Covenant Health	**Responding to Requests for Medical Assistance in Dying**	**Corporate Policy & Procedures Manual**
		Policy No. VII-B-440
		Date Approved September 12, 2017
Approved by: Vice President Medicine and Chief Medical Officer; Vice President, Mission, Ethics and Spirituality		**Date Effective** September 15, 2017
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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 live through suicide, or who voluntarily requests administration of a lethal medication resulting in their own death. These are collectively referred to as medical assistance in dying.[1]

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. Covenant Health's ethical, moral, and conscientious objection 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 persons in our care 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;

[1] For the purposes of this policy, "medical assistance in dying" is used consistent with Parliament of Canada Bill C-14 and Alberta Health Services' Medical Assistance in Dying program. It refers to 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 request of the patient. References to "physician-assisted suicide," "physician-assisted death," and "medical aid in dying" are also cited in the literature, among others such as the Canadian Society of Palliative Care Physician's Category Archives on physician-hastened death at: http://www.cspcp.ca/category/physician-hastened-death/.

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;

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

4. Providing ethics services and support through the Covenant Health Ethics Centre.

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. 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 related only to dying. A person who may be experiencing deep existential anguish needs to be appropriately supported to acknowledge, address, and ameliorate their suffering. The goal of care is to reduce such suffering.

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 appropriate personnel to explore and attempt to ascertain the nature of the person's expressed request.[2] 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 which they morally object, or that is 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.

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 (AHS) and Covenant Health.

Covenant Health is morally and legally bound to work together with patients, families and personnel to resolve potential conflict around the goals of care and find proactive solutions that seek to respect the wishes and integrity of all. In response to both a patient/resident's consented request and an external provider arrangement to assume care of the patient/resident, this may require safe and timely transfer of the patient and their records to a non-objecting institution for continued exploratory

[2] 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."

discussion and assessment.[3] Consistent with Covenant Health's mission and values, our involvement in such patient/resident and external provider requested transfers should be provided in a compassionate and respectful manner. In some cases, due to extreme medical fragility of the person in our care, or when the risk of interrupting or suspending concurrent specialized therapies would cause harm, we may allow onsite assessment of eligibility by AHS personnel.

Procedure

A. Responsible Parties

This policy recognizes the long standing Catholic moral tradition of neither prolonging death by subjecting persons to disproportionately burdensome, medically inappropriate or futile treatments, nor intentionally hastening death through assisted suicide and/or voluntary euthanasia. Our response to persons requesting medical assistance in dying therefore must be timely, compassionate and appropriate, in congruence with our institutional identity and tradition.

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 will be encouraged to fully explore and discuss care and treatment options for patients/residents.

4. Covenant Health respects the rights of patients/residents/caregivers and clinicians to explore all treatment options, but fully expects that patients/residents and clinicians 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.

B. Specific Inpatient Physician/Nurse Practitioner, Administrative and Other Personnel Responsibilities

Physician and Nurse Practitioner Responsibilities:

1. When a person verbalizes a request for medical assistance in dying, the attending physician, and/or nurse practitioner will be notified.

2. The attending physician and/or nurse practitioner must review the person's medical status and seek to understand the person's reasons for the request. Additionally:

[3] 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 health xcare organization and the conscience rights of its personnel to not provide or directly refer explicitly for same.

a) The attending physician and/or nurse practitioner will discuss the full range of treatment options with the person, including all factually relevant information,[4] inclusive of reference to Covenant Health's policy on medical assistance in dying. This may require responding to basic questions about assisted suicide and/or voluntary euthanasia, and directing those inquiring to where additional public information can be found.

b) This response may also require consultation with other health care personnel to assess the person's decision-making capacity, and to provide emotional and spiritual support, as indicated.

3. Covenant Health encourages physicians, nurse practitioners and patients/residents and/or their substitute decision-makers 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 within the Covenant Health environment including palliative and hospice services for comfort and support as appropriate.

5. When, after discussion with the attending physician or nurse practitioner, the patient/resident still expresses a desire to further explore medical assistance in dying, alternatives will be explored with clear communication that such practice is not provided in Covenant Health facilities. The person may choose to involve the AHS Care Coordination Service either through Health Link (811), or by asking Covenant Health to contact AHS at their request (see www.ahs.ca/MAID for a link to resources). Covenant Health understands what is intended to be provided is information and further exploratory discussion of options, including identification/facilitation of capacity and mental health assessments.

6. Once a discussion (on-site or teleconference) with the AHS Care Coordination Service has taken place, the patient/resident may subsequently request that this team help them navigate access to external providers. The Care Coordination Service would be responsible to arrange transfer from Covenant Health to a non-objecting institution for further assessment of eligibility. These arrangements will be made directly between the person and the AHS Care Coordination Service and Navigator, without Covenant Health participation.

7. Signing and witnessing of the Alberta Health document "Record of Request" including formal assessments of eligibility for medical assistance in dying are not permitted on Covenant Health sites. However, exceptional circumstances under which the AHS Care

[4] 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."

Coordination Service might be allowed to arrange signing of a "Record of Request" or to conduct an assessment of eligibility onsite are:

a) The person in care is extremely medically fragile and unable to endure offsite assessment involving multiple transfers without risk of serious harm, even the potential of inadvertently hastening their death; or

b) The person in care is receiving concurrent specialized treatment and palliation only provided at a Covenant site that cannot be interrupted or suspended without harm to the patient.

8. Throughout the process, Covenant Health will continue to provide ongoing treatment and care to a person while they are in our facilities. This would be to the point of time when an external provider has indicated they are assuming total care of the person, and either:

   - a transfer of the patient/resident and records has been completed to a non-objecting institution; or
   - the person requests discharge home.

9. Responding to a person's clearly consented wish to be released of their care by Covenant Health and its personnel must always be timely, safe, compassionate, and respectful, through non-coercive and non-discriminatory dialogue, in accordance with Covenant Health's mission and values.

Administrative Responsibilities:

1. Senior Director, Operations (or appropriate clinical designate) will serve as the main point of contact with the AHS Care Coordination Service and address questions arising, in keeping with the principles outlined in this policy. Escalation to the VP Medicine or to the VP Mission, Ethics and Spirituality is available, as required.

2. Senior Director, Operations (or appropriate clinical designate) must notify the Ethics Centre staff at (780) 342-8021, 1 (855) 497-5353 or by email at ethicscentre@covenanthealth.ca for monitoring and statistical purposes, as well to provide additional ethics consultation support, as required.

Nursing, Pharmacy, Allied Staff and other involved personnel:

1. Personnel will respond to inquiries about medical assistance in dying with compassion and respect. This includes listening to the person to ensure they feel heard and bringing inquiries forward to the appropriate member of the health care team.

2. Nursing, Pharmacy and other care staff, including those in Spiritual Care and Social Work will continue to provide effective pain and symptom management along with emotional and spiritual support for the patient/resident.

3. Emotional and spiritual support will be offered to family members/significant others, as required.

4. Pharmacy staff will not be involved in providing medications intended for medical assistance in dying, either directly or indirectly.

5. Regarding transfers, Covenant Health Integrated Access will hold the patient/resident's bed until confirmation has been received from the AHS Care Coordination Service that the person has undergone MAID and is deceased, or alternate arrangements have been made and the person will not be returning to Covenant Health.

6. 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 or nurse practitioner, and other involved members of the care team will document in the medical record a summary of discussion(s) with a person regarding their request for medical assistance in dying when such discussions occur. This should include all relevant information that would normally be documented as a statement of fact in compliance with regulatory and legal requirements to ensure safe management of the person's care. Documenting the scheduling of eligibility assessments, or potential transfer arranged by the AHS Care Coordination Service Team would therefore be expected, including any other required contact information to ensure timely communication.

Assessments of eligibility for the specific purposes of medical assistance in dying (excluding assessment of decision-making capacity) must not be documented on Covenant Health charts. As stated in the AHS *Comprehensive Clinical Guide for Medical Assistance in Dying for Physicians and Nurse Practitioners,* if a patient is admitted to a non-participating site, such as Covenant Health, the form is to be retained by the AHS Care Coordination Service. It is the sole responsibility of AHS personnel to produce, document, and retain such records as it relates to their processes of medical assistance in dying.

D. Consultation Services

If situations arise that present ethical and/or legal issues, Ethics Services and/or Legal Services (Risk Management) shall be contacted. The Critical Incident Stress Management Team (CISM) or the Employee Family Assistance Program (EFAP) can be contacted for additional individual or group support as needed.

Definitions[5]

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.[6]

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.[7]

"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[8].

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[9] 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.

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[5] 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, https://www.cma.ca/Assets/assets-library/document/en/advocacy/end-of-life-care-report-e.pdf 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.

[6] 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."

[7] Dean MM, Cellarius V, Henry B, Oneschuk D, and Librach L., "Framework for continuous palliative sedation therapy in Canada." *Journal of Palliative Medicine*, 2012 Aug; 15(8):870-9.

[8] While Covenant Health agrees with this definition, there are other groups and persons who define dying with dignity as inclusive of euthanasia or physician assisted death.

[9] Recognizing that intending or aiming to improve quality of life is not always possible.

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 life, 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*

Related Documents

"Comprehensive Clinical Guide for Medical Assistance in Dying for Physicians and Nurse Practitioners," *Alberta Health Services,* February, 2017. See: http://www.albertahealthservices.ca/assets/info/hp/maid/if-hp-maid-clinical-guide.pdf (Accessed July 26, 2017).

"Conscientious Objection" (formally issued as "Moral or Religious Beliefs Affecting Medical Care),"Standards of Practice, *College of Physicians and Surgeons of Alberta,* June 2016. See: http://www.cpsa.ca/standardspractice/conscientious-objection/ (Accessed July 26, 2017).

"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 July 26, 2017).

"Medical Assistance in Dying (MAID) – Advice to the Profession," *Alberta College of Pharmacists.* June 6, 2016. See: https://pharmacists.ab.ca/medical-assistance-dying-maid (Accessed July 26, 2017).

"Medical Assistance in Dying: Guidelines for Nurses in Alberta" *CARNA Provincial Council (*College & Association of Registered Nurses of Alberta, College of Licensed Practical Nurses of Alberta, College of Registered Psychiatric Nurses of Alberta), March, 2017.
See:
http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/Guidelines/MAIDGuidelinesForNurses_March2017.pdf
(Accessed July 26, 2017).

"Medical Assistance in Dying – Information for Social Workers," *Alberta College of Social Workers,* December 20, 2016. See:
http://acsw.in1touch.org/company/roster/companyRosterDetails.html?companyId=24355&companyRosterId=53
(Accessed July 26, 2017).

"Medical Assistance in Dying Policy," *Alberta Health Services,* May 5, 2016. See: https://extranet.ahsnet.ca/teams/policydocuments/1/clp-med-assist-in-death-hcs-165-01.pdf (Accessed July 26, 2017).

"Ministerial Order #38/2016 Medical Assistance in Dying Review Committee," *Minister of Health,* Alberta, June 7, 2016. See: http://www.health.alberta.ca/documents/MO-38-2016-MAID-Reg-Review-Committee.pdf (Accessed July 26, 2017).

"Nurse Practitioner Standards of Practice for Medical Assistance in Dying," *College & Association of Registered Nurses of Alberta,* December 13, 2016). See: *http://www.albertahealthservices.ca/assets/info/hp/maid/if-hp-maid-nurse-practitioners.pdf*
(Accessed July 26, 2017).

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
(Assessed July 26, 2017)

"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 Jul 26, 2017).

References

"A Catholic Perspective on Health Decisions and Care at the End of Life," Ottawa: *Catholic Health Alliance of Canada*, 2014.

"Advice to the Profession – Medical Assistance in Dying (MAID)," *College of Physicians and Surgeons of Alberta,* July, 2016. See: http://www.cpsa.ca/wp-content/uploads/2016/06/AP_Medical-Assistance-in-Dying.pdf
(Accessed July 26, 2017).

Bill C-14, "An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), *Statutes of Canada,* Assented to June 16, 2016. See: http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent (Accessed July 26, 2017).

"A Moral Analysis of Cooperating in the Wrongdoing of Physician Assisted Suicide," *Cataldo, Peter J.,* 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 (Accessed July 26, 2017).

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 (Accessed July 26, 2017).

"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 July 26, 2017).

"Physician-Assisted Suicide and Euthanasia," Furton, Edward J. *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 July 26, 2017).

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

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