MUSKOKA ALGONQUIN HEALTHCARE		**Policy/Procedure Name:**	**Medical Assistance in Dying**
Manual:	Administration	**Number:**	
Section:	Risk Management	**Effective Date:**	20 JUN 2016
Pages:	1 of 23	**Revision Date:**	May 26, 2021

Purpose

This document provides guidance for medical assistance in dying (MAID) within the hospital. It supports a consistent approach for our patients and families and ensures a patient and family-centered approach.

Scope

This policy pertains to all staff members and credentialed staff at Muskoka Algonquin Healthcare (MAHC) as well as LHIN Home and Community Care (HCC) who have been assigned work within MAHC, and the Spiritual Care Coordinator who has been contracted to work at MAHC. This policy applies to the MAID process occurring for MAHC inpatients. This policy applies to address patient inquiries or requests for Medical Assistance in Dying whenever an inquiry or request may arise within the patient's healthcare journey.

This policy does not apply to situations other than Medical Assistance in Dying and is separate and distinct from withholding or withdrawing treatment, palliative care, and palliative sedation.

Policy Statement

MAHC recognizes the provision of MAID to an eligible patient as a legal option. To support the implementation of MAID, MAHC will use its ethical framework to support medical and administrative decision-making (Appendix 1).

MAHC acknowledges and supports the right of individual health care providers to conscientiously object to participating in the provision of either the education and/or the process of MAID. Correspondingly, MAHC supports and acknowledges the right of individual health care providers that champion the provision of MAID to do so in accordance with the law and professional regulatory standards.

Both participating and conscientiously objecting health care providers must be treated in accordance with MAHC's policies governing code of conduct, workplace harassment, and healthy workplaces.

MAHC supports safe quality end-of-life care for its patients, including options for palliation and comfort care, pain and symptom management, refusal of life-sustaining treatments, continuous palliative sedation, and requests for MAID. MAHC provides care without prejudice toward patients who request various end-of-life options.

1. MAHC will respond to patient requests for MAID and inquiries in a comprehensive, timely and patient-focused manner, and in accordance with current legislation and regulatory college guidelines.

2. Any staff member, physician, Home & Community Care (HCC) employee, or contract worker at MAHC who is approached by a patient inquiring about MAID will ensure that the patient speaks with their MRP for an end-of-life conversation which may include access to physicians or nurse practitioners who are assessors and/or providers for MAID.

3. All conversations regarding end-of-life treatment options must be documented in the patient chart within the progress notes.

4. Conscientious objection by staff or physicians will be respected without prejudice by providing the patient with access to clinicians who are willing to field inquiries and/or participate in the MAID process.

5. The utmost confidentiality will be maintained for any requests in order to protect patients, providers, and the hospital from unwanted attention.

6. Patients who are eligible for medical assistance in dying must meet all of the following criteria:
   - They are eligible for health services funded by a government in Canada.
   - They are at least 18 years of age and capable of making decisions with respect to their health.
   - They have a grievous and irremediable medical condition including all of the following:
     - A serious and incurable illness, disease, or disability.
     - An advanced state of irreversible decline.
     - A disease, disability, or state of decline that is causing them enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions acceptable to the patient.
     - Be in a state in which “natural death has become 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
   - They have made a voluntary request for medical assistance in dying and that was not made because of external pressure.
   - After having been provided with information about ways to alleviate suffering
   - They have given informed consent to receive medical assistance in dying.
   - If a patient is found to satisfy the criteria for MAID but is found to be incapable by either of the two reviewing practitioners (either physicians or nurse practitioners), the patient shall be informed of their right to file an application to the Consent and Capacity Board of Ontario

(CCB). As with any other treatment decision, the burden will be on the physician or nurse practitioner to demonstrate that the patient is, in fact, incapable.

7. The MAID Committee will be a stand-alone committee and will make reports to the Ethics Committee, Quality Committee and to Senior Leadership as necessary. The MAID Committee will:

- Meet every yearly and at the call of the chair to :
  - Discuss specific cases.
  - Adjudication of complaints.
- Maintain quality assurance.
- Maintain non-identifiable information about each request for MAID in order to report twice a year to the MAHC and Quality Committee.
- Review the policy and procedure for changes and the terms of reference

Definitions

Medical Assistance in Dying (MAID):

- Administration of a substance by a physician to a person, at that person's request, that causes their death.
- Prescribing or providing a substance by a physician to a person, at that person's request, so that they may self-administer the substance and cause their own death. Currently not provided at MAHC.

Conscientious Objection:
When a member of the health care team, due to matters of personal conscience, elects not to participate in MAID it is known as conscientious objection. The level of comfort and support a team member may or may not be willing to provide could vary in scope. For example, they may be comfortable supporting a range of activities such as providing the patient with an educational pamphlet, having an exploratory discussion with the patient, or providing a second medical opinion but are not willing to prescribe, provide, or administer the medications required in MAID. Some health care team members may wish to limit their involvement in MAID to the full extent permitted by their professional Colleges.

Independent Eligibility Assessment:
An objective assessment provided by a physician or nurse practitioner ***who is not in any of the following relationships with either the other assessing physician or nurse practitioner or the patient making the request***:

Financial relationship:

- *Beneficiary* – a beneficiary under the will of the patient making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services.
- *Business* – in a business relationship with the other practitioner in which profits and losses are shared.

Professional relationship:

- A mentor to them or responsible for supervising their work.

Personal relationship:

- Connected in any way that would affect objectivity.

Capacity:

A person is capable of making a particular decision if the individual is both:

- Able to understand the information that is relevant to making that decision, and,
- Able to appreciate the reasonably foreseeable consequences of that decision or lack of decision.

Initial Consent:

Note: Neither substitute decision-maker consent nor advance consent (i.e., advance directive or living will) for MAID is permitted.

Informed medical consent must meet the following requirements:

- Individual consenting must be capable.
- The decision must be informed (i.e., the risks, benefits, side effects, alternatives, and consequences of not having treatment provided).
- Made voluntarily.
- Be treatment specific.
- Must be made in writing

Procedure

Request for MAID Initiated by a MAHC Inpatient:

1. The patient makes the first inquiry or request for MAID. The patient may choose to initiate the inquiry or request with an interprofessional team member at MAHC at which point the patient's most responsible physician (MRP) must be contacted. The interprofessional team member who receives the initial inquiry or request may conscientiously object to informing the MRP for this conversation. In that case, the team member must notify their supervisor or delegate that the patient is making an inquiry or request about MAID so that the MRP can be notified.

2. Once contacted, should the MRP conscientiously object to undertaking a conversation with the patient about medical assistance in dying, he/she should immediately contact the Chief of Staff who will assist in ensuring patient has access to this conversation through a consultant physician.

3. The MRP/consultant physician will, in conjunction with the patient, determine the pathway through which the MAHC inpatient may choose to access MAID (i.e., inpatient requesting a provision in hospital, inpatient requesting a provision in the community).

4. The date of the initial request and assessment must be documented in the progress notes of the patient chart by the MRP. The interprofessional team member who may have received the request will also document in this in the chart.

5. All conversations regarding MAID and end-of-life care are to be documented in the patient chart and within the progress notes.

6. The MRP/consultant physician may undertake the role of first assessor.

7. The ***first assessor*** consults with the MAHC inpatient on end-of-life care options including MAID:

    - Explore the patient's motivation for inquiring about/requesting MAID.
    - Review other end-of-life care options with the patient. Access to high quality, coordinated palliative care may be an option for the patient and physicians are encouraged to seek out expert advice from the North Simcoe Muskoka Hospice Palliative Care Network at 1-877-235-2224 or HOPE Huntsville Palliative Care Team at 705-787-0846.
    - If appropriate, refer to palliative care and/or other specialists to explore options for pain and symptom management, palliation and comfort care, refusal of life-sustaining treatment, and continuous palliative sedation. The numbers for these specialized consults are above.
    - Provide MAID education brochure (Appendix 2) as appropriate.
    - Confirm that the patient is eligible for health services funded by a government in Canada.
    - Confirm that the patient is at least 18 years of age.
    - Confirm the patient's capacity and that the patient is competent and capable to make health care decisions.
    - Confirm the requirements for a grievous and irremediable medical condition are met:
        - The condition is serious and incurable.
        - The patient is in an advanced state of irreversible decline.
        - Condition or state of decline causes enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions acceptable to the patient.

- Be in a state in which "natural death has become 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

- Confirm that the patient has made a voluntary request for medical assistance in dying and that it was not made because of external pressure.
- The assessor may wish to consult with any of the following: Chief of Staff, College of Physicians and Surgeons of Ontario, legal professional, MAHC Ethics Committee, etc.
- The first assessor provides the competent patient with required documentation (Appendix 3) to be completed at each step of the MAID process and initiates a referral to the second assessor should the patient wish to proceed further in their request for MAID.
- The first assessor provides the patient with access to an independent physician/nurse practitioner (refer to above for independent eligibility assessment) who has previously not been involved in the care of the patient, for a second assessment of the patient's eligibility to undertake MAID as a treatment option. If it is unclear as to whether the practitioner meets the independence requirement, consult the Canadian Medical Protective Association. Nurse Practitioners may consult the Healthcare Insurance Reciprocal of Canada and/or the Canadian Nurses Protective Association.

8. The first assessor documents their conversation and assessment in the patient chart, within the progress notes, including patient capacity assessment:
   - Patients deemed incompetent are unable to initiate MAID but continue to have access to other end-of-life treatment options.
   - Patients deemed incompetent may choose to seek a second opinion from another physician.
   - Patients deemed incompetent may choose to contact the Consent and Capacity Board.

9. MAHC first assessor provides competent inpatient with access to pharmacy consultation, social work consultation, and Spiritual Care consultation.

10. In the event that natural death is not foreseeable:
    a. Another physician or NP must provide a written opinion confirming that the person meets the criteria.
    b. If the first physician or NP does not have the expertise in the condition that is causing the person's suffering, efforts must be made to consult with a Physician on NP with that expertise.

11. At this point, the inpatient undertaking the assessment steps in MAID may choose to be discharged and continue the process in the community where Home and Community Care will support the

patient and assist the physician/nurse practitioner treatment provider. If the patient is discharged at this point, the first assessor is responsible for referring the patient to a second assessor.

12. The first assessor provides the MAHC inpatient with access to an ***independent second assessor*** (refer to definition above of independent eligibility assessment). The second assessor will follow the assessment steps identified for the first assessor as above, specifically steps 4 through 7 under the procedure section of this document. Once the first assessor has determined that the patient is able to proceed with their MAID request.

13. In the event that natural death is not foreseeable, there must be at least 90 clear days between the day on which the first assessment begins and the day on which medical assistance in dying is provided, or if the assessments have been completed and both the physicians or NPs are of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent any shorter period that the physician or NP who is to provide MAID consider appropriate in the circumstances.

14. The Manager of Pharmacy (or delegate) will ensure a pharmacist who is comfortable with the process is available to dispense.

15. After order verification in the pharmacy (either onsite or offsite), the medications are prepared for dispensing in a patient-specific and secured MAID Medication Kit.

16. The physician providing the procedure will have the medications dispensed to him/her in the MAID Medication Kit within the pharmacy. Upon completion of the procedure, the physician will return the MAID Medication Kit to the pharmacy.

Implementation of MAID at MAHC:

1. MAHC staff (navigator) will notify Trillium Gift of Life after confirmation by one physician that the patient meets the eligibility requirements to receive MAID.

2. Confirm documentation requirements have been met:
   a. Documented independent assessments
   b. Witnessed initial consent

3. MAID Navigator will be assigned to the process and the Navigator will coordinate and facilitate all internal processes using the MAID checklist (Appendix 6). At MAHC, the Navigator will be one of the following:
   a. The Inpatient Manager at the associated site or
   b. Delegate.

4. Identify a private room within MAHC to enable confidentiality, privacy, and patient and family-centered care during MAID procedure.

5. Confirm details of patient's end-of-life care plan including who will be present (nurse, doctor, family) and any additional comfort measures that may be incorporated into the treatment plan (e.g., pastoral care, music, reading, pet visitation, etc.).

6. Either the first or second assessor will prescribe and/or administer medications.

7. Large bore vascular access (e.g., PICC or intravenous access with a #20 gauge or larger) is recommended for insertion in advance of the medication administration to ensure optimal vascular access necessary for the treatment. If intravenous access is the vascular access of choice (versus PICC), two intravenous access points must be established.

8. Ensure interprofessional health care team in place who have no conscientious objection to this treatment option, including but not limited to:
    a. Physician (required)
    b. Nurse (required)
    c. Pharmacist (required)
    d. Social Worker (optional)
    e. Chaplain (optional)

9. In advance of the date/time of the treatment the team (doctor, pharmacist, nurse, and navigator) will meet to:
    a. Confirm roles.
    b. Confirm participation.
    c. Confirm the order and dosage of medications to be administered.
    d. Complete the Physician Order Set for MAID (Appendix 5).

10. Just prior to proceeding with the treatment, the physician must confirm the following and document in the chart:
    a. All required documentation has been completed.
    b. Reviews the meds with the Pharmacist.
    c. The person is given the opportunity to withdraw the request for MAID, and the physician or NP ensures that the person is giving their expressed consent. However, this verification of final consent maybe waived if certain criteria are met.
    d. Consent may be waived if (only in the case where natural death is foreseeable), before the person lost capacity to consent to MAID:
        i. They satisfied the criteria for MAID and all other relevant safeguards

ii. They entered into an arrangement in writing with the physician or NP for a substance to be administered to cause their death on a specific day
iii. They were informed by the physician or NP of the risk or losing the capacity to consent prior to the specific day and
iv. In the written agreement, they consented to the administration of a substance to cause their death on or before the specified day if they lost capacity to consent prior to that day

e. The person lost capacity to consent to MAID
f. The person neither demonstrates refusal by words, sounds or gestures nor resists the administration of the substance
   i. This means that involuntary words, sounds or gestures made in response to contact do not constitute refusal or resistance
   ii. That once the person demonstrates refusal or resistance, MAID cannot be provided to them based on the written arrangement
g. The substance is administered in accordance with the terms of the arrangement

Medication Administration with MAID at MAHC:

1. Prior to initiating MAID, establish large bore vascular access (e.g., PICC or intravenous access with a #20 gauge or larger) in advance of the medication administration to ensure optimal vascular access necessary for the treatment. If intravenous access is the vascular access of choice (versus PICC), two intravenous access points must be established. IV access can be locked until MAID initiated.

2. The physician providing the procedure will have the medications dispensed to him/her in the MAID Medication Kit within the pharmacy. Upon completion of the procedure, the physician will return the MAID Medication Kit to the pharmacy.

3. The patient receiving MAID is identified according to MAHC patient identification policy.

4. Physicians are solely responsible for medication administration with MAID.

5. Medication administration is recorded in the physician progress notes.

6. Completion of narcotic and controlled substance disposition records including any wastage of narcotics and controlled substances is recorded on narcotic disposition records.

Documentation of MAID at MAHC:

1. Ensure that all of the required documentation leading up to MAID treatment is in place and on the patient chart using the checklist (Appendix 7).

a. Date of initial conversation about MAID.
b. Clear identification of who initiated the MAID conversation.
c. Validate that the patient is eligible for health services funded by a government in
d. Canada.
e. Confirm that the patient is at least 18 years of age and capable of making decisions with respect to their health.
f. Patient's medical condition including grievous and irremediable condition, intolerable and suffering.
g. Alternative treatment plans discussed and considered.
h. Capacity assessment.
i. Attestation of physician that patient meets criteria for MAID and that request is voluntary and free of coercion.
j. Description of social supports.
k. Second assessor documentation is on the chart including:
    - Patient's medical condition including grievous and irremediable condition, intolerable and suffering.
    - Alternative treatment plans discussed and considered.
    - Capacity assessment.
    - Attestation of physician that patient meets criteria for MAID and that request is voluntary and free of coercion.
    - Description of social supports.
l. One (1) witnessed signed consent.

2. Physician to document patient consent to treatment just prior to initiating MAID treatment unless the patient meets the criteria to waive.

3. Physician to refer to MAID physician order set.

4. Physician to document time of death in the patient chart.

5. The physician leading the MAID procedure will contact the Chief Coroner's office who may choose to undertake a coroner's investigation. The Chief Coroner's office will complete the patient's death certificate.

6. Documents requested by the Coroner will be faxed as soon as possible.

7. Medications will be documented in the chart and on the form (Appendix 8).

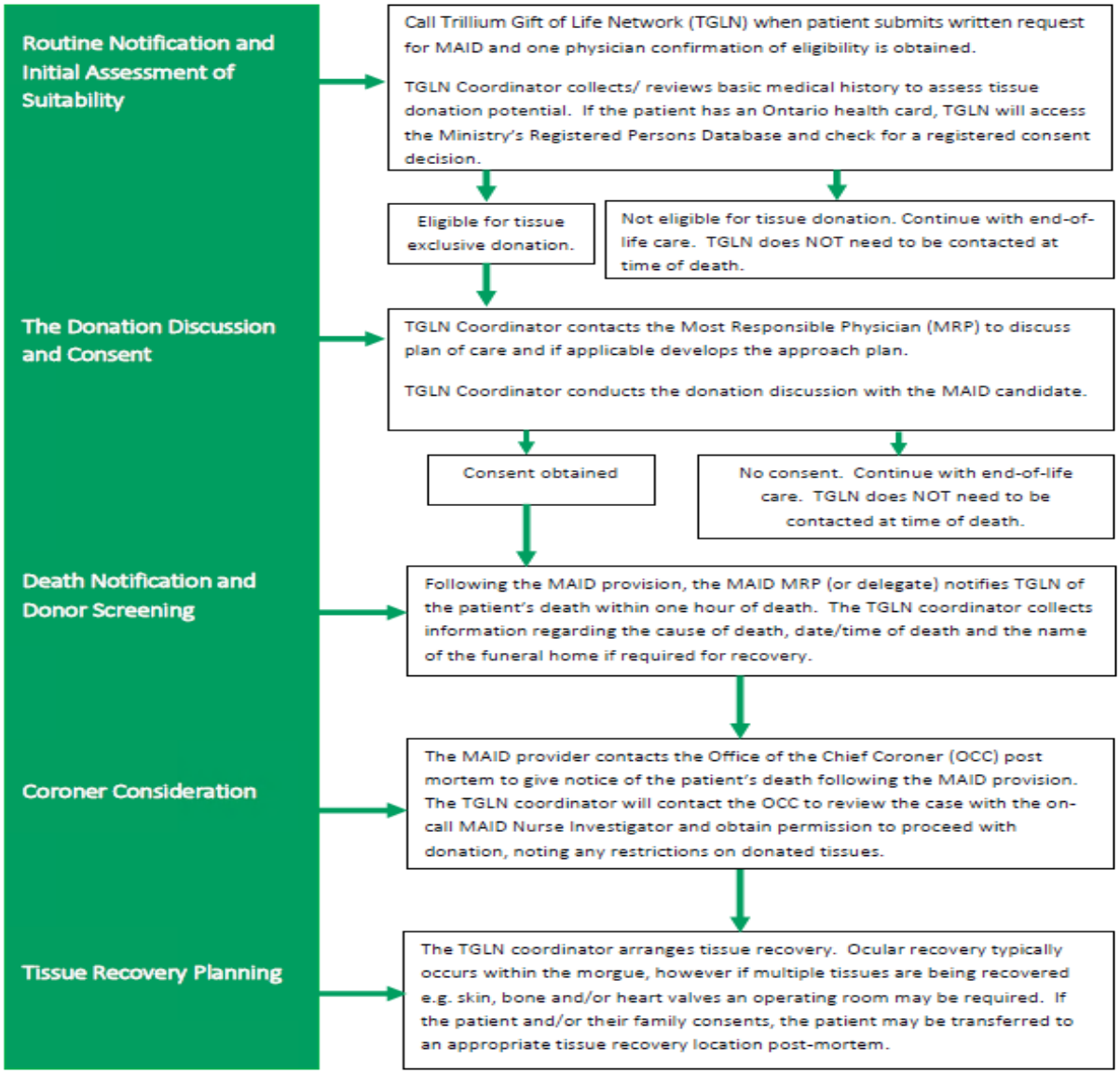
Post-MAID at MAHC:

1. Complete documentation.
2. Counsel/support family as needed.
3. Debrief with interprofessional team members regarding the MAID process including opportunities for process improvement.
4. Invite the family to participate in the interprofessional team debrief.
5. Identify additional resources that the interprofessional team may access for support.

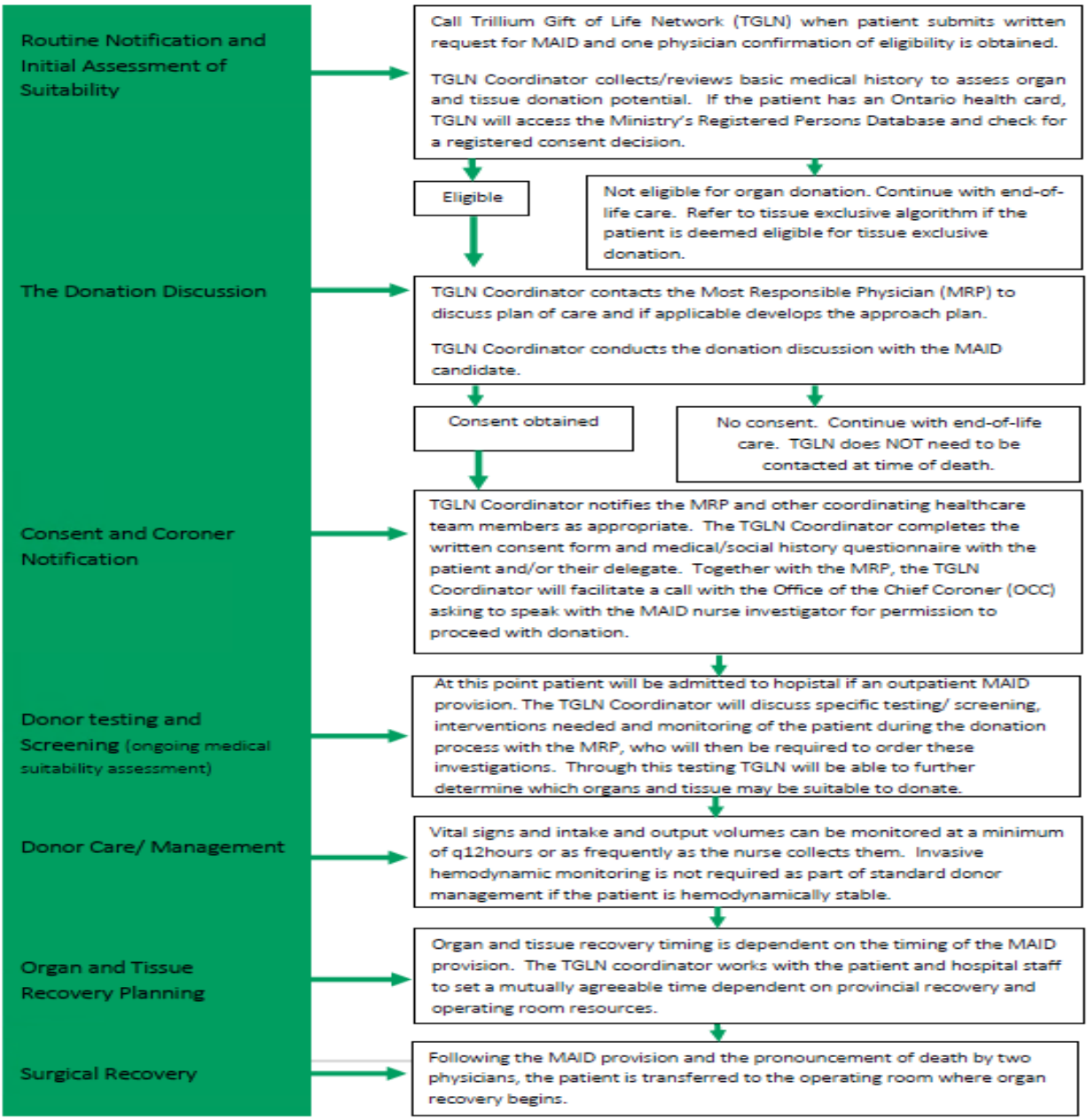
Requests from Physicians for Patients to Receive MAID as Outpatients:
For any request for MAID from outpatients refer the requestor to their most responsible provider, according to the Regional Framework (Appendix 4) and provide the information brochure available in the MAHC on-line document management system.
If the MAID procedure cannot be completed at home, the MAID advisory group should be notified to discuss other alternatives such as respite beds. When no other alternative can be found, then the group will attempt to find a suitable location in which the procedure can be performed as an outpatient. The community providers will perform the procedure under community guidelines.

MAID Patients Requesting to be an Organ/Tissue Donor:

TISSUE EXCLUSIVE DONATION/MAID ALGORITHM



ORGAN DONATION/MAID ALGORITHM



Cross Reference

1. North Simcoe Muskoka Local Health Integration Network, Policy, and Procedure
2. Medical Assistance in Dying Organ and Tissue Donation Policy and Procedure TGLN
3. Ministry of Health & Long Term Care- MAID

Notes

Standardized Statement:

A printed copy of this document may not reflect current, electronic version on the Medworxx website. Any copies of this document appearing in paper form should always be checked against electronic version prior to use.

References / Relevant Legislation

Bill C-14: Medical Assistance in Dying (Canada)
Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)
Bill 84: Medical Assistance in Dying Statute Law Amendment Act, 2017 (Ontario)

Other:

1. College of Nurses of Ontario. *Medical Assistance in Dying – Update.* June 6, 2016. http://www.cno.org/en/news/2016/06/medical-assistance-in-dying--update/

2. College of Physicians and Surgeons of Ontario. *Policy Statement #4-16 Physician Assisted Death,* June 2016. http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/PAD-Physician-Assisted-Death.pdf?ext=.pdf

3. College of Physicians and Surgeons of Ontario. *Interim Guidance on Physician Assisted Death: Frequently Asked Questions.* http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/PAD-Physician-Assisted-Death-FAQ.pdf?ext=.pdf

4. Joint Centre for Bioethics (University of Toronto). *Medical Assistance in Dying Draft Policy Template.* June 5, 2016. http://jcb.utoronto.ca/news/documents/JCB-MAID-Policy-Template-DRAFT_June52016.pdf

5. Ontario College of Pharmacists. *Physician Assisted Death: Guidance to Pharmacists and Pharmacy Technicians.* June 6, 2016. http://www.ocpinfo.com/library/practice-related/download/PhysicianAssistedDeath.pdf

6. Registered Nurses Association of Ontario. *End of Life Care During the Last Days and Hours.* 2011. http://rnao.ca/bpg/guidelines/endoflife-care-during-last-days-and-hours

Appendices

Appendix 1 - Issue Focussed Ethical Decision Making Framework
Appendix 2 - Medical Assistance in Dying Educational Brochure (available separately)
Appendix 3 - MOHLTC Request Forms for Medical Assistance in Dying located at:
https://www.health.gov.on.ca/en/pro/programs/maid/
Appendix 4 - Flow Diagram for Assessing Interim Patient Requests for Medical Assistance in Dying
Appendix 5 - MAID Procedural Checklist
Appendix 6 - Medication Documentation

APPENDIX 1

ISSUE FOCUSSED ETHICAL DECISION MAKING FRAMEWORK

The intent of this framework is to enable decision makers at Muskoka Algonquin Healthcare to address complex and challenging issues in a comprehensive and logical manner. It is a reflective process intended to stimulate discussion among decision makers that will enable them to identify explicit reasons for or against a proposed course of action and to do that in the context of the Mission, Vision, and Values. Questions relevant to Issue Focused Ethics are provided in the guideline below; some questions may not apply to every issue and other questions may need to be added.

CONTEXT

1. Identify the Issue and Decision-Making Process
- Reflective Practice
- State the conflict or dilemma
- Determine best process for decision making

2. Study the Facts
- Stakeholder perspectives
- Evidence
- Contextual Features (political, economic, stakeholder satisfaction)

3. Select Reasonable Options
- Brainstorm options first without evaluating
- Start by describing your 'ideal' situation

VALUES & ETHICS

4. Understand Values & Duties
- Which values are in conflict?
- Professional or legal obligations or standards to consider?
- Alignment with Strategic Directions, Mission, Vision and Values

STEWARDSHIP

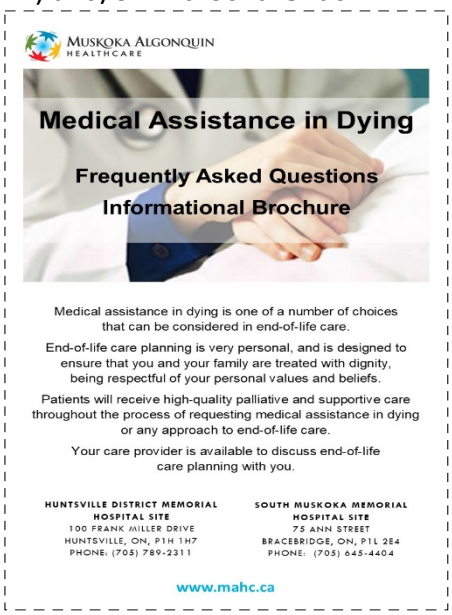
5. Evaluate & Justify Options
- Possible harm to various stakeholders?
- Benefits?
- Patient outcomes – quality of care
- Human resource implications
- Using Resources properly?
- Evaluation Plan to monitor impact?
- Financial implications?

6. Sustain & Review the Plan
- Formal evaluation process in place to monitor progress, good practices and opportunities for improvement
- Appeal process?
- Evaluation of how the decision-making process worked

APPENDIX 2 – Medical Assistance in Dying Educational Brochure

MUSKOKA ALGONQUIN HEALTHCARE		**Policy/Procedure Name:**	**Medical Assistance in Dying**
Manual:	Administration	**Number:**	
Section:	Risk Management	**Effective Date:**	20 JUN 2016
Pages:	17 of 23	**Revision Date:**	May 26, 2021

Located in stand-alone document in shared drive (SharePoint < Department Sites < Patient Safety & Quality < _Med-AID) and/or in brochure rack.



MUSKOKA ALGONQUIN HEALTHCARE

Medical Assistance in Dying

Frequently Asked Questions Informational Brochure

Medical assistance in dying is one of a number of choices that can be considered in end-of-life care.

End-of-life care planning is very personal, and is designed to ensure that you and your family are treated with dignity, being respectful of your personal values and beliefs.

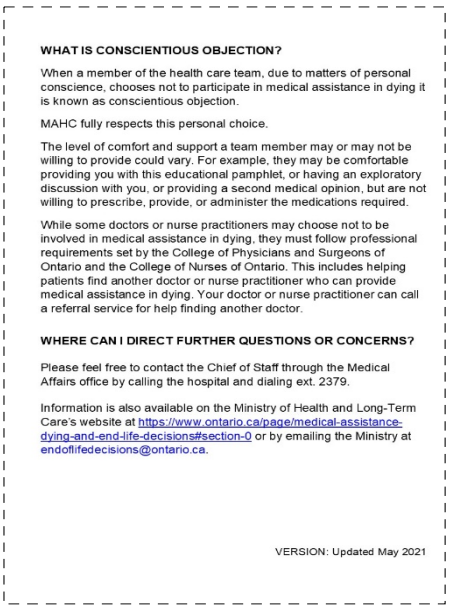
Patients will receive high-quality palliative and supportive care throughout the process of requesting medical assistance in dying or any approach to end-of-life care.

Your care provider is available to discuss end-of-life care planning with you.

HUNTSVILLE DISTRICT MEMORIAL HOSPITAL SITE
100 FRANK MILLER DRIVE
HUNTSVILLE, ON, P1H 1H7
PHONE: (705) 789-2311

SOUTH MUSKOKA MEMORIAL HOSPITAL SITE
75 ANN STREET
BRACEBRIDGE, ON, P1L 2E4
PHONE: (705) 645-4404

www.mahc.ca



WHAT IS CONSCIENTIOUS OBJECTION?

When a member of the health care team, due to matters of personal conscience, chooses not to participate in medical assistance in dying it is known as conscientious objection.

MAHC fully respects this personal choice.

The level of comfort and support a team member may or may not be willing to provide could vary. For example, they may be comfortable providing you with this educational pamphlet, or having an exploratory discussion with you, or providing a second medical opinion, but are not willing to prescribe, provide, or administer the medications required.

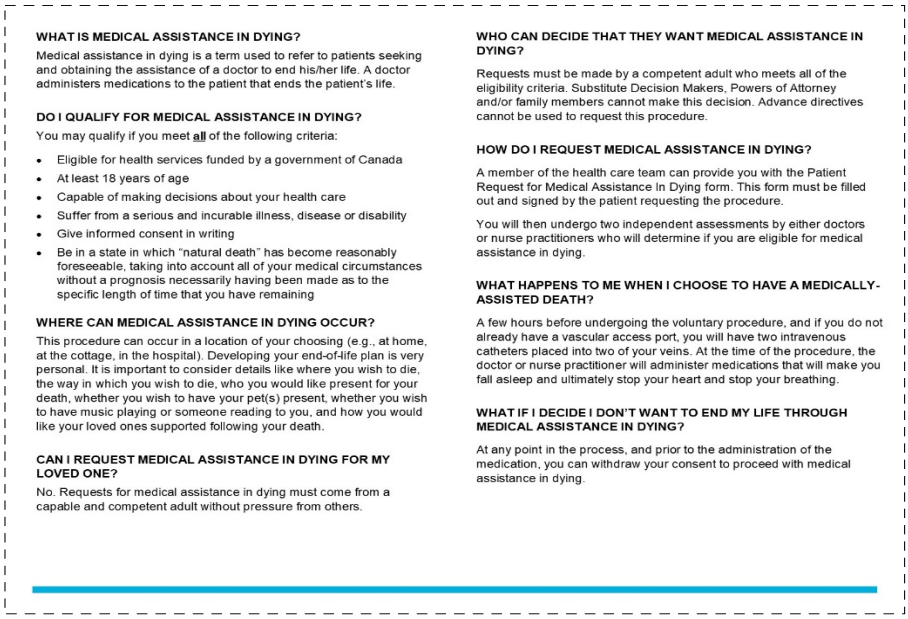
While some doctors or nurse practitioners may choose not to be involved in medical assistance in dying, they must follow professional requirements set by the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario. This includes helping patients find another doctor or nurse practitioner who can provide medical assistance in dying. Your doctor or nurse practitioner can call a referral service for help finding another doctor.

WHERE CAN I DIRECT FURTHER QUESTIONS OR CONCERNS?

Please feel free to contact the Chief of Staff through the Medical Affairs office by calling the hospital and dialing ext. 2379.

Information is also available on the Ministry of Health and Long-Term Care's website at https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions#section-0 or by emailing the Ministry at endoflifedecisions@ontario.ca.

VERSION: Updated May 2021



WHAT IS MEDICAL ASSISTANCE IN DYING?

Medical assistance in dying is a term used to refer to patients seeking and obtaining the assistance of a doctor to end his/her life. A doctor administers medications to the patient that ends the patient's life.

DO I QUALIFY FOR MEDICAL ASSISTANCE IN DYING?

You may qualify if you meet **all** of the following criteria:

- Eligible for health services funded by a government of Canada
- At least 18 years of age
- Capable of making decisions about your health care
- Suffer from a serious and incurable illness, disease or disability
- Give informed consent in writing
- Be in a state in which "natural death" has become reasonably foreseeable, taking into account all of your medical circumstances without a prognosis necessarily having been made as to the specific length of time that you have remaining

WHERE CAN MEDICAL ASSISTANCE IN DYING OCCUR?

This procedure can occur in a location of your choosing (e.g., at home, at the cottage, in the hospital). Developing your end-of-life plan is very personal. It is important to consider details like where you wish to die, the way in which you wish to die, who you would like present for your death, whether you wish to have your pet(s) present, whether you wish to have music playing or someone reading to you, and how you would like your loved ones supported following your death.

CAN I REQUEST MEDICAL ASSISTANCE IN DYING FOR MY LOVED ONE?

No. Requests for medical assistance in dying must come from a capable and competent adult without pressure from others.

WHO CAN DECIDE THAT THEY WANT MEDICAL ASSISTANCE IN DYING?

Requests must be made by a competent adult who meets all of the eligibility criteria. Substitute Decision Makers, Powers of Attorney and/or family members cannot make this decision. Advance directives cannot be used to request this procedure.

HOW DO I REQUEST MEDICAL ASSISTANCE IN DYING?

A member of the health care team can provide you with the Patient Request for Medical Assistance In Dying form. This form must be filled out and signed by the patient requesting the procedure.

You will then undergo two independent assessments by either doctors or nurse practitioners who will determine if you are eligible for medical assistance in dying.

WHAT HAPPENS TO ME WHEN I CHOOSE TO HAVE A MEDICALLY-ASSISTED DEATH?

A few hours before undergoing the voluntary procedure, and if you do not already have a vascular access port, you will have two intravenous catheters placed into two of your veins. At the time of the procedure, the doctor or nurse practitioner will administer medications that will make you fall asleep and ultimately stop your heart and stop your breathing.

WHAT IF I DECIDE I DON'T WANT TO END MY LIFE THROUGH MEDICAL ASSISTANCE IN DYING?

At any point in the process, and prior to the administration of the medication, you can withdraw your consent to proceed with medical assistance in dying.

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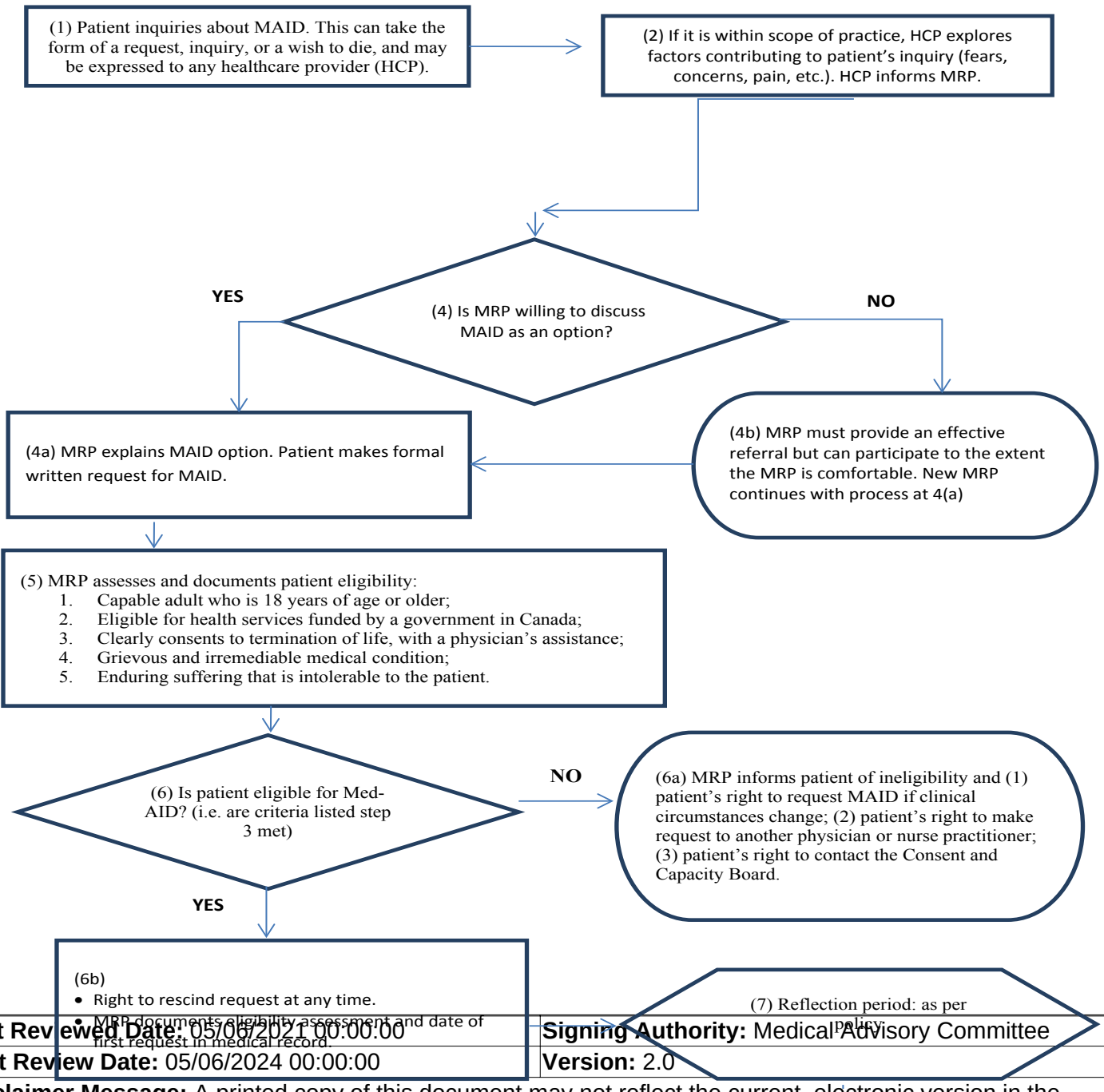
APPENDIX 3 – MOHLTC Request Forms for Medical Assistance in Dying

Located online at: https://www.health.gov.on.ca/en/pro/programs/maid/

APPENDIX 4
Flow Diagram for Medical Assistance in Dying (MAID)

Diagram based on Bill C-14, C-7 and the College of Physicians and Surgeons of Ontario Medical Assistance in Dying



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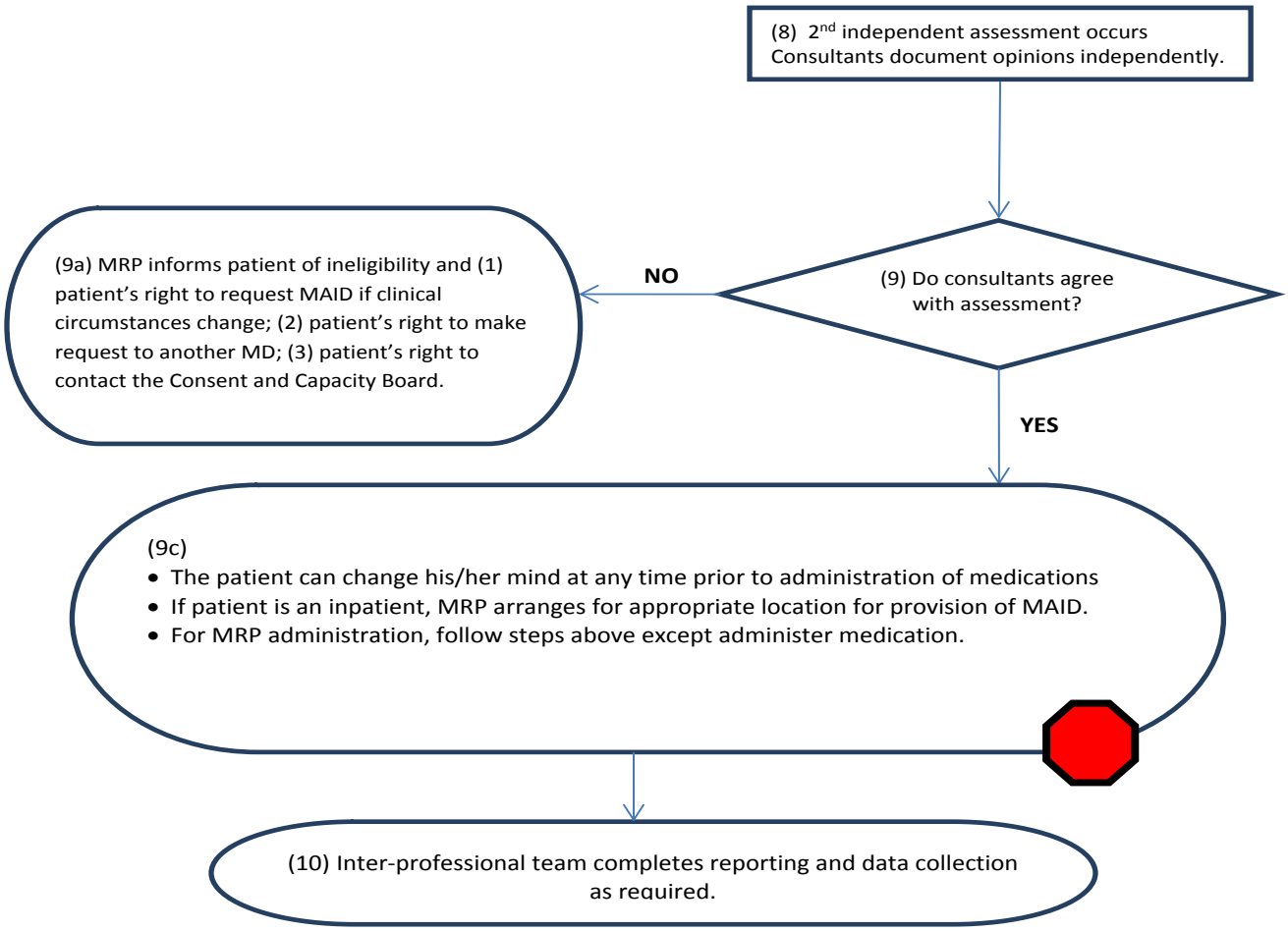

APPENDIX 5

Procedural Checklist

	Date
Call TGLN when the first assessment is completed and determined patient is a candidate.	
Day Before Procedure	
Inpatient Manager:	
• Confirm that the physician order set is available for the physician • Confirm IV access has been initiated • Confirm the nurse	
• Confirm with patient that funeral home has been contacted and ask for details related to the day of the procedure to ensure all is in place	
Date of initial conversation about MAID	
Confirm the following is on the Patient chart	
• Date of initial conversation about MAID	
○ Clear verification of who initiated the MAID conversation	
○ Written request of patient with 1 independent witnesses- **Clinician Aid A**	
• First assessor documentation on the chart indicating that the patient meets the criteria for MAID and that the request is voluntary and free of coercion **Clinician Aid B** ○ Capacity assessment completed ○ Alternative treatment plans have been discussed and considered ○ Patient's medical condition is grievous and irremediable, has intolerable suffering, and foreseeable death	
• Second assessor documentation is on the chart including: **Clinician Aid C** ○ Patient's medical condition is grievous and irremediable, has intolerable suffering, and a foreseeable death ○ Alternative treatment plans have been discussed and considered ○ Capacity assessment completed ○ Attestation of second assessor that patient meets criteria for MAID and that the request is voluntary and free of coercion	
Validate that the patient is eligible for health services funded by a government in Canada	
• Confirm Pastoral Care and or Social Work representative	
• Witnessed signed consent	
Day of Procedure	
• Physician to collect kit from the pharmacy.	
• Review documents for completion	

During Procedure: Medication administration is recorded in the chart by the physician in the physician progress notes	
Post Procedure: • Physician declares death and documents in the chart. • Physician contacts Chief Coroner's office: **416-314-4100**. • Physician completes the narcotic and controlled substance disposition record including any wastage of narcotics/controlled substances • The physician will return the kit to pharmacy upon completion of the procedure. • TGLN is called if the patient is a donor at **1-877-363-8456**	
• Debrief with interprofessional team members regarding the MAID process including opportunities for process improvement.	
• Once the family has left the area, the nurse prepares the body for the morgue.	
• The nurse takes the body to the morgue.	

APPENDIX 6

Medication List

Drug	Dose	Dose Given	Time Given	Dr Initials	Nurse Initials	Lot	Expiry (DD/MM/YYYY)
Midazolam	**10 mg**						
Propofol	**1000 mg**						
Rocuronium	**200 mg**						
Lidocaine (local anaesthetic if no central line)	**40 mg**						
Magnesium (local anaesthetic if no central line)	**1000 mg**						
Bupivacaine for asystole dose to be drawn by provider ONLY if required	0.5% 100 mL for IV direct administration (provided as 5 – 20 mL vials),						