Medical Aid in Dying

October 21, 2018

OLTCC conference

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Focus Practice in Care of the Elderly

Observations and Reflections

- Not experts on MAID, we all continue to learn

- Provide information and front line pearls to any provider who may consider being involved in this care

- Culture of “Mutual respect”

Objectives:

- Review statistics from Coroner's Office
- Initial patient request
- Patient consent
- Assessments
- Preparation of care delivery
- Care Delivery of patient, after care for family, providers and support staff
- LTC considerations
- Billing codes
- Questions

Faculty/Presenter Disclosure

- **Faculty:** Kerstin Mossman

- **Relationships with financial sponsors:**
  - **Grants/Research Support:** None
  - **Speakers Bureau/Honoraria:** None
  - **Consulting Fees:** None
  - **Patents**: None
  - **Other:** None

Disclosure of Financial Support

- **This program has received no financial support.**
- **This program has received no in-kind support.**
- **Potential for conflict(s) of interest:**
  - None.

Mitigating Potential Bias

Not applicable

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  - **Grants/Research Support:** None
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Mitigating Potential Bias

– Not applicable

Carter vs. Canada

- 2015 ruling by the Supreme Court of Canada

- Found that the prohibition of assistance in dying limited the right to life, liberty and security under section 7 of the Canadian Charter of Rights and Freedoms

- Kay Carter: spinal stenosis, 89 y/o. Died in Zurich, Switzerland on January 15, 2010. Her daughter Lee and her siblings perused the case feeling that her mother should not have had to seek care away from Canada.

- She was the 10th Canadian to die at the Dignitas clinic in Zurich, but the first to make her case publicly known.

Canadian Legislation

- Came into effect July 2016
- Specific criteria & processes required
- Over 1500 cases in Ontario
- Next Steps to be reviewed:
  - *Pediatric patients*
  - *Patients with Mental Health Diagnosis'*
  - *Advanced consent*

Other Laws

- Ontario's Bill 84, the Medical Assistance in Dying Statue Law Amendment Act, 2017, The Coroners Act to ensure effective oversight of MAID.
- In April 2017 the Nursing Act 1991 was amended to enable NPs to prescribe controlled drugs and substances, including those used in the provision of MAID.
- The court acknowledges that the laws deprive some people of life, forcing them to end their lives prematurely, due to the fear that they will be unable to participate in MAID at the point that their suffering was intolerable.

Medical Aid in Dying

- Bill C-14, came into effect on June 17, 2016
- 1587 cases in Ontario as of May 31, 2018
- Average age 73, youngest 22, oldest 104
- Female 390, male 391 (Sept 2017 statistic)
- Care delivered mostly in hospital (52%) and home (40%)
- Underlying condition: cancer related, ALS, other neurological illness, heart and lung illnesses
- Care provided by 330 clinicians, 317 physicians, 13 NPs
- 106 hospital providers which covers 45 % of Ontario hospitals

Criteria for patients to qualify

1. Must be covered by OHIP or government funded care

2. At least 18 yrs old

3. Capable of making healthcare decisions

4. Make a voluntary request, in writing

5. Have grievous & irremediable medical condition
    - *Serious & incurable illness, disease or disability*
    - *Advanced state of irreversible decline in capability*
    - *Their condition causes them enduring physical or psychological suffering that is **intolerable** to them AND can not be relieved under conditions that they find **tolerable***

6. Natural death has become **reasonably foreseeable** without a prognosis necessarily having been made as to the specific length of time that they have remaining

7. Be capable at the time of the procedure

Provincial MAID Coordination Service

How to Contact CCS for MAID:

- **Toll free at 1-866-286-4023. The care coordination service information line is available 24 hours a day, 7 days a week. 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.

- **109 clinicians registered with CCS**

- **As of May 2018, 1952 calls, 797 referrals**

Process Map for MAID

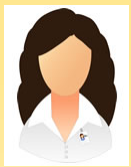
Patient inquiry, request and referral

First Assessor

Written Consent

Second Assessor

Reflection Period (10 clear days)

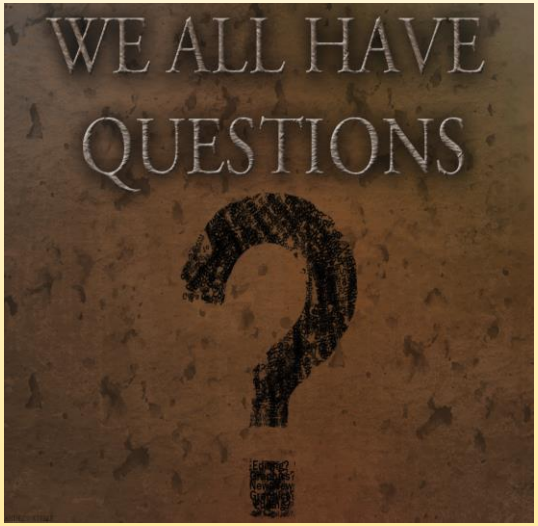


Orchestrating MAID – patient's wishes for day of care delivery

Procedure and care delivery

Step 1: Patient Initial Inquiry – Observations and Reflections

- Exploring request
- Providing education
- Effective referral
- Palliative care
- Goals of care conversation
- Can take many conversations
- Outline steps of process and repetition of aspects of process (often most frustrating part for patient)
- Clarification of ongoing care of patient



Step 2: First Assessment – Observations and Reflections

- Clinician Aid Form B
- MRP and the First Clinician OR Second Clinician may have overlapping roles and responsibilities or may be the same individual
- Chart review
- Interview with patient, capacity
- Documentation, template for note
- Further input from capacity assessors (aphasia), palliative care, psychiatry
- Recommendations if patient not eligible
- Contacting CMPA
- Reasonably foreseeable death clarification:

"..their natural death has become reasonably foreseeable, taking into account all of their medical circumstances". See page 7 of judgement below.

http://www.camapcanada.ca/ABDecision.pdf

Step 3: Written consent by patient – Observations and Reflections

- Clinician Aid Form A
- Witness criteria
- Dying with Dignity support
- Substitute signatory:

If the patient is capable in any way of putting a mark on Form A (using non-dominant hand, mouth holding pen) then they should be the one to do that. It does not have to look like their usual legal signature.

The authorized third person must believe that he/she would not receive "a financial or other material benefit resulting from that person's [the patient's] death".

Step 4: Second Assessment – Observations and Reflections

- Independent from 1st assessor
- Physician Advisory Service at the CPSO advices that members of an on call group can serve as the second independent assessor for MAID requests.
- Clinician Aid Form C
- Timing of assessment

Step 5: Reflection Period – Observations and Reflections

- Ongoing care of patient
- Review with MRP
- Planning for MAID care
- 10 clear days definition
- ! Exception: **If both clinicians share the opinion that the patient's death, or the loss of their capacity to provide informed consent is imminent — a shorter period is allowed, as deemed appropriate by the first clinician for the circumstances.**

Step 6: Orchestrating MAID – Observations and Reflections

- Patient's wishes: who is present, where (bed, recliner), time, attention to small details
- Location of care delivery: LTC, home, hospice
- Pharmacy support: common for 5 day advance order request
- LHIN HCC support re IV initiation (2 peripheral sites vs PICC line)
- Orders: order set with pharmacy if possible
- Choosing date and time (early or mid morning not ideal)

Step 7: MAID Care Delivery – Observations and Reflections

- Medications: Midazolam, Lidocaine, Propofol, Rocuronium. Consideration how to transport medications to room. 20-30min for medication administration.
- Preparing room (Kleenex, seats, set up of bed, patient position, automatic bed turn off)
- Explanations of physical changes to attendees
- Reconfirming consent: verbal is preferred method at this time
- Record keeping: procedure log
- Pronouncing of death
- Options if 1st and 2nd assessor not available for care delivery

MAID After Care – Observations and Reflections

- Review with family
- Review with coroner's office, contact now is a nurse investigator. All notes need to be submitted to coroner's office.
- Death certificate completed by physician providing MAID
- Self care, wellness and resilience of physicians and nurses

MAID Documentation – Observations and Reflections

- All Clinician Aid Forms need to be in patient's chart with 1st assessor
- Procedure note
- Medication orders
- LHIN HCC orders
- Document phone calls and other visits

- Copies of all other assessments related to MAID (palliative care, psychiatry)

MAID Care in LTC Homes

- Clarify if home is in support of care or conscientious objector
- All assessments can be done in LTC Home
- Pharmacy support for medications
- Staff support
- Care delivery if patient not in private room

MAID Billing Codes

- Use of existing codes
- No fee code for chart review, telephone conversations with lawyer and other staff (LHIN HCC, pharmacy, staff)
- K 023, time code for number of units spent with patient and for care delivery
- Travel codes (B966) + home visit premiums (if not in LTC)
- Case Conference code (K700 vs K124 vs K705)
- Counselling of relatives, scheduled visit (K015)

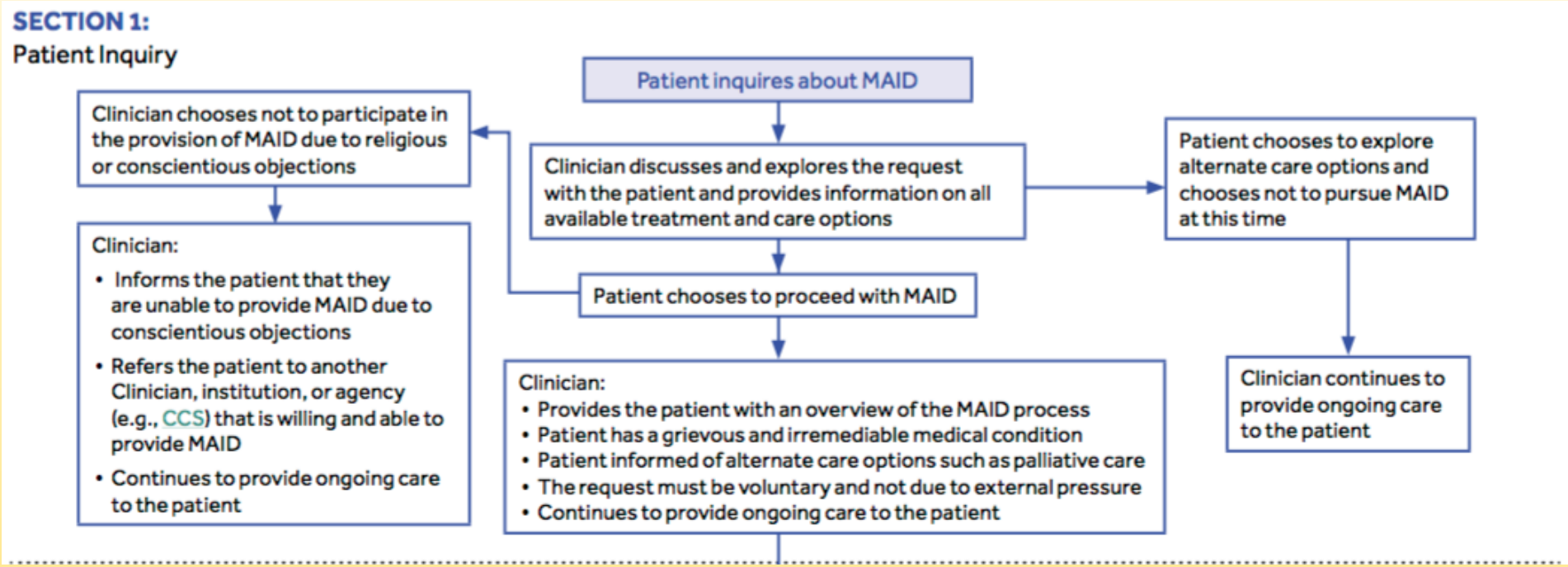
Thank You for Listening!

DISCUSSION & QUESTIONS

References

- Coroner's report on MAID, last update May 2018
- CPSO resource via website for member log in only
- CMPA publication, Volume 10, No. 2, June 2018 "Medical Assistance in dying: where do we stand two years later?
- University of Toronto information deck
- Centre for Effective Practice. (2017, December). *Medical Assistance in Dying (MAID): Ontario.* Retrieved from https://thewellhealth.ca/wp-content/uploads/2018/02/CEP_MAID_Rev3.2.2.pdf
- Joint Centre for Bioethics- Aid to Capacity Evaluation (ACE) . (n.d.). *Aid to Capacity Evaluation (ACE).* Retrieved from http://www.utoronto.ca/jcb/disclaimers/ace.htm
- MOHLTC. (2018). *Clinician Aid A, B and C, Patient Handout*

MAID Eligibility Pathway



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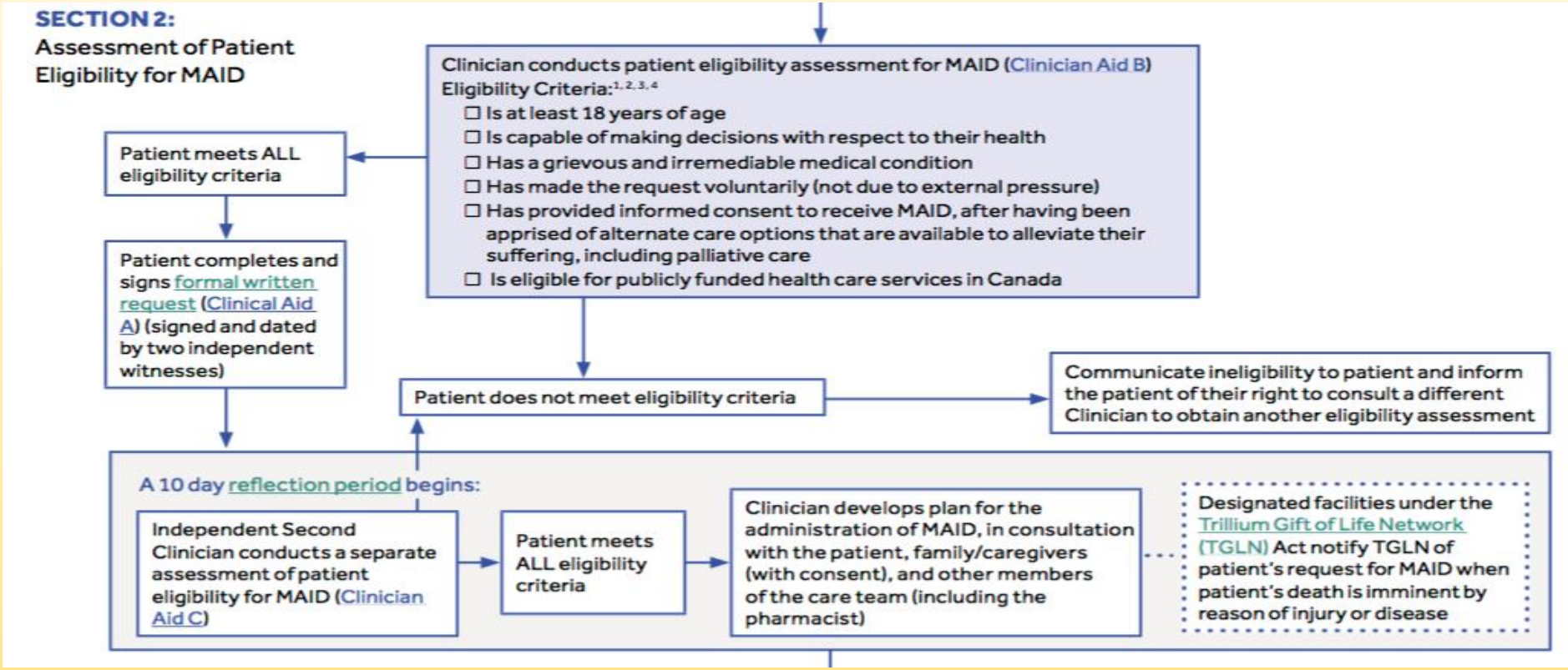

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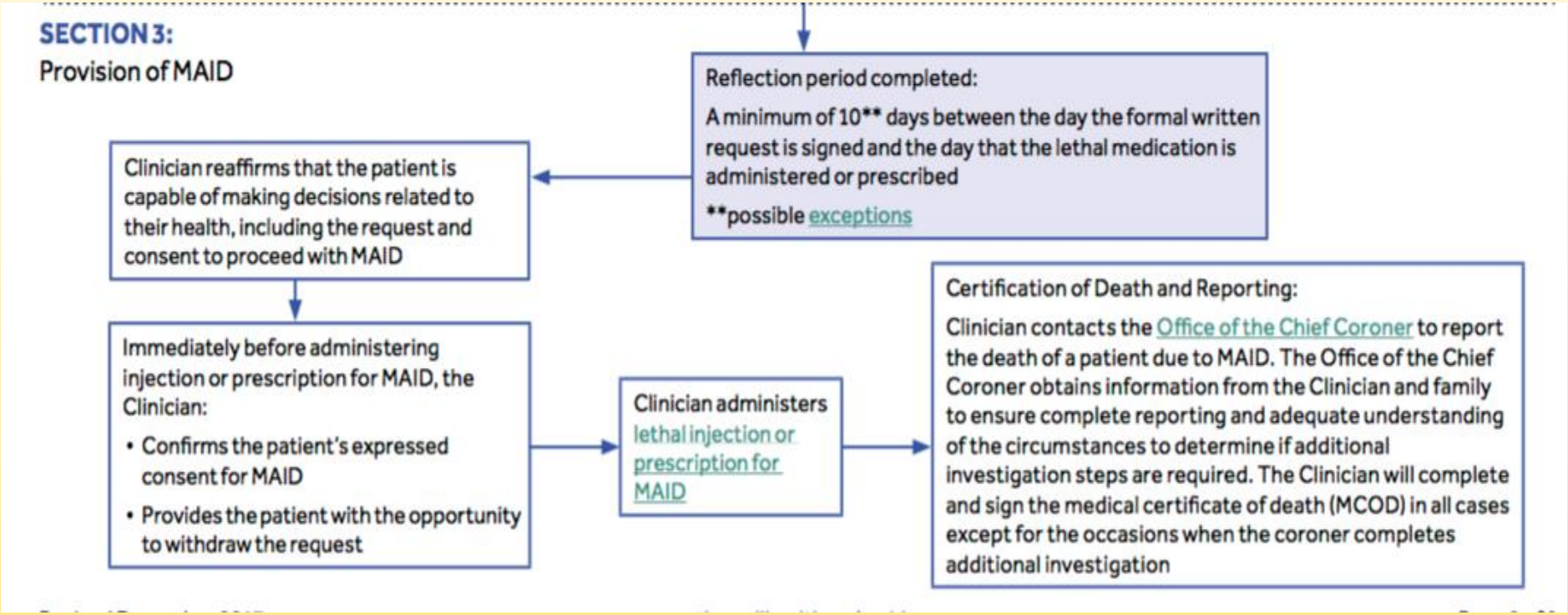
Provision of MAID



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Aid to Capacity Evaluation (ACE) Administration: First step in the capacity assessment process

1. Able to understand medical problem
2. Able to understand proposed treatment
3. Able to understand alternative to proposed treatment (if any)
4. Able to understand option of refusing proposed treatment (including withholding or withdrawing proposed treatments)
5. Able to appreciate reasonably foreseeable consequences of accepting proposed treatment
6. Able to appreciate reasonable foreseeable consequences of refusing proposed treatment (including withholding or withdrawing proposed treatment)
7. A) The person's decision is affected by depression?

   B) The person's decision is affected by psychosis?

Finally an overall Impression: definitely capable, probably capable, probably incapable, definitely incapable