Medical Assistance in Dying (MAID) aka Assisted Dying (AD)

Bill C-14

to

Bill C-7

May 2023

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Conflict of Interest Disclosure

- No Relationships with Commercial Interests
- Disclosure of Commercial Support – Nothing to disclose
- Mitigating Potential Bias – discussion today is based on evidence and personal opinion

Today's Discussion

- Brief Update – MAID as a treatment option
  - New Legislation - Bill C-7, March 2021 (Bill C-14 to Bill C-7)
  - Eligibility Criteria – Track 1 and Track 2
- MAID in Canada, Ontario and SHN - we are all not the same!
- A patient asks about MAID, What do I do?
- Discussion – How does AD fit into my practice?

  (intellectually, emotionally, spiritually, culturally)

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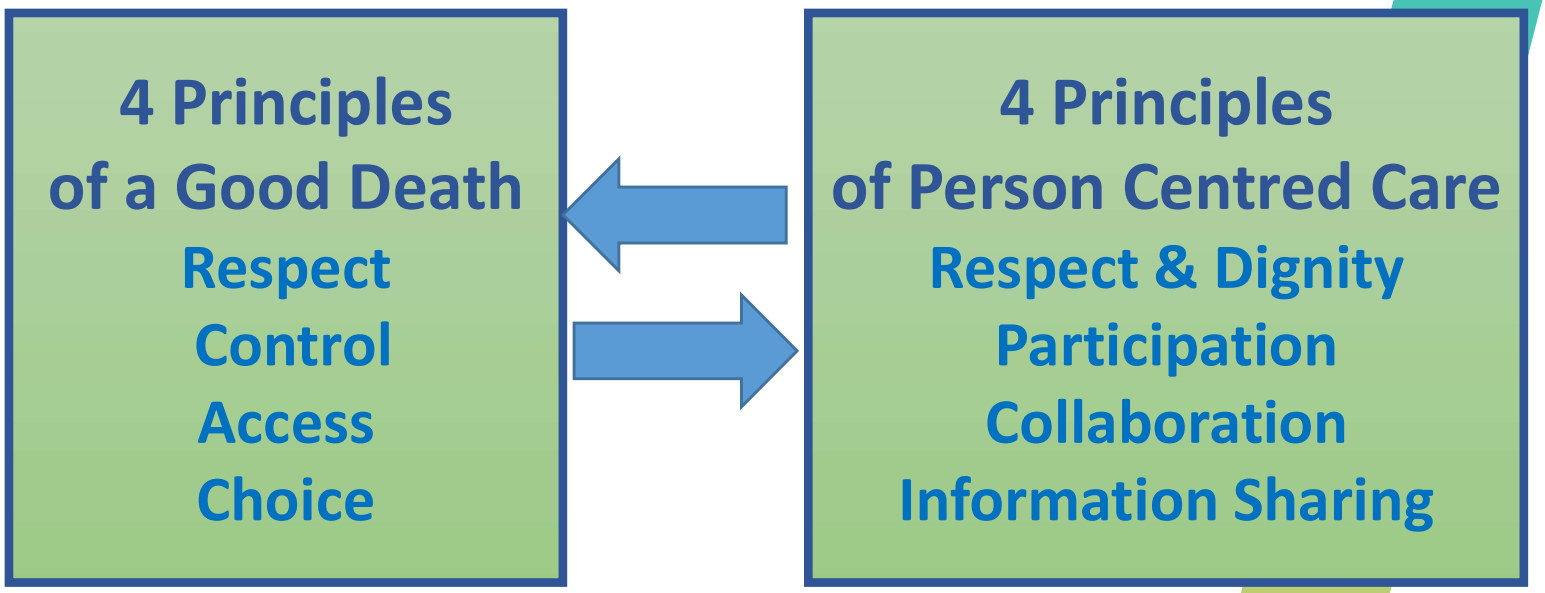
“To have a good death”

What does this mean to you?

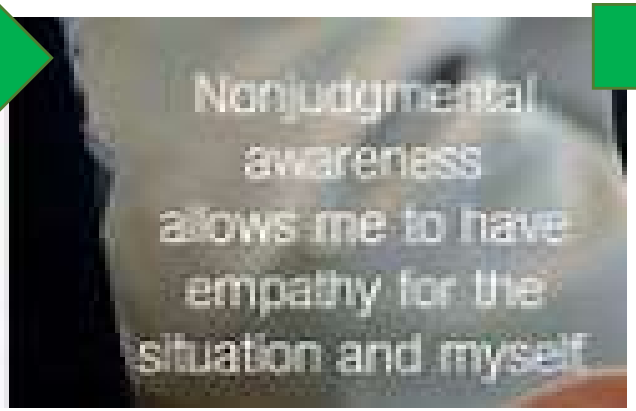


How do you feel about MAID/AD?

AND

How does MAID/AD make you feel?

My 7 Year Visual Representation of 'Coming to terms' with Assisted Dying



2 **Terminally-Ill Patients And End** Of Life Issues - **Jewish Visiting**

Jewish law prohibits any active intervention that would hasten the death of a terminal patient. The patient should be kept as comfortable as possible.

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO

Government of Canada

Ontario
Ministry of Health
Ministry of Long-Term Care

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MAiD is NOT Palliative Care
MAiD is A Choice in End of Life Care

How is MAiD different from (1) Palliative Sedation, (2) Withdrawing Treatment, or (3) Refusing Treatment?

1, 2 and 3 are treatment choices as part of the palliative philosophy.

The INTENT of palliative care is comfort care.

Death may incidentally occur due to the patient's underlying condition.

AD allows MDs/NPs to administer a substance to a patient, at their request, that causes their death before the incurable disease takes their life.

The INTENT of the treatment is the Patient's death.

Assisted Dying is NOT Suicide

Assisted Dying

Person has a terminal or life limiting disease

Person must have decision-making capacity; the decision must be enduring

Death is peaceful & expected, usually with the person surrounded by loved ones

Good bereavement outcomes

Community acceptance as a legal treatment option

Suicide

Person is not otherwise dying

No medical pathway or scrutiny

Often impulsive, involving mental illness

Death is often violent, traumatic and usually undertaken alone

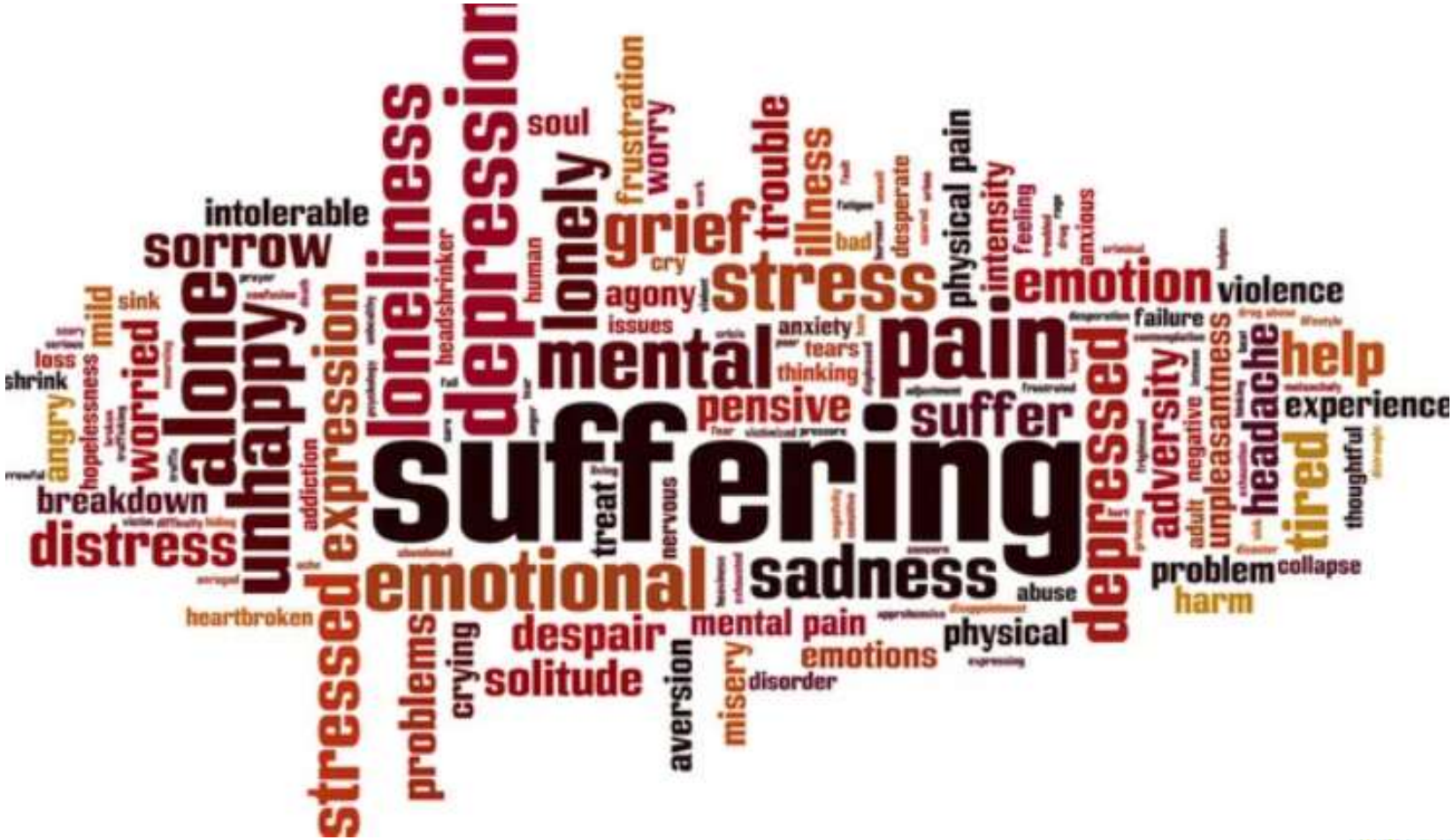
Terrible bereavement outcomes

Community overwhelmingly wants to prevent suicide; criminal offence to assist

> BMJ. 2003 Jul 26;327(7408):189. doi: 10.1136/bmj.327.7408.189.

Effects of euthanasia on the bereaved family and friends: a cross sectional study

Nikkie B Swarte [1], Marije L van der Lee, Johanna G van der Bom, Jan van den Bout, A Peter M Heintz


suffering
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agony
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headshrinker
issues
bad
desperate
anxious

MAID/AD Eligibility Criteria

A person **≥18** years old, **capable** of making health care decisions, making a **voluntary** request, can **provide informed consent** after having been informed of the means available to relieve their suffering, including palliative care, and has a **grievous and irremediable medical condition** is defined as:

- having a serious and **incurable** illness, disease or disability; and,
- being in an **advanced state** of irreversible decline in capability; and,
- experiencing **enduring physical or psychological suffering**, due to the illness, disease, disability or state of decline, that is **intolerable to the person** and cannot be relieved in a manner that they consider acceptable; ~~and~~
- ~~where the person's **natural death has become reasonably foreseeable**, taking into account all of their medical circumstances, without requiring a specific prognosis as to the length of time the person has left to live.~~

Legislative Changes to MAID

Bill C-7 has amended C-14 of the Criminal Code

AD now has two "Tracks"

Track 1: Reasonably Foreseeable Natural Death (RFND)

Track 2: Not Reasonably Foreseeable Natural Death (Not-RFND)

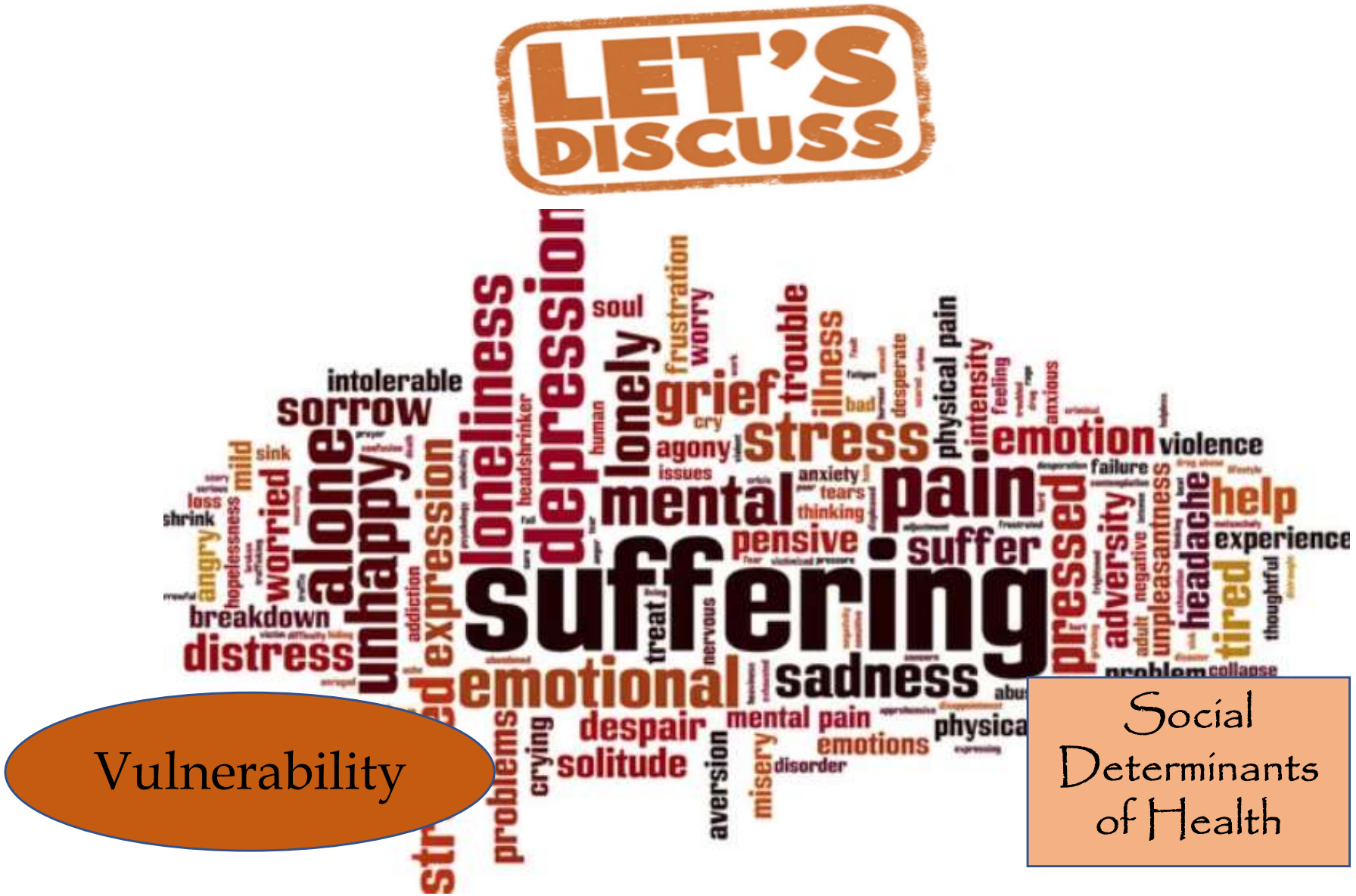
(advanced requests - complex clinical conditions, dementia and mental illness)

- 10-day reflection period has been removed
- Final consent can be **waived** in advance - Track 1 only
- Only one person is required to witness a written request
- **Strengthened Safeguards protect vulnerable persons – Track 2**
- Additional federal reporting ('new' role – preliminary assessor)

FOUR New, Strengthened Safeguards for MAID

For Track 2 (Not RFND)

1. Enforced 90-day waiting period between the 1st assessment and the provision of MAID.
2. One eligibility assessors must have **expertise** in the condition causing the person's suffering, written opinion must be provided.
3. Patient **must be informed** of the means available to relieve their suffering and be **offered** consultations with relevant professionals including counselling, disability support services, community services and palliative care.
4. MD/NP **must discuss ways to relieve the person's suffering** with the person and agree that the person has **given serious consideration** to those means.



Should suffering from mental illness be treated differently to suffering from physical illness?

CURRENT MAID DATA: CANADA

Number of MAID provisions in Canada in 2022	10,064, 3.3% of all deaths
Year over Year increase in MAID cases	**32%**
Total MAID cases since 2016	**31,664**
Demographics	Men 52% | Average age 76 Women 48% | Average age 77
Track breakdown	Track 1 97.8% Track 2 2.2%
Diagnosis (Track 1)	**66% Cancer** 19% Cardiovascular 12% Respiratory 12% Neurologic
Diagnosis (Track 2)	46% Neurologic
Track 2 patients receiving palliative care	81% received 88% offered

Health Canada's Third Annual Report on MAID in Canada (2022)

CURRENT MAID DATA: CANADA

Most commonly cited suffering	86% loss meaningful activities 83% loss of ability to perform ADLs
Increase in AD practitioners	17% increase (1,577)
AD Practitioner	94% Physicians 6% NPs
Procedure Settings	44% private home including RH, LTC 28% hospital 20% PC facilities 6% residential care facilities
Cases that proceeded to MAID	81%
Reasons for withdrawal of consent	**62% changed mind** **39% Palliative Care is sufficient**

Health Canada's Third Annual Report on MAID in Canada (2022)

Year over Year MAID at SHN

	2016	2017	2018	2019	2020	2021	2022	30 April 2023	TOTAL
Requests	1	5	15	40	29	45	60	**33**	228
Procedures	1	1	3	6	7	8	10	**7**	43
% conversion	100%	20%	20%	15%	24% COVID	18%	17%	**21%**	18.8%

- Most requests were verbal only - 47% of verbal requests decided on a palliative approach to care
- 1:1 Male:Female completed procedure
- All procedures performed by a physician
- **10 people died before procedure date**
- 1 person changed their mind on day-of procedure

Principles of 'A Good Death'
Respect, Control, Choice, Access

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Ontario and SHN MAID Review Aug 2016 - April 2023

	SHN	ONTARIO
Malignant disease	**30%**	**63%**
Non-Malignant disease	**48%**	18% Cardiorespiratory 9% Neurodegenrative 10% Other
Both	**22%**	

- Ontario malignancy rates - stable over 3 years
- **Non-malignant disease requests are increasing at SHN year over year**

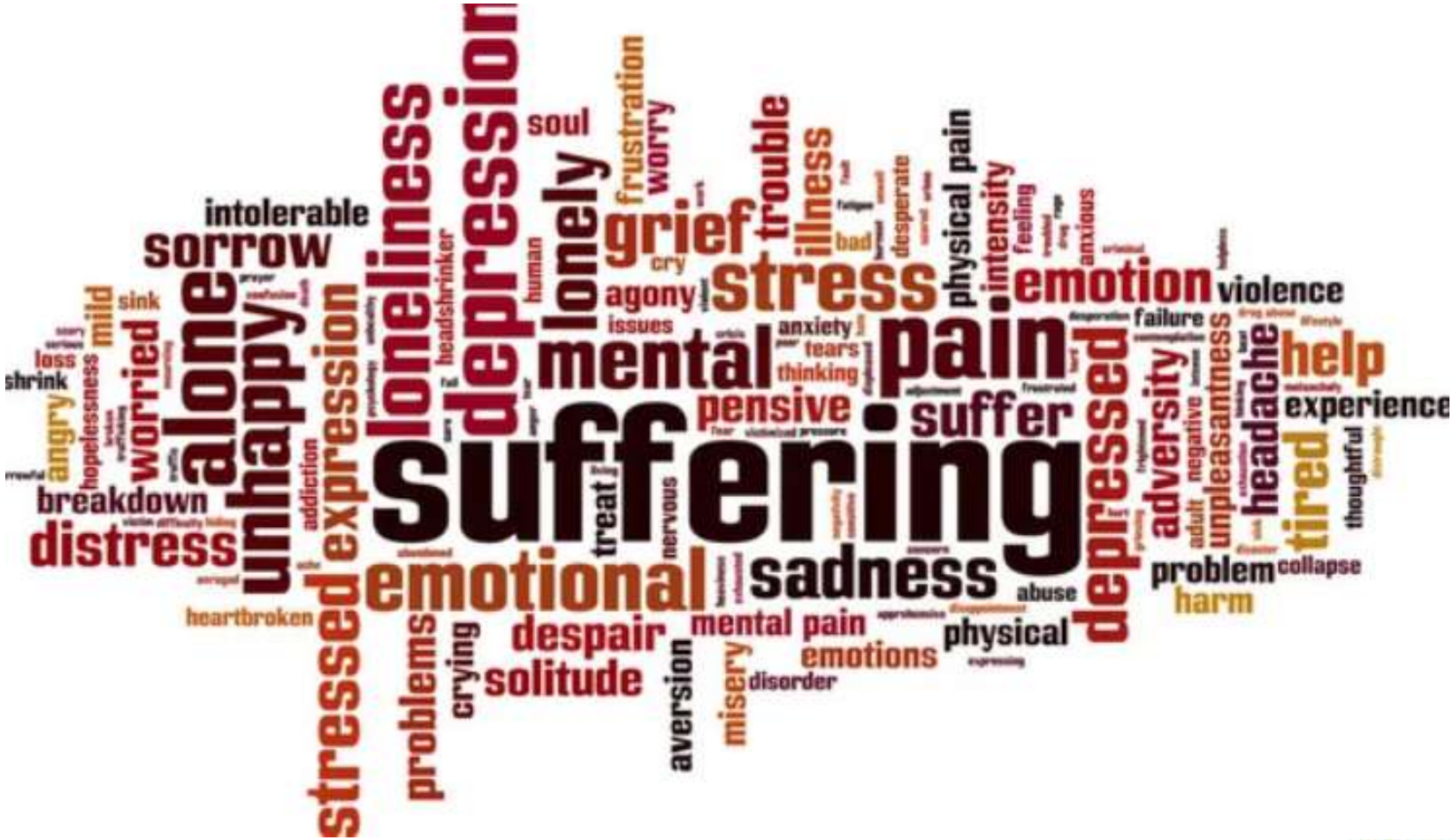
Ontario and SHN MAID Review
Aug 2016 - April 2023

SHN	Ontario
Average age **72** (35 – 98 years) [requested]	Average age 76 (18 – 114 years) [completed]
50:50 Male:Female (Identify as)	50:50 Male:Female
	3 self-administered AD since legalization
0 cases of organ donation 2 attempted cases	96 cases of organ donation since 2016
2 Track 2 procedures discharged into community 2 Attempts at Waivers – both died before waiver and MAID	Track 2 procedures (2022): 159 patients Waiver of final consent (2022): 178 patients

- NP growth opportunity as practitioners (0 at SHN currently)

At SHN we 'MAID In Place'
August 2016 - April 2023

Facility	Unit/Department	Procedures
Birchmount	Mental Health Unit	1
Birchmount	Surgery	5
Birchmount	Cardiology	3
Birchmount	Medicine	2
Birchmount	**Total**	**11**
Centenary	Surgery	8
Centenary	Medicine	3
Centenary	Margaret Birch Wing	2
Centenary	**Total**	**13**
General	Tower 6 - PCU	12
General	Medicine - 4C and CP4	7
General	**Total**	**19**
Total		43


suffering
depression
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trouble
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emotion
violence
physical pain
intensity
feeling
anxious
desperate
bad
cry
agony
issues
anxiety
tears
thinking
failure
help
experience
headache
tired
adversity
unpleasantness
negative
adult
pensive
suffer
depressed
emotional
sadness
distress
breakdown
worried
sink
mild
loss
shrink
angry
hopelessness
addiction
expression
stressed
problems
crying
solitude
despair
mental pain
emotions
physical
abuse
problem
collapse
harm
heartbroken
aversion
misery
disorder
nervous
treat
human
headshrinker
thoughtful

Let's Get Practical

A patient asks about MAID; What do I do?

All members of Regulated Health Care Colleges have a legal obligation with assisted dying as this treatment option is a human right.

Ontario
Ontario Human Rights Commission
Commission ontarienne des droits de la personne

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Initial
Assisted Dying Conversations

Engage in a supportive conversation.

(**explore**, validate, clarify)

A **"desire to die conversation"** is a starting point to discuss:

1. What is the actual 'nature' of the request?
2. What are the person's goals of care?
3. Talk about their life-limiting disease and treatment
   - Treatment options and symptom management
   - A palliative approach to care (Quality of Life/Comfort Care including palliative sedation – at home, in the community)
4. **FINALLY - Is the person making an assisted dying request?**

1. Can a nurse have this conversation with a person?
2. R u courageous enough to have this conversation?
3. Who must you refer to?
4. Who else can you refer them to?

More in depth Guide to a MAID Exploratory Conversation

I understand you've been diagnosed with … can you tell me about that?

Listen for

1. Duration of illness
2. Attempts at disease management
3. RFND or Not RFND

How long have you been thinking about receiving an AD?

Explore how the illness and/or disability has caused suffering.

Prompts

- What is the hardest thing about having this illness?
- What are the things you can't do anymore?
- Are you still able to … (get out of bed, walk, use the bathroom, enjoy food, have fun, etc)
- Tell me about your symptoms …
- What makes life worth living for you?

Listen for

1. Reduced autonomy/independence
2. Inability to perform ADLs, IADLs
3. Discomfort (physical, psychological, etc)
4. **Functional decline**

Preliminary Assessor Role

What improves your symptoms or helps you cope with these 'problems' better?

Is there anything else you want to share?

Is the Person Making a Voluntary Request

Bill C-7 *"A person's decision must be made freely, without coercion or undue influence from family members, health care providers or others".*

Conversations such as the initial discussion/request **AND** final consent discussion should take without family, care givers, friends.

Is the AD request a **"well-reasoned request"?**

Previous suicide attempts

Psychiatric disorders

Urgency

Coercion Undue influence

Assessing Capacity

Capacity is specific to time and treatment;

ie: specifically with respect to consenting to assisted dying

personal beliefs, values, culture influence decision-making

Is the person able to **understand** the information relevant to deciding to consent to assisted dying?

Is the person able to **appreciate** the reasonably foreseeable consequences of consenting to assisted dying?

Some Questions to help start a capacity assessment conversation

1. Can you tell me what you understand of your condition?
2. Tell me about your suffering?
3. How has life changed for you with this life-limiting disease?
4. If an AD was not an option, what else could we do to help you?

There are many tools available to assist with capacity assessment.

Mental Illness as Sole Underlying Condition was to become legalized on 17th March 2023, ON HOLD until March 2024 to enable comprehensive standards of best practice to be developed.

It is important to remember 3 points about Capacity for MI as SUC

1. Once the ability to apply for an AD due to mental illness as a sole underlying condition (MISUC) becomes a legal right; we must remember that the threshold for decision making with a mental illness is the same as that of people who don't have a mental illness.
2. Having a mental disorder does not imply incapacity.
3. Capacity for an assisted death is capacity to make a treatment decision.

MAID in Canada, From C-14 to C-7. Jocelyn Downie, CM, FRSC, FCAHS, SJD. James S Palmer Chair in Public Policy and Law; Schulich School of Law; University Research Professor: Dalhousie University. (May 2021).

How will Track 2 Requests Affect us?

Practical challenges to care workflows

1. Patients with advance requests for MAID will visit the hospitals/clinics/MD offices to see specialists/'clinicians with expertise' within the 90 day safeguard period for consultation re alleviating their suffering (Track 2, Not-RFND).

2. Patients can request MAID where "Mental Illness is the Sole Underlying Condition" (MISUC).

MISUC on hold as of January 2023 until March 2024


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FOR YOUR CONSIDERATION

Mental Illness

as the Sole Underlying Condition

in a request for an assisted death

Frailty

Which Track of AD does a person with frailty 'fit in to'?

Track 1: Natural Death is Reasonably Foreseeable

Track 2: Natural Death is Not Reasonably Foreseeable

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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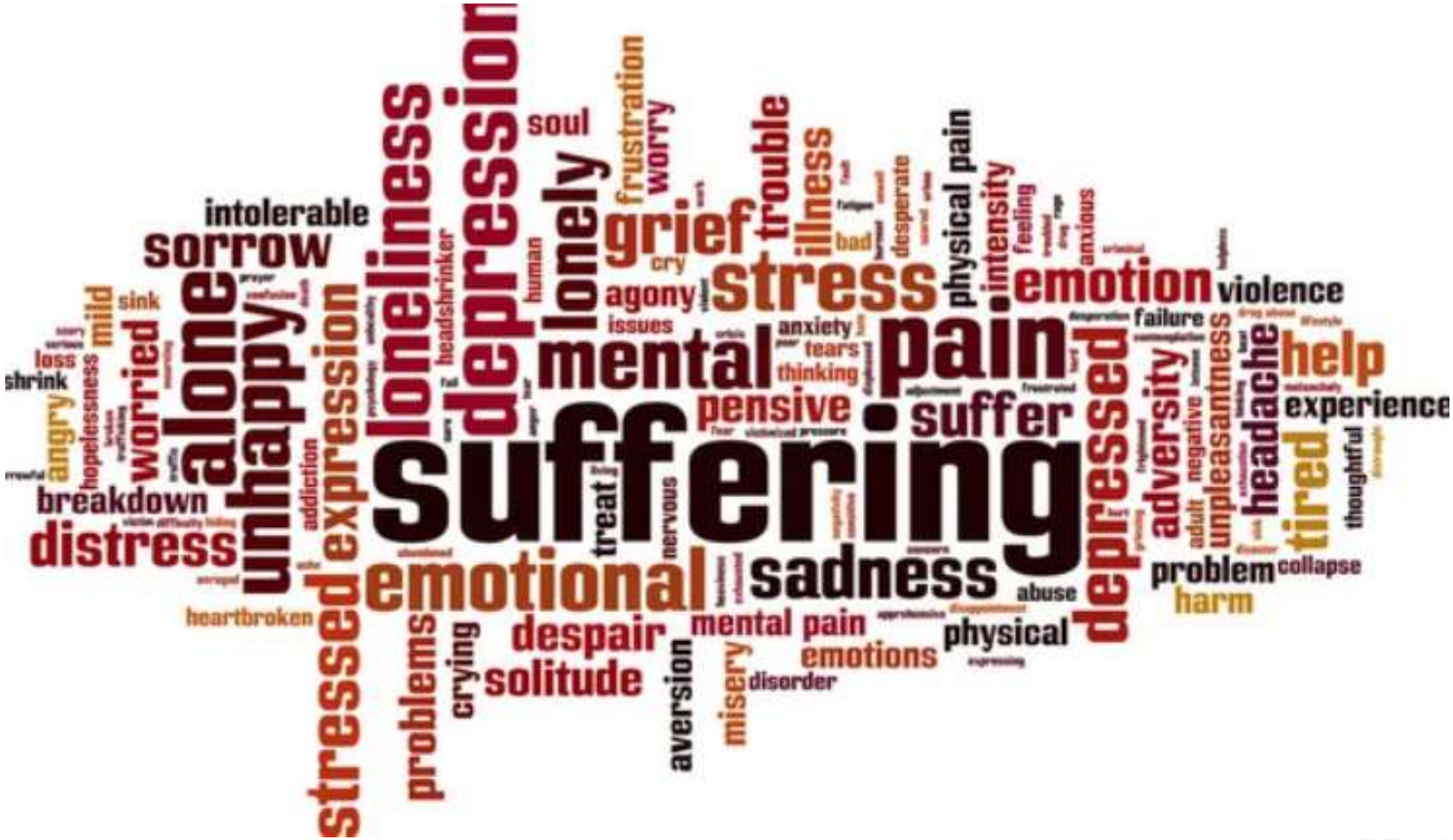
Inspiring Minds

SHN


suffering
depression
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unhappy
sorrow
intolerable
grief
lonely
soul
frustration
worry
trouble
illness
stress
pain
mental
emotion
violence
physical pain
intensity
feeling
anxious
desperate
bad
cry
agony
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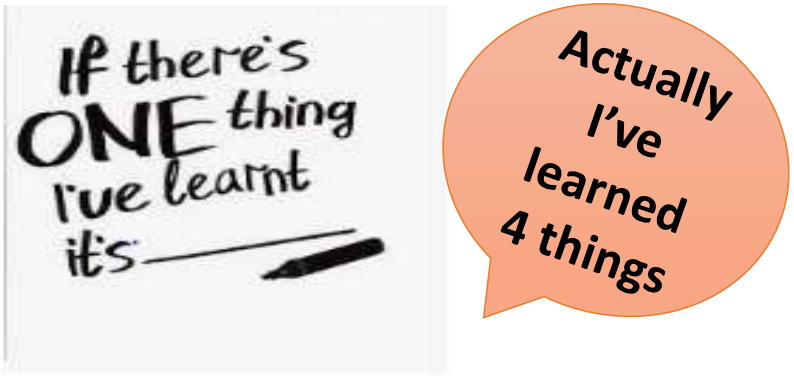
failure
help
experience
headache
tired
adversity
unpleasantness
negative
adult
pensive
suffer
emotional
sadness
distress
breakdown
expression
stressed
problems
crying
despair
solitude
mental pain
emotions
physical
depressed
problem
collapse
harm
abuse
heartbroken
aversion
misery
disorder
treat
nervous
addiction
worried
sink
mild
hopelessness
loss
shrink
angry
thoughtful
human
headshrinker



Asking for a conversation about the 'desire to die' or MAID
is the beginning of a crucial conversation,
it may have nothing to do with MAID as a treatment.

MAID is here to stay, find a way to deal with it!

A person's functional status (self-care ability & mobility)
is one of the most important prognostic tools we have,
across the disease spectrum (cancer, organ failure and frailty).

Validated by Lunney & Lyn in JAMA 2003

MAID is a legal treatment choice; what ever your opinion,
always put in a referral to the correct practitioner/team. (criminal law)


Pause
resources
Insert
Home

CAMAP | ACEPA

Canadian Association of MAiD Assessors and Providers | Association canadienne des évaluateurs et prestataires de l'AMM

FOR THE PUBLIC

CAMAP Publications and Guidelines

Reasonably Foreseeable Natural Death

- The Interpretation and Role of "Reasonably Foreseeable" in MAiD Practice (February, 2022)
- The Clinical Interpretation of "Reasonably Foreseeable" (June, 2017)

Capacity Assessment

- Assessment for Capacity to give Informed Consent for Medical Assistance in Dying (MAiD)

MAiD and Dementia

- MAID and Dementia

MAiD and Palliative Care

- Key Messages: End of life and MAiD

Bringing Up MAiD as a Care Option

- Bringing up MAiD

MAiD Oversight

- Position Statement on the Oversight of MAiD

MAiD and COVID-19

- Statement on government regulations and policies during COVID-19
- Guidance for MAiD assessors and providers during COVID-19
- Guidance for Virtual Witnessing for a Request for Medical Assistance in Dying (MAiD)

MAiD Administration

- Intravenous MAiD Medication Protocols in Canada
- Oral MAiD Part 1: Medication Protocols
- Oral MAiD Part 2: Processes for Providing
- Failed MAID in the Community

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MOHLTC MAID Website

https://www.health.gov.on.ca › pro › programs › maid

Medical Assistance in Dying - Health Care Professionals - MOH

Medical Assistance in Dying

- Introduction
- Medical Assistance in Dying
- Patient Eligibility
- Patient Requests and Assessments
- Assessment Period When Death is Not Reasonably Foreseeable
- Accessing Medical Assistance in Dying: How to Contact the Care Coordination Service
- Substitute Decision-Makers
- Administering Medical Assistance in Dying
- Waiver of Final Consent
- Family Members, Caregivers, Friends
- Dispensing Drugs
- Accommodating Patients
- Where Medical Assistance in Dying Can Take Place
- Conscientious Objection and Obligations to Patients
- Monitoring Medical Assistance in Dying
- Reporting Deaths from Medical Assistance in Dying
- Federal Regulations and Ontario's Hybrid Approach to the Reporting Requirements
- Funding for Medical Assistance in Dying Services

You can create your own documents if you want

- Voluntary clinician aids:
  - Clinician Aid A – Patient Request for Medical Assistance in Dying
  - Clinician Aid B – (Primary) "Medical Practitioner" or "Nurse Practitioner" Medical Assistance in Dying Aid
  - Clinician Aid C – (Secondary) "Medical Practitioner" or "Nurse Practitioner" Medical Assistance in Dying Aid
- Process Overview and Checklist: Reporting a MAID death to the Office of the Chief Coroner of Ontario [PDF]
- Medical Assistance in Dying - Information for Patients [PDF]
- Guidance for Reporting on Medical Assistance in Dying – Health Canada Webpage
- Regulations for the Monitoring of Medical Assistance in Dying – Canada Gazette II, Online Publication

IT'S YOUR LIFE. IT'S YOUR CHOICE.

DYING WITH DIGNITY CANADA

Navigate a request for MAID

Everything you need to know about requesting medical assistance in dying (MAID) in your province or territory.

Find an Independent Witness

Dying With Dignity Canada's Independent Witness Program can help connect you with trained volunteers to sign your request for medical assistance in dying (MAID).

Home | About | Get Informed | Find Support | Give Support | Blog | Podcast | More

BRIDGE C-14

A Network of Peer-to-Peer Connections and Community Supports Through All Stages of Medical Assistance in Dying (MAiD)

By providing meaningful connections and access to resources, Bridge C-14 is a non-profit organization that works to help improve the lives of individuals and their loved ones throughout all stages of the assisted death process across Canada.

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Assessment Tools

Capacity

NICE Capacity and Consent Tool http://www.nicenet.ca/files/NICE_Capacity_and_Consent_tool.pdf
(2 sections-consent to treatment and decisional mental capacity and capacity assessment) ✔ ✔ ✔

The Mini Mental State Examination (MMSE) **Informs** does not determine capacity

https://www.mountsinai.on.ca/care/psych/on-call-resources/on-call-resources/mmse.pdf
(assess mental status, 11 Q; tests 5 areas of cognitive function: orientation, registration, attention and calculation, recall, and language)

Aid to Capacity Evaluation (ACE)
http://www.jcb.utoronto.ca/tools/documents/ace.pdf
(to help clinicians systematically evaluate capacity when a patient is facing a medical decision)

Vulnerability

Assessing Vulnerability in a system for physician-assisted death in Canada. Issued by The Canadian Association for Community Living, Revised 04/16/20 ✔ ✔ ✔

http://www.sacl.org/fileadmin/user_upload/CACLVulnerabilityAssessmentApr82016-Final.compressed.pdf

Other Prognostic Tools

Clinical Frailty Scale – Scoring frailty in people with dementia ✔ ✔ ✔

Neurodegenerative Diseases – Very difficult to prognosticate – Function and Frailty often used

Disease Specific Tools – COPD/BODE, Seatle Heart Failure Model, Liver Disease/MELD

Palliative Prognostic Index (PPI) – Specifically for prognosis, has pps and other indicators i.e. oral intake, delirium, edema, dyspnea ✔ ✔ ✔

Palliative Performance Scale (PPSv2) – Current functional level (only validated for certain cancers BUT useful in all life-limiting diseases to inform not predict)

Supportive and Palliative Care Indicators Tool (SPICT) – Identify people at risk of deteriorating health and dying

Ask the "surprise question" Would you be surprised if this person died within a year ✔ ✔ ✔

1 Accessing Assisted Dying Ontario Services Available

Care Co-ordination Service (CCS) Established May 2017

GOAL: To assist patients and clinicians access information and supports for MAiD and other end-of-life options. Toll-free: **1-844-243-5880**

CCS is able to connect patients to a doctor or NP who can provide MAiD eligibility assessments and related services.

Ontario has provided voluntary, standardized clinician aids that reflect the requirements set out in the federal legislation.

Physicians/NPs are encouraged to complete the clinician aids in addition to their usual medical record-keeping requirements, as outlined by their regulatory colleges.

Voluntary Clinician Aids:

- ❑ Clinician Aid A Patient Request for Medical Assistance in Dying
- ❑ Clinician Aid B (Primary) "Medical Practitioner" or "Nurse Practitioner" Medical Assistance in Dying Aid
- ❑ Clinician Aid C (Secondary) "Medical Practitioner" or "Nurse Practitioner" Medical Assistance in Dying Aid

- Assisted Dying Resource from the Centre for Effective Practice
- Process Overview and Checklist: Reporting a MAID death to the Office of the Chief Coroner of Ontario [PDF]
- Medical Assistance in Dying - Information for Patients [PDF]
- Guidance for Reporting on Medical Assistance in Dying – Health Canada Webpage
- Regulations for the Monitoring of Medical Assistance in Dying – Canada Gazette II, Online Publication, Medical Assistance in Dying

2 Accessing Assisted Dying Ontario Services

Telehealth

A free, confidential, telephone-accessed service with RNs

GOALS: 1. Assess the caller's health concerns

2. Give advice

No diagnosis made, no medications prescribed

RN directs the caller to the most appropriate level of care

RN may put the caller in contact with a health care professional who can advise the caller concerning treatment.

References

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Thank you for your time
and participation

IV Medication Protocol in Hospital

1. **Midazolam** (sedation)10-15 mg IV over 3 – 5 minutes

Explain: May snore, this is not uncomfortable for patient

2. **Lidocaine** 1-2% without epinephrine 40-60 mg IV (2 mls) over 10-30 seconds (if allergic to Lidocaine, Magnesium Sulphate 1000mg IV + 5mL 0.9% NaCl over 5 minutes)
3. **Propofol 500-1000** mg IV (100 ml) over 5 minutes (wait 30-45 seconds

   to ensure coma is induced before proceeding with neuromuscular blocker, check eye opening)

Explain: Decreased or cessation of breathing with NO suffering

Explain: cyanosis
Explain: only if occurs - Muscle fasciculations = normal but rare

4. **Rocuronium** (muscle paralysis) 100-200mg IV – rapidly over 10-15 seconds
5. **Bupivacaine** (heart block) 600mg IV over 30-60 seco

Explain: Rarely you can see a heart can beat after procedure is complete

NaCl 0.9% 5-10 mL for flush as needed,
OR IV fluid at a constant rate.

Oral Medication Protocols
(Community)

Oral Medication is NOT used in Hospitals

(only 3 cases in Canada since 2016)

1. The practice of oral administration for assisted dying across Canada is not standardized
2. Clinician has to carry "IV backup" kit
3. Premedication with an anti-emetic (metoclopramide, ondasetron)
4. Anxiolytic (Lorazepam is often given before the coma-inducing compounds)
5. Coma inducing 'cocktail' (phenobarbital, chloral hydrate, morphine or Diazepam, Digoxin, Propanolol & Morphine)

Has a 3-5% failure rate !!!!

Physician Effective Referral

Rights of Conscientious Objection

- RCPSC Professional Obligations and Human Rights Policy - "*Physicians do not have to provide services that conflict with their conscience or religious beliefs*"
- No health care provider is required to assess for nor provide AD

Limits of Conscientious Objection

Minimum Referral
Ontario Care Co-ordination Service (CCS) **OR** Telehealth

- Must not impede access to an assisted death
- Inform the patient the objection is d/t **personal**, NOT clinical reasons
- Provide information about all options for care that may meet the patient's needs and/or wishes
- Must not abandon care – continue with non-MAiD related usual care
- Make an **"effective referral"** to someone who will provide MAiD or transfer care entirely

FACT SHEET: Ensuring Access to Care – Effective Referral

When physicians limit the health services they provide for reasons of conscience or religion, the CPSO requires that they provide patients with an 'effective referral'. [1]

What is an effective referral?

A physician makes an effective referral when he or she takes positive action to ensure the patient is connected in a timely manner to another physician, health-care provider, or agency who is non-objecting, accessible and available to the patient.

Objective: Ensuring Access to Care, Respecting Patient Autonomy

An effective referral does not guarantee a patient will receive a treatment, or signal that the objecting physician endorses or supports the treatment. It ensures access to care and demonstrates respect for patient autonomy.

All effective referrals involve the following steps:

1 The physician takes positive action to connect a patient with another physician, health-care provider or agency.

The physician can make the referral him/herself OR assign the task to another. The physician must ensure the designate complies with the CPSO expectations for an effective referral.

2 Referrals must be made to non-objecting physicians, health-care providers or agencies that are accessible and available to the patient.

The physician, health-care provider or agency must be accepting patients/open, must not share the same religious or conscience objections as the referring physician and must be in a location that is reasonably accessible to the patient or via telemedicine where appropriate.

3 Referrals must be made in a timely manner, so that the patient will not experience an adverse clinical outcome due to a delayed referral.

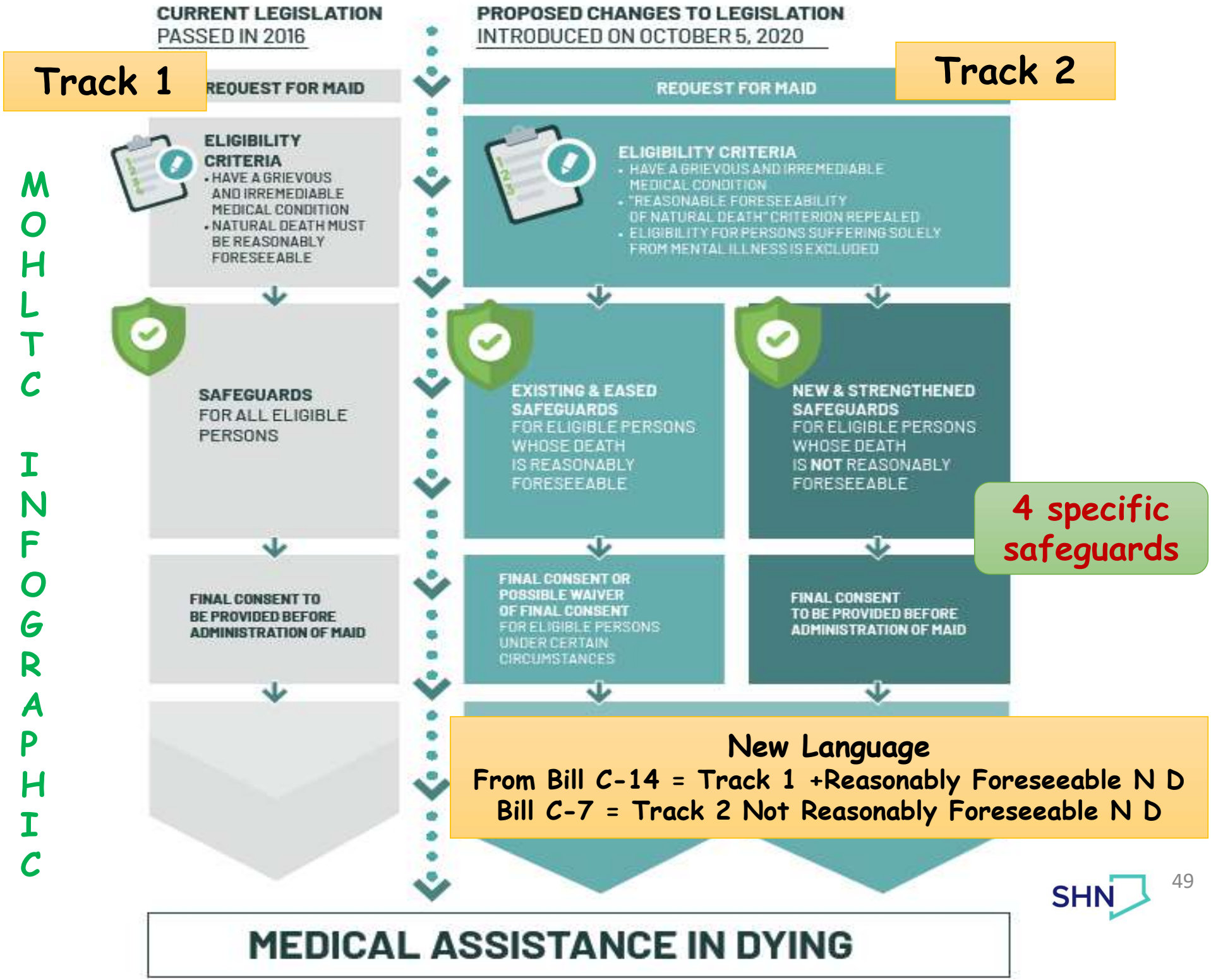
A patient would be considered to suffer an adverse outcome due to a delay if their untreated pain or suffering is prolonged, their clinical condition deteriorates, or the delay results in the patient no longer being able to access care (e.g., for time sensitive matters such as emergency contraception, an abortion or when a patient wishes to explore medical assistance in dying.)

The care co-ordination service information line is available 24 hours a day, 7 days a week and may be reached toll free at 1-866-286-4023. Referral services are available Monday to Friday 9 am – 5 pm EST in English and French (translations for other languages can also be requested). TTY services are also available at 1-844-953-3350.

SHN

MAiD Legislation - History Lesson

Year	Legislation (with additional details)
2015	***Carter v Canada*** - Supreme Court of Canada decision. The prohibition of assisted suicide was challenged as contrary to the *Canadian Charter of Rights and Freedoms* The Court struck down this provision in the *Criminal Code*, giving Canadian adults who are mentally competent and suffering intolerably and enduringly with a life-limiting disease the right to an assisted death
2016	Parliament passed *Bill C-14* now part of the Criminal Code which exempts MDs/NPs from certain criminal offences if they provide/assist in providing assisted dying according to the eligibility requirements and safeguards in the law Federal Government developed a care framework to follow Professional Colleges eg: CPSO, CNO, OCP created guidance documents
2017	Ontario's MAID Statute Law Amendment Act enacted (1) To provide legal protection for HCPs (2) For the coroner to oversee MAID **(only in Ontario)**
2018	Reporting becomes a Federal requirement under the Criminal Code Pan-Canadian monitoring regime became mandatory (2 year prison sentence ☹ ☹ ☹)
2019	Truchon v Canada, Quebec Superior Court decided that the Code requirement that a person could be eligible for MAID **only** if natural death was "reasonably foreseeable" **was contrary** to the *Canadian Charter of Rights and Freedoms*
2020	*Bill C-7* enacted Fulfillment of Bill C-14 was the requirement for independent reviews for the three previously restricted MAID circumstances


MOHLTC INFOGRAPHIC
CURRENT LEGISLATION
PASSED IN 2016
PROPOSED CHANGES TO LEGISLATION
INTRODUCED ON OCTOBER 5, 2020
Track 1
Track 2
REQUEST FOR MAID
REQUEST FOR MAID
ELIGIBILITY CRITERIA
• HAVE A GRIEVOUS AND IRREMEDIABLE MEDICAL CONDITION
• NATURAL DEATH MUST BE REASONABLY FORESEEABLE
ELIGIBILITY CRITERIA
• HAVE A GRIEVOUS AND IRREMEDIABLE MEDICAL CONDITION
• "REASONABLE FORESEEABILITY OF NATURAL DEATH" CRITERION REPEALED
• ELIGIBILITY FOR PERSONS SUFFERING SOLELY FROM MENTAL ILLNESS IS EXCLUDED
SAFEGUARDS FOR ALL ELIGIBLE PERSONS
EXISTING & EASED SAFEGUARDS FOR ELIGIBLE PERSONS WHOSE DEATH IS REASONABLY FORESEEABLE
NEW & STRENGTHENED SAFEGUARDS FOR ELIGIBLE PERSONS WHOSE DEATH IS NOT REASONABLY FORESEEABLE
4 specific safeguards
FINAL CONSENT TO BE PROVIDED BEFORE ADMINISTRATION OF MAID
FINAL CONSENT OR POSSIBLE WAIVER OF FINAL CONSENT FOR ELIGIBLE PERSONS UNDER CERTAIN CIRCUMSTANCES
FINAL CONSENT TO BE PROVIDED BEFORE ADMINISTRATION OF MAID
New Language
From Bill C-14 = Track 1 +Reasonably Foreseeable N D
Bill C-7 = Track 2 Not Reasonably Foreseeable N D
MEDICAL ASSISTANCE IN DYING

2018

The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition

The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition

CCA | CAC

ASSESSING **EVIDENCE**. INFORMING **DECISIONS**.

SUMC
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MEDICAL ASSISTANCE IN DYING AND MENTAL DISORDER AS THE SOLE UNDERLYING CONDITION: AN INTERIM REPORT

Report of the Special Joint Committee on Medical Assistance in Dying

Hon. Marc Garneau and Hon. Yonah Martin
Joint Chairs

JUNE 2022

44th PARLIAMENT, 1st SESSION

SHN