exemption from the *Criminal Code* prohibition on physician-assisted dying. At the time of her application, Ms. S was almost completely paralyzed, living in significant pain, and required constant care and support. It was expected that, at most, she had six months to live.

Despite being a longtime resident of Calgary, Ms. S was unable to find a physician who was willing to provide her with a physician-assisted death in Alberta. As such, she sought the assistance of two physicians in Vancouver, and crafted a plan to die on private property in British Columbia. The assistance of a pharmacist to dispense the necessary mediations was essential to carry out her plan; however, no nurses would be involved.

The Court's Decision

The Alberta Court was clear that its role in these types of applications was limited to the narrow task of determining whether a particular applicant meets the criteria for a physician-assisted death articulated in *Carter 2015* and applying or authorizing the *Carter 2016* exemption. This inquiry is individual and fact specific. In *Re HS*, the Court had no difficulty in concluding that:

1. Ms. S was a competent adult person;
2. she clearly consented to the termination of her life;
3. she had a grievous and irremediable medical condition;
4. her condition was causing her enduring, intolerable suffering; and
5. her suffering could not be alleviated by any treatment acceptable to her.

BILL C-14: Medical Assistance in Dying

On June 17, 2016, the federal government passed Bill C-14, which now governs MAiD in dying across the provinces and territories. The government adopted the term "medical assistance in dying" in the place of "physician-assisted dying" in order to reflect the reality that the health care team involved in the process of assisted dying includes more than just physicians.

Bill C-14 sets out procedures that must be followed before a person can access MAiD. Before a physician or nurse practitioner provides a person with MAiD, the physician or nurse practitioner must:

1. Satisfy themselves that the patient meets the four criteria for MAiD. These criteria are:
   a. the patient must be eligible for health services funded by the Government of Canada;
   b. the patient must be 18 years old and capable of making decisions with respect to their health;
   c. the patient must have voluntarily requested medical assistance in dying and have given informed consent to receive MAiD; and

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d. the patient must have a grievous and irremediable medical condition. For a condition to qualify as grievous and irremediable, the illness, disease, or disability must be serious and incurable, it must cause the person enduring suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable, and the person must be in an advanced state of irreversible decline in capability in which a natural death is reasonably foreseeable.

2. Ensure that the person's request for MAiD was made in writing, and was signed and dated after the person was informed that their natural death had become "reasonably foreseeable" and before two independent witnesses who also signed and dated the request.

3. Ensure that another, independent physician or nurse practitioner has provided a written opinion confirming that the person meets the four criteria set out above.

4. Ensure that there are at least 10 clear days between the day on which the request was signed by the person and the day on which MAiD is provided, or a shorter period of time if deemed appropriate in the circumstances.

5. Ensure that the person has been informed that they may, at any time and in any manner, withdraw their request for MAiD.

Bill C-14 also brought several changes to the *Criminal Code*. It added exemptions to section 241 of the *Criminal Code*, which prohibits the provision of assistance in terminating life. The exemptions apply to physicians, nurse practitioners and individuals who aid physicians and nurse practitioners, as well as pharmacists who dispense a substance prescribed for MAiD. Bill C-14 also introduced a new section 227, which allows MAiD if the conditions outlined above are met.

In addition to these exemptions, Bill C-14 also introduced several new offences to the *Criminal Code* that apply when the conditions above are not met. Section 241.4 prohibits forgery in relation to a request for MAiD, as well as the destruction of documents relating to MAiD where the intent is to interfere with the provision of MAiD.

Another change is the addition of section 241.31, which authorizes the federal Minister of Health to make regulations relating to the provision, collection, use and disposal of information regarding requests and provision of MAiD. This section also requires physicians, nurse practitioners who receive a written request for MAiD to provide information, as required by the regulations, to the Minister of Health or the Minister's designated recipient. Pharmacists must do the same when dispensing a substance for MAiD.

Recent Statistics

In April 2017, the federal government issued an Interim update on medical assistance in dying in Canada which indicates that between June 17, 2016 and December 31, 2016, MAiD deaths accounted for approximately 0.6% of all deaths in Canada. By way of comparison with other jurisdictions, the proportion of MAiD deaths was 3.75% in the Netherlands and 1.83% in Belgium in 2015, and 0.37% in Oregon in 2016. Recent statistics suggest that more than 1,300 MAiD deaths have taken place in Canada since it became legally available, the majority of which took place in British Columbia and Ontario.

In British Columbia, in 2016 43.6% of MAiD deaths took place at home, 30.3% took place in hospital, 9% took place in hospice care, with the remaining 17% taking place in unspecified settings. Similarly, in Ontario, 58.2% of MAiD deaths took place at home and 34.3% took place in hospital. In all reporting jurisdictions except Saskatchewan and the Atlantic provinces, proportionately more women than men received MAiD, and the most common underlying medical conditions were (in order of frequency) cancer-related, neuro-degenerative, and circulatory/respiratory conditions.

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PROFESSIONAL REGULATION OF MAiD IN BRITISH COLUMBIA

Bill C-14 leaves some matters to be determined by provincial governments, health care institutions and regulatory bodies for physicians and nurse practitioners. Each province and territory has adopted a variety of processes and procedures to deal with requests for MAID.

The BC government has implemented several safeguards in addition to the federal requirements under Bill C-14:

1. A regulated health professional must witness an eligibility assessment conducted via the Telehealth videoconferencing system.

2. If either or both of the doctors or nurse practitioners is concerned about a patient's capability to provide informed consent, they must request a capability assessment from a third doctor or specialist.

3. The pharmacist must directly dispense the drugs to the prescribing doctor or nurse practitioner. Any unused drugs must be returned to the pharmacy.

4. The doctor or nurse practitioner must be present with the patient during the self-administration or administration of medical assistance in dying and remain with the patient until death is confirmed. This cannot be delegated to another person or professional.

The BC government has also enacted a regulation that requires all deaths resulting from MAiD be reported to the BC Coroners Service.

Guidance for Physicians

The College of Physicians and Surgeons of British Columbia ("CPSBC") has issued professional standards and guidelines for physicians relating to medical assistance in dying. ("PSAG") In addition to outlining the criteria provided in the *Criminal Code*, the PSAG offer additional information about the rights of the patients, the physicians, and the process.

(a) **Patient rights and autonomy** - The PSAG emphasize that patients have the right to make their own decisions about their bodily integrity and to have access to unbiased and accurate information about relevant medical issues and treatments. Physicians must provide their patients with information and services in a non-discriminatory fashion.

(b) **Physician rights and obligations** – The *Criminal Code* does not compel anyone to provide MAiD. Physicians have the right to decide whether or not to perform MAiD. CPSBC does expect physicians to provide patients with enough information and assistance to permit them to make informed choices for themselves. Physicians who object to providing MAiD are required to provide an effective transfer of care for their patients by advising patients that other physicians can see them, suggesting they visit an alternate physician or service, and facilitating the transfer of medical records if the patient requests it. Physicians should not pressure patients to disclose or justify their own beliefs, or discuss their personal beliefs in detail.

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(c) **Process and documentation** – Two independent medical assessors ("MAs") must give their opinion as to whether the patient meets the criteria for MAiD. Only physicians and nurse practitioners can be MAs. They must be independent of each other as well as independent from the patient. They must ensure that there are at least 10 days between the day the request was signed by or on behalf of the patient and the day on which MAiD is provided, or if the patient's death or loss of capacity to provide informed consent is imminent, any shorter period they consider appropriate in the circumstances. Physicians must inform the patient of the patient's diagnosis and prognosis, feasible alternatives, the option to rescind the request at any time, and the risk of taking the prescribed substances. The patient's medical record must include extensive records and documentation relating to the patient's care, request for MAiD, and confirmation that the appropriate steps were followed.

The College has also provided additional FAQs for physicians that can be found here.

Guidance for the Multidisciplinary Health Care Team

Before Bill C-14 was enacted, nurse practitioners, pharmacists, and other members of the health care team were not included in the *Carter* exemption. The *Criminal Code* changes now specifically exempt nurse practitioners and pharmacists from the *Criminal Code*, as well as those other individuals who assist nurse practitioners and physicians in MAiD.

The College of Registered Nurses of British Columbia ("CRNBC") has issued a Scope of Practice Standards that related to the role of nurses and nurse practitioners in providing MAiD. Nurse practitioners may determine the eligibility of a person requesting MAiD, provide MAiD, and provide assistance in the provision of MAiD. However, registered nurses who are not also nurse practitioners may only aid a physician or nurse practitioner in the provision of MAiD, and must successfully complete additional education and follow an established decision support tool. They may not prescribe, compound, dispense or administer any substance for the purpose of MAiD. The CRNBC also advises registered nurses to respond with empathy to patient requests for MAiD, ensure the patient has access to all information required to make an informed decision, assess the cultural and spiritual needs and wishes of the patient, and to work with their organizations and other members of the health care team to ensure the patient receives high quality, coordinated and uninterrupted continuity of care. Additional FAQs for nurses can be found here.

The College of Pharmacists of British Columbia updated its *Health Professions Act* bylaws to recognize the role of pharmacists in the MAiD process. The updated bylaws authorize pharmacists to delegate preparation duties to a pharmacy technician for the purposes of MAiD. However, dispensing remains limited to pharmacists. The College has also issued guidelines in line with Bill C-14 for pharmacists who choose to provide pharmacy services in the context of a medically assisted death:

1. the pharmacist must be satisfied that the assisted death is being led by a medical practitioner or nurse practitioner;

2. the pharmacist must ensure he or she does not lead the assisted death process or is seen as leading it, and cannot administer the prescribed drugs to the patient;

3. the drugs used for the assisted death must be prescribed by the medical practitioner or nurse practitioner and can only be dispensed by the pharmacist directly to the medical practitioner or nurse practitioner;

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4. before dispensing the drugs, the pharmacist confirms with the medical practitioner or nurse practitioner leading the process that he or she has made a medical determination that the patient satisfies the criteria for MAiD, and should document the confirmation.

MAiD AND PSYCHIATRIC ILLNESS: The Debate Continues

While Bill C-14 addresses many of the issues raised by the Special Joint Committee on Physician-Assisted Dying, it appears to ignore one of the committee's key recommendations, namely, that medical assistance in dying be available to patients with non-terminal illnesses who are not near death.

The question of whether individuals suffering from psychiatric disorders ought to have access to MAiD has remained controversial and largely unanswered by the federal government.

In the interim period before Bill C-14 came into force, the question of whether an individual suffering from a psychiatric disorder could obtain access to MAiD came before the courts in Alberta.

E.F. was a 58 year old woman who applied to the Alberta Court of the Queen's Bench in April of 2016 seeking judicial authorization to access MAiD. The basis of her request was a medical condition diagnosed as a "severe conversion disorder", a psychiatric condition causing extreme physical pain with no clear physiologic origin, which she claimed caused her to endure chronic and intolerable suffering. While her condition was diagnosed as a psychiatric one, her capacity and cognitive ability to make informed decisions, including the decision to terminate her life, were not at issue.

The Court of the Queen's Bench authorized E.F. to obtain MAiD and that authorization was challenged in an appeal to the Alberta Court of Appeal which ultimately upheld the lower court's decision. The Alberta Court of Appeal affirmed that individuals who suffer from psychiatric disorders were not precluded from seeking MAiD under the Supreme Court of Canada's interim criteria, provided they were competent and capable of clearly consenting to end their life. However, since the coming into force of Bill C-14, the legislative criteria for MAiD preclude individuals from seeking MAiD in those cases where mental illness is the sole underlying medical condition.

The recent death by suicide of Adam Mayer-Clayton, a 27 year old business school graduate and vocal advocate for access to MAiD for individuals suffering from psychiatric disorders has again brought attention to this issue. Among other psychiatric disorders, Mr. Mayer-Clayton reportedly suffered from a somatoform disorder similar in nature to the conversion disorder suffered by E.F., which he claimed caused him pain from which he could find no relief. However, he did not meet the criteria to access MAiD under the current legislative scheme, and instead took his own life earlier this month.

To date, the Canadian Psychiatric Association has not taken a clear position on MAiD for psychiatric patients, and has instead supported the federal government's "more considered and less rushed approach". The American Psychiatric Association has adopted the position that "a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death". However, in those countries where it is permitted, the use of MAiD for patients with psychiatric conditions is increasing. In the Netherlands, two people sought and obtained MAiD deaths because of mental disorders in 2010; by 2015 that number had grown to 56, which was approximately 1% of the total deaths from MAiD. In Belgium, 3.9% of individuals who underwent

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euthanasia in 2013 did so because of a neuropsychiatric disorder, and a comparable percentage reported that their suffering was exclusively psychological.[1]

The Canadian federal government has asked the Council of Canadian Academies ("CCA"), a federally funded non-profit organization, to report on how the law governing MAiD may be extended to include mature minors, advance requests, and requests where mental illness is the sole underlying medical condition. However, as of late January 2017, the CCA was only in the early stages of its review and its report is not expected until late 2018. Realistically, it may be years before we can expect to see any change to the existing legislative scheme for individuals suffering from mental illness. ➤

[1]Paul S. Appelbaum, "Should Mental Disorders Be a Basis for Physician-Assisted Death?" (2017) Volume 68, Issue 4, Law & Psychiatry, 315-317, online: http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700013#_i3.

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RISK NOTE

SUBJECT: Medical Assistance in Dying HCPP Coverage for Nurses, Nurse Practitioners and Pharmacists Employed by an HCA

HCPP has received many inquiries from covered Health Care Agencies (HCAs) with respect to coverage for nurses, nurse practitioners and pharmacists who are employed by an HCA and participate in Medical Assistance in Dying (MAiD). This Risk Note is primarily intended to clarify the coverage available under HCPP in these circumstances. HCA employees are encouraged to contact their HCA risk management staff for risk management advice and guidance related to MAiD.

BACKGROUND and ROLES

On February 6, 2015 the Supreme Court of Canada decision in *Carter v Canada (Attorney General),* 2015 SCC5, [2015] 1 S.C.R. 331 struck down provisions in the *Criminal Code* that prohibited MAiD, in certain limited circumstances. Because of the *Carter* decision, amendments to the *Criminal Code, RSC 1985, c.C-46* were necessary and on June 17, 2016 federal Bill C-14 was passed into law. This means that it is now legal in Canada for an individual to request and receive a substance intended to end their life, subject to the parameters set out in Bill C-14[1].

Accordingly, MAiD is permitted only by the administering by a physician or nurse practitioner of a substance to a person, at their request, that causes their death; or by the prescribing or providing by a physician 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. In BC, the College of Physicians and Surgeons of BC released Professional Standards and Guidelines effective June 23, 2016 for physicians to follow when providing MAiD. Also effective June 23, 2016 both registered nurses and nurse practitioners were able to aid in the provision of MAiD as set out by the College of Registered Nurses of BC (CRNBC) in its revised RN Scope of Practice standard. Although within the parameters of Bill C-14, nurse practitioners in BC were initially unable to determine eligibility of a person for MAiD or to provide MAiD since a practice standard for this was not in place. Effective July 27, 2016 the CRNBC board approved and put into immediate effect standards, limits and conditions related to the role of nurse practitioners in determining eligibility for and providing MAiD and as such, MAiD can now be provided by nurse practitioners in BC while acting in accordance with the standard. In BC, the vast majority of nurse practitioners are employed by a BC health authority and therefore covered by HCPP.

Pharmacists dispense substances that have been prescribed by a physician or nurse practitioner for Medical Assistance in Dying. The College of Pharmacists of BC has updated its Code of Ethics, amended its practice standards and developed guidelines for pharmacists choosing to participate in MAiD. Physicians or nurse practitioners who, in providing MAiD prescribe or obtain a substance from a pharmacist for that purpose must inform the pharmacist that the substance is intended for MAiD before the pharmacist dispenses the substance.

[1] http://www.parl.gc.ca/LegisInfo/BillDetails.aspx?Language=E&Mode=1&billId=8177165

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HCPP COVERAGE

HCPP will respond to allegations or legal actions related to MAiD subject to the terms and conditions of its coverage agreements. HCPP extends to cover employees of a covered Health Care Agency while acting within the scope of their employment, including employed nurses, nurse practitioners and pharmacists.

In the case of MAiD, HCPP will consider coverage for allegations of a criminal offence up until the time formal charges against an employee are laid by the Crown, provided the employee is acting in good faith that he/she is in compliance with Bill C-14 parameters. Note that on June 8, 2016 the BC Criminal Justice Branch issued a statement and Guidelines for Prosecutors Dealing With Physician-Assisted Death to clarify that "*when the conditions of* Carter *are met, there is no substantial likelihood of a conviction for charges against physicians or other healthcare professionals involved in carrying out a physician-assisted death, including nurses and pharmacists, nor would the public interest test be met*." [2]

RISK MANAGEMENT

If an employee of a HCA is asked about or approached to participate in MAiD, HCPP recommends **contacting the HCA's risk management department or MAiD co-ordination office for guidance and support**. Any allegations or legal action related to an employee's role in MAiD should be reported immediately to the HCA's risk management department for handling and referral to HCPP where appropriate.

RESOURCES

- College of Registered Nurses of BC MAiD Resource Centre: https://www.crnbc.ca/Standards/resourcescasestudies/beinganurse/MAID/Pages/Default.aspx
- College of Pharmacists of BC Resources: http://www.bcpharmacists.org/medical-assistance-dying
- College of Physicians and Surgeons of BC Standards and Guidelines for MAiD: https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf
- BC Ministry of Health MAiD Resource webpage: http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying
- Government of Canada MAiD Resource Centre: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html
- Canadian Association of MAiD Assessors and Providers: http://camapcanada.ca/

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[2] http://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/prosecution-service/media-statements/2016/16-12-physician-assisteddeath.pdf

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The Clinical Interpretation of "Reasonably Foreseeable" in Bill C-14

The Canadian Association of MAID Assessors and Providers (CAMAP) published its Clinical Practice Guideline (CPG) on the clinical interpretation of the meaning of "reasonably foreseeable" in Bill C-14 at its first annual conference in early June 2017.

In June 2016 medical assistance in dying (MAID) became available for Canadians without a court order being necessary. MAID had been permissible for the previous 16 months with a court order under the historic Carter decision of the Supreme Court of Canada (SCC).

Under the terms of the new law, which is still known customarily as Bill C-14, competent adults may seek MAID if they (1) have a grievous and irremediable condition, (2) are suffering intolerably and are unable to have that suffering relieved through treatments that are acceptable to them, (3) are in an advanced state of decline of capability and (4) have a naturally foreseeable death. They must be assessed as eligible by two clinicians. The clinicians are usually physicians but nurse practitioners may also be MAID assessors or providers.

Bill C-14 differs in material ways from the Carter decision of the SCC. The Carter decision required only that there be intolerable suffering. The federal government deliberately inserted requirements in order to make MAID available only as an end-of-life regime. These additional requirements are that the person be "in an advanced state of decline" and that their natural death be "reasonably foreseeable". The government justified this on the grounds that it was necessary to protect vulnerable groups such as the elderly and the disabled. There was also a desire not to legitimize suicide by those who are mentally ill. This was seen as especially important in a country where suicide by First Nations youth is tragically more common than it is for youth with a different cultural heritage. We cannot know how much this weighed on the mind of a Justice Minister who herself has First Nations heritage. We also cannot know the influence that any personal views had upon the advice given to the Justice Minister by the Health Minister who is both a practising Christian and a physician. Both groups are traditionally less accepting of MAID than the general public, which across Canada supports MAID at levels of more than 80%, with the figure reaching 87% in British Columbia. The government also chose not to allow advance requests, requests from mature minors, or requests where the sole medical condition is a mental illness, although these inclusions had been recommended by a Special Joint Committee of the Senate and the House of Commons.

Perhaps because it would have been so clearly unconstitutional, the government chose not to attempt to bring in the most restrictive type of regime, represented in the physician-assisted suicide laws of the six jurisdictions in the United States of America that have legalized MAID through statute. In California, the District of Columbia, Oregon, Vermont and Washington physician-assisted suicide is only permissible if the patient has a prognosis of six months or less. Furthermore, only physician assisted suicide is allowed. Euthanasia by lethal injection is not. This means that extremely frail people, or those who for reasons of their disease are unable to swallow medication or to do so quickly enough to take the full dose necessary for death before falling asleep, cannot access MAID in those locations. Finally, the physician is not required to be present at the time of the taking of the medication, which most Canadian jurisdictions demand and which is inevitable in the case of MAID by intravenous injection. This leads to failure far more often than in the Canadian system, where failure has only occurred in a handful of cases in patients having intravenous injections at home. In these cases the cannula has failed requiring admission to hospital for completion of the medically assisted death. Thanks to the requirement that a clinician remains with the patient, if the oral route has not led to death within a period agreed between the clinician and the patient, the intravenous route is used to ensure death.

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The inclusion in Bill C-14 of the criteria "advanced state of irreversible decline in capability" and "natural death has become reasonably foreseeable" in the definition of "grievous and irremediable medical condition" has proved to be extremely problematic for physicians and nurse practitioners, whom I will here refer to jointly as "clinicians". Debate over the exact meaning of both terms has been on-going since Bill C-14 was first published. The problem is that "reasonably foreseeable", in particular, is not a term that appears in any medical textbook, and there has never previously been a reason to worry overmuch about exactly how advanced a patient's state of irreversible decline has become, at least from a definitional viewpoint. Now, when the consequences of getting an assessment "wrong" could be a spell of up to 14 years in prison, clinicians are keen to get as much clarity as possible.

The federal government has attempted to provide this clarity by publishing a number of documents. The first document was Bill C-14 itself. In the definition of a "grievous and irremediable condition" it is noted that the natural death must be "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". Although this is what distinguished the Canadian regime from the less permissive American regimes, it actually does little to clarify and in fact muddies the waters further. A "Legislative Background" document and later a "Glossary" were published alongside the new Bill to educate parliamentarians and the public as to the government's intentions in the drafting of it. The former attempted to explain that "Eligibility would be assessed on a case-by-case basis, with flexibility to reflect the uniqueness of each person's circumstances, but with limits that require a natural death to be foreseeable in a period of time that is not too remote". The Glossary restated this as “"Natural death has become reasonably foreseeable" means that there is a real possibility of the patient's death within a period of time that is not too remote. In other words, the patient would need to experience a change in the state of their medical condition so that it has become fairly clear that they are on an irreversible path toward death, even if there is no clear or specific prognosis...the person's death would need to be foreseeable in the not too distant future.”

The case that confused physicians most was that of Kay Carter herself, who was one of the two people whose suffering led to the SCC case. Kay Carter had spinal stenosis which is a non-fatal condition but which led to her having greatly reduced mobility and which contributed to her frailty. The average life expectancy of an 87 year old female (her age when the case commenced) is about six years. Clearly Kay Carter's life expectancy would be less than average but by how much? The lawyers who took the case to the SCC are of the opinion that Kay Carter would not have qualified for MAID under the more restrictive terms of Bill C-14. The Minister of Justice disagreed, stating to the Senate on June 1, 2016, "I am 100% certain that Kay Carter would be eligible under Bill C-14 to access medical assistance in dying...Her death had become reasonably foreseeable by virtue of her age and frailty. The flexibility that we sought to inject in the eligibility criteria was to provide medical practitioners the ability to assess their patients' circumstances and to provide for that patient to be able to be eligible for medical assistance in dying. Kay Carter would have fulfilled that criteria (*sic*)".

In an attempt to clarify the meaning of "reasonably foreseeable", the CAMAP published its CPG on the subject in June 2017. CAMAP is an association of professionals involved in the assessment and provision of MAID in Canada. It is the only professional association doing this work. Its aim is to support clinicians, to educate the public and the health care community about MAID and to provide leadership on determining the highest standards and guidelines of care in MAID provision.

CAMAP's draft guideline, developed by its Committee on Standards and Guidelines, was circulated to all provider members of the organization for comment. After improvements suggested by CAMAP's MAID provider members had been incorporated the text was finalized by the Committee and published on June 2. Some criticism has been levelled at the process of the development of the CPG because it was felt by others that wider circulation of the draft CPG for comment was warranted. It is unlikely that such an approach would have led to useful change in the

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content as the emphasis was on clinical practice and no other bodies such as the CMPA or CMA have any concentration of expertise in this area, unlike CAMAP. Furthermore, CAMAP was aware that the CPG was needed urgently, as uncertainty over interpretation of "reasonably foreseeable" was causing a great deal of anxiety in MAID clinicians and was also leading to the inappropriate denial of eligibility to MAID across the country. For example, the United Hospitals Network in Toronto was operating a policy that any person with a prognosis greater than 12 months would not be approved for MAID. There was therefore some urgency about finalizing the CPG.

The CPG makes four recommendations and gives examples of cases in order to assist clinicians in their assessment of patients.

The first recommendation reminds clinicians that Bill C-14 legislates that MAID is an end-of-life regime in Canada. One criticism of the development of the CPG, from the CMA, is that the leaders of CAMAP are "pro-MAID". The implication is that CAMAP seeks to "bend the rules". This is explicitly not the case. CAMAP simply wishes to ensure that the letter and the intent of the law are followed in such a manner that all those who are eligible for MAID under the law as it stands are found to be eligible and may access MAID if they wish it.

The second recommendation is that clinicians should consider interpreting "reasonably foreseeable" as meaning "reasonably predictable". One indication that CAMAP is on the right track here is that a criticism of this recommendation that has been heard is that "foreseeable" and "predictable" are essentially synonymous. However, discussion within the provider membership of CAMAP made it clear that this is a useful suggestion. Essentially, predictability is a concept more easily considered than foreseeability within the art of prognostication. What the recommendation and its attendant explanatory text assert is that a person's death can be regarded as foreseeable when their current medical problems, their age, and their frailty together can be *predicted* to be *likely* to cause their death rather than some other as yet unknown cause.

The third recommendation is that clinicians should neither employ or support strict time frames for prognosis. As already noted, some hospitals will not allow MAID if the prognosis is greater than one year. Lawyers have suggested that a clinician's legal risk rises worryingly the further the prognosis is beyond 6 months. This approach is not supported by the law and if followed will lead to eligible people being found ineligible. A recent case heard in Ontario's Superior Court of Justice confirmed that it is the task of the clinicians to decide whether the patient's death is reasonably foreseeable - whether the patient is on a trajectory towards death - but without any specific prognosis being necessary.

The fourth recommendation encourages clinicians to see the problem of determining eligibility as a clinical decision like any other. Therefore, if an individual clinician is uncertain as to a person's eligibility, then the solution is to turn to professional medical bodies and other MAID clinicians more experienced in the service, rather than to lawyers, which has often been the approach in the first year of legal medically assisted dying. Seeking the advice of other clinicians in the field is the approach that clinicians take to any other medical problem; it should be the same for MAID.

The issue of "reasonably foreseeable" and the attendant issue of "advanced state of irreversible decline in capability" will continue to trouble clinicians but it is the hope of CAMAP that the CPG will reduce the number of cases where this is true by removing those where the concern is due to legalistic or definitional issues arising out of excessively cautious, or simply inaccurate, interpretations of the law. There will always be some cases where the clinical aspects of the person's situation make their eligibility uncertain initially. As the fourth recommendation in the CPG makes clear, the approach in these cases should be exactly the same as in any other uncertain medical case i.e. discussion with other clinicians more expert in the medical field concerned.

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A legal challenge regarding the inclusion of the requirement that the person's natural death is reasonably foreseeable and that they be in an advanced state of irreversible decline in capability has already been mounted and the case is now being heard in British Columbia. It will take time for the case to proceed through the various necessary layers before it reaches the Supreme Court and the outcome is not knowable. Until then clinicians will continue to work within the constraints of Bill C-14. CAMAP's CPG on the clinical interpretation of "reasonably foreseeable" is an important tool to help them in this. ➤

CAMAP's Clinical Practice Guideline on the interpretation of "reasonably foreseeable" can be found at:
http://www.camapcanada.ca/cpg1.pdf

Jonathan Reggler
Member, Board of Directors
Canadian Association of MAiD Assessors & Providers
http://www.camapcanada.ca/

CAMAP
Canadian Association
of MAiD
Assessors & Providers

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Council of Canadian Academies Undertaking Studies Related to Medical Assistance in Dying

In December 2016, the Council of Canadian Academies (CCA) was asked by Minister of Health Jane Philpott and Minister of Justice and Attorney General of Canada Jody Wilson-Raybould to undertake independent reviews related to medical assistance in dying. Specifically, the CCA is tasked with examining three particularly complex types of requests for medical assistance in dying that were identified for further review and study in the legislation passed by Parliament in 2016. These cases are: requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition.

CCA's Expert Panel on Medical Assistance in Dying is being led by the Honourable Marie Deschamps, C.C., *Ad. E.*, Former Justice of the Supreme Court of Canada and Adjunct Professor, McGill University and Université de Sherbrooke. Comprised of 44 individuals, the Panel brings together Canadian and international experts who have expertise, knowledge, and leadership experience in many disciplines including law, medicine, ethics, social sciences, and health sciences, among others. In order to effectively address the three types of requests for medical assistance in dying, the Expert Panel has also been divided into three working groups, each with a Chair.

What is the charge to the Expert Panel?

The Expert Panel is tasked with compiling and assessing available evidence to inform the ongoing policy discussions on the issues related to medical assistance in dying by responding to the following question:

What is the available evidence on, and how does it inform our understanding of, medical assistance in dying (MAID) in the case of mature minors, advance requests, and where mental illness is the sole underlying medical condition, given the clinical, legal, cultural, ethical, and historical context in Canada?

As with all CCA Expert Panels, it will assess the state of knowledge for the purpose of informing decision-making and will not make explicit recommendations.

Main Question:

What is the available evidence on, and how does it inform our understanding of, medical assistance in dying (MAID) in the case of mature minors, advance requests, and where mental illness is the sole underlying medical condition, given the clinical, legal, cultural, ethical, and historical context in Canada?

General Sub-questions:

- What are the potential implications for individuals and other affected persons, including their families, care providers, and health professionals, related to MAID for the three topic areas?

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- What are the potential impacts on society of permitting or prohibiting requests for MAID for the three topic areas?*
- What are the potential risks and safeguards that might be considered related to MAID for the three topic areas?
- What are the relevant gaps in domestic and international knowledge and research related to MAID for the three topic areas?

** For example, suicide prevention strategies and medical response; availability and efficacy of palliative care, dementia-related, and mental health services and supports; risks to vulnerable populations; discrimination and stigma related to chronological age, dementia and related illnesses, and mental illness; risks of inducements.*

Topic Area Questions:

Requests for MAID by Mature Minors

- What is the impact of chronological age on the legal capacity to request and consent to MAID?
- What are the unique considerations related to mature minors requesting MAID (e.g., mature minors vs. adults and MAID vs. other healthcare decisions)?

Advance Requests for MAID

- How is an advance request for MAID similar to or different from advance directives for health care under existing provincial/territorial regimes?
- What are the unique considerations to be taken into account depending on when an advance request is made?**

*** That is: 1) before diagnosis; 2) after diagnosis but before onset of suffering; 3) after all of the eligibility criteria and procedural safeguards have been met, except for the 10 day waiting period and the reconfirmation immediately prior to provision of MAID.*

Requests for MAID Where Mental Illness is the Sole Underlying Medical Condition***

- What is the impact of mental illness in its different forms on an individual's legal capacity to request and consent to MAID?
- What are the unique considerations related to individuals living with mental illness (including mature minors) requesting MAID where the mental illness is the sole underlying medical condition?****

**** For certainty, the study is concerned with requests where mental illness is the sole underlying medical condition does not include circumstances where a person with a mental illness is eligible under the existing law.*

***** Both in communities or institutions*

Why was this work initiated?

The legislation on medical assistance in dying required the Minister of Health and the Minister of Justice/ Attorney General to initiate independent reviews within 180 days of Royal Assent. That 180-day period expired on December 14, 2016.

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The CCA was requested to convene an expert panel to undertake these reviews. The reviews are required to be completed within two years and will be made available to Parliamentarians and the public by December 2018.

The overarching purpose of this work is to compile and assess relevant knowledge, information and evidence to inform the ongoing policy and public discussions on the issues related to medical assistance in dying in the three circumstances.

Background on the CCA

The CCA is a not-for-profit organization that undertakes independent, evidence-based expert panel assessments and workshops to inform public policy development in Canada. CCA projects are conducted by multidisciplinary, multi-sectoral panels of experts from across Canada and abroad. CCA reports provide evidence to inform decision -making processes rather than explicit recommendations. To date, the CCA has published over 40 reports on topics such as business innovation, shale gas extraction, food security, and health data.

Established in 2005 with an initial grant from the Government of Canada, the CCA has become well known for its rigorous process and its comprehensive analyses of complex issues. The CCA was founded by three independent organizations that represent some of the finest minds in Canada – the Royal Society of Canada, the Canadian Academy of Engineering, and the Canadian Academy of Health Sciences. Their Fellows and senior decision-makers sit on CCA's Board of Governors and Scientific Advisory Committee, and they are a key source of membership for expert panels. All CCA reports are freely available to the public and published in both official languages.

For additional information on the CCA's current and completed studies, visit www.scienceadvice.ca. ➤

Source: Council of Canadian Academies

Council of Canadian Academies
Conseil des académies canadiennes

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Federal Monitoring of Medical Assistance in Dying

On June 2-3, 2017 the inaugural conference of the Canadian Association of MAID Assessors and Providers (CAMAP) took place in Victoria. The conference program included a presentation on federal monitoring of MAID by Sandra Tomkins (senior policy analyst, Health Canada). Pertinent points included:

Context

The legislation which amended the *Criminal Code* to create exemptions for MAID requires the federal Minister of Health to make regulations respecting the collection of information for the purpose of monitoring MAID.

The legislation specifies that medical practitioners and nurse practitioners who receive written requests for MAID must provide information for monitoring purposes[1]. It also includes a separate sanction for failing to provide information.

Purpose of Monitoring

The purpose of monitoring is to provide transparency and foster public trust regarding the application of the legislation at a national level. Monitoring requires data on individual cases to build an aggregate picture of MAID in Canada, but does not involve scrutiny of individual cases. Annual monitoring reports will include pan-Canadian information on:

- Core statistics on requests for MAID and their outcomes;
- Dynamics of requests, such as trajectories and timelines;
- Medical circumstances of those assessed for MAID (e.g., medical conditions giving rise to requests), and the nature of suffering of those receiving MAID;
- Socio-demographic characteristics of those receiving MAID;
- Relevant findings regarding the application of eligibility criteria and safeguards (e.g., which criteria were not met, in cases found ineligible)

Regulatory Development Process and Timelines

Regulatory development typically takes 18-24 months.

It is expected that the MAID monitoring regulations will come into force in 2018. There is no requirement to provide information for federal monitoring purposes in the meantime, or to provide retroactive information.

Key Considerations

Principles and considerations informing the development of the regulations include the importance of:

- protecting the privacy of patients and providers;

[1]There is also a requirement for pharmacists who dispense a substance in connection with the provision of MAID.

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- minimizing the administrative burden on providers by harmonizing requirements between respective federal and provincial/territorial data needs and processes;

- clarity regarding the intended use of the data;
- clarity regarding providers' obligations (i.e., what information must be provided, to whom, when, and how); and

- reflecting the realities of real-time practice, especially regarding timelines for providing information.

Consultations with stakeholders have reinforced the importance of these considerations.

Anticipated requirements

The regulations remain a work in progress. It is anticipated that they will identify several categories of information, including:

- Core information about the patient/practitioner/request

- Results of eligibility assessment

- Application of safeguards

- Provision of MAID (self-administered)

- Provision of MAID (provider-administered)

In cases where MAID was provided, information under all categories will be required. More limited information will be required in other cases, e.g., if the request was transferred or withdrawn, or if the patient was found ineligible.

Next steps

It is anticipated that pre-publication of the draft regulations for public consultation in *Canada Gazette I* will take place in the late summer/fall of 2017.

Information regarding monitoring requirements will be communicated via regulatory bodies and other relevant organizations in advance of implementation.

For more information, please refer to the accompanying presentation slides.➤

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Health Canada Santé Canada

Canada

Federal Monitoring of Medical Assistance in Dying

Sandra Tomkins, Senior Policy Analyst
Strategic Policy Branch, Health Canada

Canadian Association of MAID Assessors and Providers Conference
Victoria, B.C.
June 3, 2017

YOUR HEALTH AND SAFETY... OUR PRIORITY.

2

Overview

- Federal responsibilities arising from the legislation
- Preliminary considerations
- What is monitoring?
- International approaches
- Legislative context
- Regulatory development process and interim reporting
- Key considerations
- Summary of anticipated requirements
- Next steps

Annexes

A: Draft outline of annual monitoring report

B: Overview of anticipated information requirements and filing obligations

C: Links

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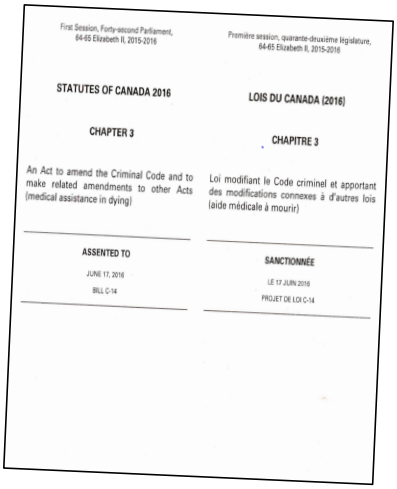
Federal responsibilities arising from the legislation

- Make regulations for the purpose of monitoring medical assistance in dying (in progress)
- Initiate independent reviews of issues relating to:
  - Requests by mature minors
  - Requests where mental illness is the sole underlying medical condition
  - Advance requests

  (underway - reports to be tabled in Parliament by December 2018)
- Establish guidelines on the information to be included on death certificates in cases where MAID has been provided

  (completed – available on Health Canada website)


First Session, Forty-second Parliament, 64-65 Elizabeth II, 2015-2016

Première session, quarante-deuxième législature, 64-65 Elizabeth II, 2015-2016

STATUTES OF CANADA 2016

LOIS DU CANADA (2016)

CHAPTER 3

CHAPITRE 3

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)

Loi modifiant le Code criminel et apportant des modifications connexes à d'autres lois (aide médicale à mourir)

ASSENTED TO

JUNE 17, 2016

BILL C-14

SANCTIONNÉE

LE 17 JUIN 2016

PROJET DE LOI C-14

Also: Parliamentary review of the provisions of the legislation (and the state of palliative care in Canada), to commence in June 2020

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Preliminary considerations

- Federal legislation requires the federal Minister of Health to make regulations respecting the provision and collection of information for the purpose of monitoring MAID
- The scope of the regulations is established by the legislation, e.g.:
  - filing obligations for medical practitioners/nurse practitioners, and pharmacists
  - provision of information relating to written requests for, and provision of, MAID
- The regulations must clearly indicate:
  - Who is required to provide information
  - The information to be provided, in what circumstances, and when
  - To whom information must be provided
  - The use of the information, including disclosure, protection, publication and disposal
- Data on MAID is required for different purposes by different parties
- Regulatory development typically takes 18-24 months, and includes stakeholder and public consultation at various stages
- Development of the regulations is a work in progress, and implementation of MAID is concurrently evolving in real time

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What is monitoring?

Monitoring refers to the collection and analysis of data related to the implementation of the *Criminal Code* exemptions which permit MAID in Canada

It is **not** oversight of:
- the delivery of health care services, or
- compliance with the *Criminal Code* exemptions (i.e., review of individual cases to determine whether applicable laws have been complied with)

... which are provincial/territorial responsibilities

Purpose: provide transparency and foster public trust at a national level

Objectives
- Support public accountability in relation to MAID
- Support public protection and safety by reporting on the application of the eligibility criteria and safeguards required by the legislation, from a national perspective
- Identify and monitor trends in relation to MAID
- Make data available to qualified researchers for independent research (secondary objective)

Product: annual report

MAID Annual Monitoring Report – outline

[data aggregated nationally, with other breakdowns as numbers permit]

Portrait of MAID in Canada in 20xx
- Core statistics – requests and outcomes
- Dynamics of requests for, and provision of, MAID (e.g., referrals, timelines)
- Medical circumstances of those assessed for MAID
- Nature of suffering for persons receiving MAID
- Socio-demographic characteristics of those receiving MAID
- Relevant findings respecting the application of eligibility criteria and safeguards

Trends
- As annual data becomes available from year to year

See Annex A for more detailed information

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International approaches

Common elements of international reports:
- Number of cases annually and their outcomes
- Description of the application of the law
- Number of physicians involved in MAID, and their characteristics
- Patient characteristics
- Patients' medical circumstances, and the nature of the concerns leading to their request for MAID
- Circumstances of death

Variations in the Canadian context
- Collection of data on *written requests* for MAID (not necessarily resulting in provision of MAID)
- Responsibility for compliance and monitoring lies with different levels of government
  - Some data needs are overlapping

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Legislative context

The legislation establishes the authority to make the regulations, and their parameters

Filing information — medical practitioner or nurse practitioner 241.31 (1) Unless they are exempted under regulations made under subsection (3), a medical practitioner or nurse practitioner who receives a written request for medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.

Filing information — pharmacist

(2) Unless they are exempted under regulations made under subsection (3), a pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.

Regulations

(3) The Minister of Health must make regulations that he or she considers necessary

(a) respecting the provision and collection, for the purpose of monitoring medical assistance in dying, of information relating to requests for, and the provision of, medical assistance in dying, including

(i) the information to be provided, at various stages, by medical practitioners or nurse practitioners and by pharmacists, or by a class of any of them,

(ii) the form, manner and time in which the information must be provided,

(iii) the designation of a person as the recipient of the information, and

(iv) the collection of information from coroners and medical examiners;

(b) respecting the use of that information, including its analysis and interpretation, its protection and its publication and other disclosure;

(c) respecting the disposal of that information; and

(d) exempting, on any terms that may be specified, a class of persons from the requirement set out in subsection (1) or (2).

Offence and punishment

(4) A medical practitioner or nurse practitioner who knowingly fails to comply with subsection (1), or a pharmacist who knowingly fails to comply with subsection (2), (a) is guilty of an indictable offence and liable to a term of imprisonment of not more than two years; or (b) is guilty of an offence punishable on summary conviction.

Offence and punishment

(5) Everyone who knowingly contravenes the regulations made under subsection (3) (a) is guilty of an indictable offence and liable to a term of imprisonment of not more than two years; or (b) is guilty of an offence punishable on summary conviction.

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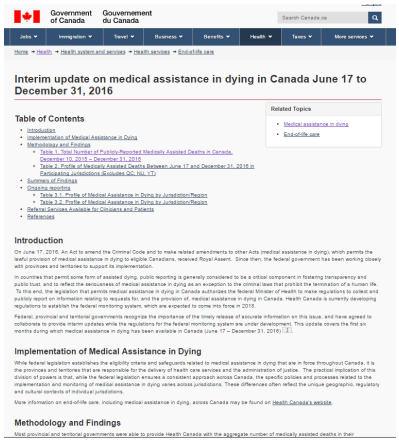
Regulatory development process and interim reporting

- Regulatory development process typically takes 18-24 months, and includes:
  - Policy development, including preliminary consultations
  - Preparing draft regulations
  - Approval of draft regulations by Department of Justice and Minister of Health
  - Pre-publication in *Canada Gazette I* for public consultation (summer/fall 2017, TBD)
  - Revisions and re-drafting, as necessary
  - Approval of final regulations by Department of Justice and Minister of Health
  - Enacted regulations published in *Canada Gazette II*
  - Regulations come into force (in 2018, TBD)
    - Filing obligations commence
    - No requirement to file information prior to regulations coming into force, or to do so retroactively
- Commitment to interim reporting
  - Aggregate data provided by provincial and territorial governments, including number of medically assisted deaths; most common underlying medical conditions; basic demographic information
  - Initial update in April 2017 (data for June-December 2016)
  - Further releases at six-month intervals


Government of Canada / Gouvernement du Canada

Interim update on medical assistance in dying in Canada June 17 to December 31, 2016

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Key considerations

- Importance of protecting the privacy of patients and providers
- Potential overlap of federal and provincial/territorial data needs
- Avoiding administrative burden on providers
- Information required from providers must be the minimum needed for the purpose of monitoring
  - Role of personal information; socio-demographic characteristics
- Clarity regarding the intended use of data
- Clarity for providers regarding their obligations
- Timelines for reporting (vis à vis real-time practice)

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Summary of anticipated requirements

Information categories

- Basic information about the patient/practitioner/request
- Supplementary (socio-demographic) information about the patient*
- Results of eligibility assessment
- Application of safeguards
- Provision of MAID: prescribing or providing a substance
- Provision of MAID: administration of a substance
- Dispensing a substance (pharmacist)

Which information will be required, and when, varies

- Practitioner directs/transfers the request elsewhere
- Practitioner determines the patient is ineligible
- Patient withdraws the request*
- Patient dies from another cause*
- Practitioner provides MAID – administration of a substance
- Practitioner provides MAID – prescribing or providing a substance
- Follow-up – none of the above has occurred within [45] days

MAID Annual Report – outline

Portrait of MAID in Canada in 20xx

- Core statistics – requests and outcomes
- Dynamics of requests for, and provision of, MAID (e.g., timelines)
- Medical circumstances of those assessed for MAID
- Nature of suffering for persons receiving MAID
- Socio-demographic characteristics of those receiving MAID
- Relevant findings respecting the application of eligibility criteria and safeguards

Trends

- As annual data becomes available from year to year

**A practitioner can only be required to provide information that he or she can reasonably be expected to have – some items are "if known"*

See Annex B for further detail

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Next steps

- Continued development of regulations
  - Public consultation phase (summer/fall 2017 - TBD)
  - Coming into force in 2018 (TBD)
- Planning and preparation for implementation
  - Continued dialogue with provincial/territorial authorities and stakeholder organizations
  - Communications activities (including via regulatory bodies and other relevant organizations)
  - Information and aids on Health Canada website
- Roll-out and commencement of data collection
  - Initially paper-based, eventual online database (TBD)
- Reporting
  - First monitoring report will follow an initial period of data collection
  - Thereafter on an annual basis
  - Further interim reports in the meantime

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Annex A: Draft outline of annual monitoring report

MAID Annual Monitoring Report – draft outline

[data aggregated nationally, with other breakdowns as numbers permit]

Portrait of MAID in Canada in 20xx

Core statistics

- Number of written requests for MAID, and breakdown-down of their outcomes
  - e.g., numbers found eligible/not eligible
    - of those found eligible, how many resulted in MAID
      - of MAID deaths, how many were self-administered or provider-administered
- System-level information on MD/NPs and pharmacists, e.g.,
  - Number involved in MAID requests, and breakdown by MD/NP, and by specialty for MDs
  - Number of cases per provider (range, average)

Dynamics of requests for, and provision of, MAID, including:

- Trajectories (e.g., received directly, or through referrals/care coordination services)
- Role of consultations with other professionals
- Timelines and settings

Medical circumstances of those assessed for MAID, including

- Data relating to the "grievous and irremediable medical condition" criteria, e.g., illnesses, diseases or disabilities giving rise to requests for MAID

Nature of suffering for persons receiving MAID

- As described by the patient

Socio-demographic characteristics of those receiving MAID, including

- age, gender, marital status, principal occupation during working life

Relevant findings respecting eligibility criteria and safeguards, including

- eligibility criteria which were not met, in cases where requests were not granted

Trends

- As annual data becomes available from year to year

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Annex B: overview of anticipated information requirements and filing obligations

Trigger	Information required	Timeframe (TBD)
Directing or transferring the request elsewhere	- Basic information about the patient/practitioner/request - Information about the transfer (e.g., type, timelines)	Within [10] days of providing the referral/transfer
Determination of ineligibility	- Basic information about the patient/practitioner/request - Results of eligibility assessment	Within [10] days of finding the patient ineligible
Patient withdraws request	- Basic information about the patient/practitioner/request - Results of eligibility assessment (if completed) - Socio-demographic information about the patient (if eligibility was established) - Information about the withdrawal of the request (e.g., date and manner)	Within [10] days of becoming aware of the patient withdrawing his or her request
Death of patient from another cause	- Basic information about the patient/practitioner/request - Results of eligibility assessment (if completed at the time of patient's death) - Socio-demographic information about the patient (if eligibility was established) - Cause of death (as recorded on death certificate, if completed by the practitioner)	Within [10] days of becoming aware of the patient's death
MAID – administration of a substance	- Basic information about the patient/practitioner/request - Supplementary (socio-demographic) information about the patient - Results of eligibility assessment - Application of safeguards - Information about the administration of the substance (e.g., date, setting)	Within [10] days of the patient's death from MAID
MAID – prescribing or providing a substance	- Basic information about the patient/practitioner/request - Supplementary (socio-demographic) information about the patient - Results of eligibility assessment - Application of safeguards - Information about the prescription or provision of a substance for MAID (e.g., date, setting) If applicable and if known: - Information re: circumstances of self-administration of MAID	Within [10] days of prescribing or giving the substance to the patient
Requirement to follow up: none of the above outcomes has occurred within [45] days	- Basic information about the patient/practitioner/request - Status of patient and status of request, if known - Results of eligibility assessment (if completed) - Socio-demographic information about the patient (if eligibility was established)	Within [10] days of the [45] day point

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Annex C: Links

(right-click and choose "open hyperlink" to launch)

To the legislation amending the *Criminal Code* (medical assistance in dying)
http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html

To the backgrounder on the legislation
http://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/

To federal guidelines for the completion of death certificates in cases where MAID is provided
https://www.canada.ca/en/health-canada/services/publications/health-system-services/guidelines-death-certificates.html

To the interim update (data on MAID deaths, June – December 2016)
https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html

To information on the independent reviews (Council of Canadian Academies website):
http://www.scienceadvice.ca/en/assessments/in-progress/medical-assistance-dying.aspx

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Questions?

Thank you

Contact information:

end.of.life.care_soins.fin.de.vie@hc-sc.gc.ca

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About Our Organization

We are the Client Services Team for the Health Care Protection Program (HCPP). HCPP is a self-insurance program which is funded by the Health Authorities of BC. The program is housed within the offices of the Risk Management Branch of the Ministry of Finance which also has responsibility for similar programs such as the Schools Protection Program, the University, College & Institute Protection Program and the Midwives Protection Program. As part of the services of our program, we provide risk management services including risk mitigation, risk financing, and claims and litigation management to HCPP member entities including all the Health Authorities and various other stand-alone health care agencies in the Province of BC. ***Handle with Care*** is published twice a year by HCPP.

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