

	<b>Responding to Requests for Medical Assistance in Dying</b>	<b>Corporate Policy &amp; Procedures Manual</b>
		<b>Policy No.</b> VII-B-440 <b>Date Approved</b> May 24, 2016
<b>Approved by:</b> Vice President Medicine and Chief Medical Officer Vice President, Mission, Ethics and Spirituality		<b>Date Effective</b> May 24, 2016
		<b>Next Review</b> (1 year from Effective Date) June 2017

## Purpose

The purpose of this policy is to provide a consistent ethical and compassionate approach, reflective of the *Health Ethics Guide* and Catholic teaching when responding to a person in care within Covenant Health who requests assistance to end their own lives through suicide, or who voluntarily requests administration of a lethal medication to have death inflicted upon them. These are collectively referred to as medical assistance in dying.<sup>1</sup>

## Policy Statement

As a Catholic health care organization, Covenant Health is committed to the inherent dignity of every human being throughout the entire continuum of life from conception to natural death. The organization's ethical and moral opposition to medical assistance in dying and the organization's unequivocal position to not provide or explicitly refer for same needs to be recognized, respected and honoured by all persons served by, or working within Covenant Health including, but not limited to: funders, regulatory bodies, advocacy groups and the larger community.

## Applicability

This policy applies to all Covenant Health facilities, staff, physicians, volunteers, students and to any other persons acting on behalf of Covenant Health ("personnel"). It does not apply to physician practices conducted external to Covenant Health such as those physicians who hold multiple site privileges, or to other Covenant Health staff in any role they may have concurrently working at non-Covenant Health sites or facilities.

## Responsibility

While Covenant Health personnel shall neither unnecessarily prolong nor hasten death, the organization nevertheless reaffirms its commitment to provide quality palliative/hospice and end-of-life care, promoting compassionate support for dying persons and their families, including:

1. Honouring patient/resident self-determination through the use of advanced care planning, goals of care designation, and/or personal directives, including clear recognition of the role of substitute decision-makers/agents chosen by and acting on behalf of the patient/resident;
2. Offering quality palliative/hospice and end-of-life care that addresses physical, psychological, social, and spiritual needs of persons who are dying and their families, and;

<sup>1</sup> For the purposes of this policy, "medical assistance in dying" is used to describe the assistance provided to a person with the aim of intentionally ending his/her life, as well as voluntary euthanasia, whereby a legally recognized health professional directly administers a lethal dose of medication (or equivalent) in accordance with the wishes of the patient. While this terminology is consistent with Parliament of Canada Bill C-14, references to "physician-assisted suicide," "physician-assisted death," and "medical aid in dying" are also cited in the literature, among others. For example, see the Canadian Society of Palliative Care Physicians' Category Archives on physician-hastened death at: <http://www.cspcp.ca/category/physician-hastened-death/>, or the College of Physicians and Surgeons of Alberta's refined Advice statement to the profession on physician-assisted death at: <http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/>. Further definitions are listed below.

3. Delivering effective and timely pain and symptom management as outlined in the *Health Ethics Guide*, the foundational ethics resource used by Covenant Health.

## Principles

An expressed request from a person in our care for medical assistance in dying must be respectfully acknowledged in a non-coercive and non-discriminatory manner.

Although Covenant Health and its personnel are prohibited from participating in any actions of commission or omission that are directly intended to cause death, the values of Covenant Health nevertheless ethically oblige personnel to explore and to try to ascertain the nature of the person's expressed request.<sup>2</sup>

This response should focus on providing information and access to appropriate physical, psychological and spiritual supports to help address the person's needs that may underlie their expressed request.

This policy recognizes that suffering is part of the human experience which occurs throughout life and is not necessarily related to dying. A person in deep existential anguish needs to be appropriately supported to acknowledge, address, and ameliorate their suffering. The goal of care is to reduce such suffering.

As a publicly-funded institution, Covenant Health recognizes that personnel serving persons in our care may be conflicted when responding to a request for medical assistance in dying given the range of societal views on the issue. Covenant Health has an institutional obligation to uphold its principles of faith and morals by which it is bound as a Catholic health care provider and as recognized by the *Cooperation and Services Agreement*, established between Alberta Health Services and Covenant Health.

Covenant Health is morally and legally bound to work together with both patients, families and personnel to resolve potential conflict around the goals of care to find proactive solutions that respect the wishes and integrity of all. In some cases, in response to both a patient's consented request and an external provider arrangement to assume care of the patient, this may require safe and timely transfer of the patient and their records to a non-objecting institution for continued exploratory discussion and assessment.<sup>3</sup> Consistent with Covenant Health's mission and values, care in arranging such patient and external provider requested transfer should be provided in a compassionate and non-discriminatory manner.

As affirmed in *Our Commitment to Ethical Integrity* and in the *Health Ethics Guide*, Covenant Health will support those in good conscience who cannot participate in an activity they personally deem to be immoral, or contrary to their professional codes of conduct. It is our responsibility to do so without abandoning those who may be impacted by such conscientious or professional decisions by reviewing extenuating circumstances on a case-by-case basis and exercising prudential judgment.

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<sup>2</sup> In this context, omissions of care excludes withdrawing or withholding disproportionately burdensome therapies deemed not to be directly intending to cause death, even if death is a foreseen but unintended consequence of such omissions. See: *Health Ethics Guide*, Article 20, including Articles 77-79 – "Refusing and Stopping Treatment."

<sup>3</sup> Covenant Health recognizes and abides by all legislative requirements and regulatory standards governing access to medical assistance in dying elsewhere, while reciprocally, fully expecting others to respect Covenant Health's institutional integrity as a Catholic care organization and the conscience rights of its personnel to not provide or directly refer explicitly for same.

**Procedure**

## A. Responsible Parties

1. Covenant Health will inform all individuals receiving care of the person's right to make decisions concerning their medical care consistent with institutional consent policies, including the right to accept or withdraw medical or surgical treatment and the right to formulate advance directives.
2. Covenant Health will transparently provide information on its policy related to medical assistance in dying, adhering with the principle of non-abandonment and the duty to inform.
3. Patients/Residents, families, caregivers, physicians and other members of the care team are encouraged to fully explore and discuss care and treatment options for patients and residents.
4. Covenant Health respects the rights of all patients/residents/caregivers and physicians to explore all such treatment options, but fully expects that patients/residents and physicians/caregivers will respect and adhere to Covenant Health's position as set forth in this policy while providing care within Covenant Health facilities, programs and services. This involves respecting the parameters as set forth in allied health care team members' respective scopes of practice.

## B. Specific Inpatient Physician/Nursing/ Staff Responsibilities

The position and policies of Covenant Health are based on the *Health Ethics Guide* and the Catholic fundamental values of respect for the sacredness of life from conception to natural death, compassionate care of dying and vulnerable persons, and respect for the integrity of the medical, nursing, and allied health professions. The policy recognizes the long standing Catholic moral tradition of neither prolonging death by subjecting persons in care to disproportionately burdensome, medically inappropriate or futile treatments, nor intentionally hastening their death through assisted suicide and/or voluntary euthanasia (medical assistance in dying).

## Physician Responsibilities:

1. When a person verbalizes a request for medical assistance in dying, the attending physician will be notified.
2. The attending physician must review the person's medical status and seek to understand the person's reasons for the request. The attending physician will discuss the full range of treatment options with the person, including all factually relevant information,<sup>4</sup> inclusive of reference to Covenant Health's policy on medical assistance in dying. This may require responding to questions regarding what is entailed by assisted suicide and/or voluntary euthanasia, the process involved, and/or type of medications used as a statement of fact. This response may also require consultation with other health care personnel to assess the

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<sup>4</sup> Michael Panicola and Ron Hamel, "Conscience, Cooperation, and Full Disclosure: Can Catholic health care providers disclose 'prohibited options' to patients following genetic testing?" *Health Progress* 87, no.1 (January-February, 2006), 52-59.

See also, the *Health Ethics Guide*, 2012, "Organizational Response to Conscientious Objection," Article 165. While no person is required to participate in activities deemed to be immoral, "the exercise of conscientious objection must not put the person receiving care at risk of harm or abandonment." Moreover, "this may require informing the person receiving care of other options of care."

person's decision-making capacity, and to provide emotional and spiritual support, as indicated.

3. Covenant Health encourages physicians and patients/residents and/or their substitute decision-maker to engage in conversations regarding the person's treatment/care options at the end of life, and actively support the provision of quality palliative/hospice care.
4. The patient/resident is informed of the options for meeting the person's care needs including palliative and hospice services for comfort and support as appropriate.
5. When, after discussion with the attending physician the patient still clearly expresses a desire for medical assistance in dying, alternative arrangements will be explored with clear communication that such practice is not provided in Covenant Health facilities. The person may choose to contact the Alberta Health Services Medical Assistance in Dying Resource Team to provide neutral information and further exploratory discussion of options, including identification/facilitation of capacity and mental health assessments, either directly through *Health Link* or by asking Covenant Health to contact AHS at their request (see [www.ahs.ca/MAID](http://www.ahs.ca/MAID) for link to resources).
6. Once a discussion (on-site or teleconference) with the AHS Resource Team around factually relevant options and resource needs has taken place, the person may subsequently request the Resource Team to help them navigate access to external providers, who will then arrange transfer from Covenant Health to a non-objecting institution for further assessment, and potentially, provision of medical assistance in dying. These arrangements will be made directly between the person and the AHS Resource Team and Navigator, without Covenant Health participation.
7. Covenant Health will continue to provide ongoing treatment and care to the person until such time as a notification has been received from an external provider indicating they are assuming total care of the person, and their willingness to arrange transfer of the person and their records to a non-objecting institution, or the patient requests discharge home, as the case may be.
8. Responding to the person's clearly consented wish to be released of their care by Covenant Health and its personnel must nevertheless be timely, safe, compassionate, and respectful, through non-coercive and non-discriminatory dialogue, in accordance with Covenant Health's mission and values.
9. If the person who desires medical assistance in dying chooses to stay in a Covenant Health facility, the patient/resident is informed that Covenant Health's employees and volunteers do not provide or assist the person to fulfill this desire while the patient/resident is participating in Covenant Health services.
10. Covenant Health does not prevent patients/residents from independently seeking information on medical assistance in dying outside of Covenant Health such as, but not limited to, the AHS Resource Team and Navigator care coordination system.
11. To provide additional administrative and ethics support, and the opportunity for policy monitoring and evaluation, the VP Medicine & Chief Medical Officer and/or

VP Mission, Ethics and Spirituality will be notified of all cases involving the AHS Resource Team and Navigator care coordination system.

Nursing, Pharmacy and Allied Staff:

1. Nursing, Pharmacy and other care staff, including those in Spiritual Care and Social Work, provide the person effective pain and symptom management along with emotional and spiritual support
2. Emotional and spiritual support will also be offered to family members/significant others.
3. Notwithstanding potential evolving roles for Nurse Practitioners and Pharmacists recognized by legislation and the parameters of their respective scopes of practice, the relevant procedural steps identified under Physician Responsibilities and the principles of this policy shall apply.
4. The exercise of conscientious objection as a fundamental right of all personnel, insofar as the person in care is not put at risk of harm or abandonment, shall apply.

C. Documentation

The attending physician and other involved members of the care team as relevant, will document in the medical record a summary of discussion(s) with a person regarding his/her request for medical assistance in dying. This should be in compliance with all regulatory and legal requirements.

D. Consultation Services

If situations arise that present ethical and/or legal issues, contact Ethics Services and/or Legal Services (Risk Management)

**Definitions<sup>5</sup>**

**Advance care planning:** is a process whereby individuals indicate their treatment goals and preferences with respect to care at the end of life. This can result in a written directive, or advance care plan, also known as a living will.<sup>6</sup>

**“Dying with dignity”:** indicates a death that occurs within the broad parameters set forth by the patient with respect to how they wish to be cared for at the end of life. It is NOT synonymous with euthanasia or physician-assisted death.

**Euthanasia:** means knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person's life and that includes the following elements: the subject has an incurable illness; the agent knows about the person's condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.

**Medical aid in dying:** refers to a situation whereby a physician intentionally participates in the death of a patient by directly administering the substance themselves, or by providing the means whereby a patient can self-administer a substance leading to their death.

**Palliative care:** is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other symptoms, physical, psychosocial and spiritual.

**Palliative sedation:** refers to the use of sedative medications for patients who are terminally ill with the intent of alleviating suffering and the management of [intolerable and refractory] symptoms. The intent is not to hasten death although this may be a foreseeable but unintended consequence of the use of such medications. This is NOT euthanasia or physician-assisted death.

**Physician-assisted death:** means that a physician knowingly and intentionally provides a person with the knowledge or means or both required to end their own lives, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. This is sometimes referred to as physician-assisted suicide. Euthanasia and physician-assisted death are often regarded as morally equivalent, although there is a clear practical distinction, as well as a legal distinction, between them.

**Withdrawing or withholding life sustaining interventions:** such as artificial ventilation or nutrition, that are keeping the patient alive but are no longer wanted or indicated, is NOT euthanasia or physician assisted death.

Source: *Canadian Medical Association, 2014*

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<sup>5</sup> The definitions used in this policy are based on the Canadian Medical Association, which were used as a common reference point during a national dialogue and public consultation on end-of-life care. For stylistic reasons only, and to ensure grammatical consistency with this policy, hyphens were purposely added to any reference to “physician assisted suicide”. See: “End-of-Life Care: A National Dialogue, <http://www.cma.ca/advocacy/end-of-life-care>, as well as the link to the CMA policy statement, noted in the Reference section below. The bracket additions on the definition for Palliative Sedation, and the inclusion of Continuous Palliative Sedation Therapy (CPST) have been added, and are not included in the CMA policy statement.

<sup>6</sup> Advance directives are intended to be informative rather than dispositive in nature. Even though a directive may contain a previous expressed wish for physician assisted suicide this does not obligate the Catholic health care organization to compromise its own institutional integrity. See *Health Ethics Guide* (2012), Article 91: “A person’s written or oral health care preferences are to be respected and followed when those directions do not conflict with the mission and values of the organization.”

**Continuous palliative sedation therapy (CPST):** intentional lowering of a patient's level of consciousness in the last one to two weeks of life. It involves the proportional (titrated) and monitored use of specific sedative medications to relieve refractory symptoms and intolerable suffering. Sedation as a consequence of medications used to relieve a specific symptom is not regarded as CPST.<sup>7</sup>

## Related Documents

"Discussion Paper on Euthanasia and Physician-Assisted Dying," *Covenant Health Palliative Institute*, 2013.

*Early Induction of Labour*, Policy VII-B-10, Covenant Health

"Evidence-Based Management Tools, Protocols and Guidelines," *Edmonton Zone Palliative Care Program*. See: <http://www.palliative.org/guidelines.html> (Accessed May 1, 2016)

"Impact of Physician Assisted Death (PAD) within Alberta Health Services Provincial Steering Committee Draft Terms of Reference," *Alberta Health Services*, October 2015.

"Medical Assistance in Dying: Initial Interim Policy Draft," *Alberta Health Services*, May 5, 2016.

"Moral or Religious Beliefs Affecting Medical Care," Standards of Practice, *College of Physicians and Surgeons of Alberta*, no. 29, April 2014: See: <http://www.cpsa.ca/standardspractice/moral-or-religious-beliefs-affecting-medical-care/> (Accessed May 1, 2016).

*Our Commitment to Ethical Integrity* (Code of Conduct), Covenant Health

"Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying: Final Report," November 30, 2015. See: [http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport\\_20151214\\_en.pdf](http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf) (Assessed May 1, 2016)

"Transfer of Care," Standards of Practice, *College of Physicians and Surgeons of Alberta*, no. 41, April 2014. See: <http://www.cpsa.ca/standardspractice/transfer-of-care/> (Accessed May 1, 2016).

<sup>7</sup> Dean <sup>MM1</sup>, Cellarius V, Henry B, Oneschuk D, Librach Canadian Society Of Palliative Care Physicians Taskforce SL. Framework for continuous palliative sedation therapy in Canada. *Journal of Palliative Medicine*, 2012 Aug;15(8):870-9. doi: 10.1089/jpm.2011.0498.

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“Advice to the Profession – Physician-Assisted Death,” *College of Physicians and Surgeons of Alberta*, December, 2015. See: <http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/> (Accessed May 1, 2016).

Cataldo, Peter J. “A Moral Analysis of Cooperating in the Wrongdoing of Physician Assisted Suicide,” Commissioned by the *Catholic Health Alliance of Canada*, March 2016.

“CHPCA Issues Paper on Euthanasia, Assisted Suicide and Quality End-of-Life Care,” April, 2010. See: [http://www.chpca.net/media/7835/PAD\\_Issues\\_Paper\\_-\\_April\\_24\\_2010\\_-\\_Final.pdf](http://www.chpca.net/media/7835/PAD_Issues_Paper_-_April_24_2010_-_Final.pdf) (Accessed May 1, 2016).

*Cooperation and Service Agreement between Alberta Health Services and Covenant Health*, 2010.

“CMA Policy Statement: Euthanasia and Assisted Suicide.” Ottawa: *Canadian Medical Association, Update 2014*. See: [https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA\\_Policy\\_Euthanasia\\_Assisted%20Death\\_PD15-02-e.pdf](https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf) (Accessed May 1, 2016).

*End-of-Life Care: A National Dialogue*, Ottawa: *Canadian Medical Association*, 2014. See: <https://www.cma.ca/Assets/assets-library/document/en/advocacy/end-of-life-care-report-e.pdf> (Accessed May 1, 2016).

Furton, Edward J. “Physician-Assisted Suicide and Euthanasia.” *Catholic Health Care Ethics: A Manual for Ethics Committees*, Peter J. Cataldo and Albert S. Moraczewski, OP, eds. Chapter 13 (Boston: National Catholic Bioethics Center, 2002).

*Health Ethics Guide*, Ottawa: Catholic Health Alliance of Canada, 2012.

“Physician-Hastened Death, Category Archives.” *Canadian Society of Palliative Care Physicians*. See: <http://www.cspcp.ca/category/physician-hastened-death/> (Assessed May 1, 2016)

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**Revisions**

N/A