

 Covenant Health	Responding to Requests for Medical Assistance in Dying	Corporate Policy & Procedures Manual
		Policy No. VII-B-440 Date December 3, 2018
Approved by: Chief Medical Officer Chief Mission and Ethics Officer		Date Effective December 3, 2018
		Next Review (3 years from Effective Date) December 2021

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 voluntarily requests assistance to intentionally end their own life, or who voluntarily requests administration of a lethal medication resulting in their own death. The fulfilment of these acts, when complying with Canadian law are collectively referred to as medical assistance in dying (MAID).¹

Policy Statement

As a Catholic health care organization, Covenant Health is committed to uphold the inherent dignity of every human being throughout the entire continuum of life from conception to natural death. Therefore, Covenant Health will not provide nor explicitly refer for MAID given the incompatibility of MAID with the organization’s mission and ethical tradition. At the same time, Covenant Health is committed to the principles of justice and non-abandonment, and thus must ensure persons in our care seeking further information, assessment, and potentially, provision of MAID are able to access navigation resources within the health system which can facilitate these processes independently of Covenant Health.

This balancing of rights that respects the interests of all without compromising personal or institutional integrity equally expresses Covenant Health’s mission and tradition of service.

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”) when acting on behalf of Covenant Health or at one of our facilities. It does not apply to a health practitioner whose practice is conducted external to Covenant Health, such as 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. Questions of actual or perceived conflict of interests raised while acting simultaneously on behalf of Covenant and an external provider must be declared and managed appropriately among the clinical care team.

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, sometimes known as *assisted suicide*, 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/wp-content/uploads/2015/10/CSPCP-Key-Messages-FINAL.pdf> (Accessed Nov 27, 2018)

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 advance 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, at the patient/resident's or families' request and agreement, 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 MAID must be respectfully acknowledged in a non-coercive and non-discriminatory manner. The response should focus on providing information and access to appropriate physical, psychological and spiritual supports, as requested, 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 through the deliberate prescribing or administration of a lethal agent.² The values of Covenant Health nevertheless ethically oblige appropriate personnel to explore and seek to understand the nature of the person's expressed request, and to provide unconditional support.

As affirmed in *Our Commitment to Ethical Integrity* and in the *Health Ethics Guide*, including the standards of practice of regulated members, Covenant Health will support those in good conscience who cannot participate in an activity to 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 circumstances on a case-by-case basis and exercising prudential judgment. At minimum, provision of information on MAID to the patient/resident, and ensuring reasonable access to the Alberta

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."

Health Service Care Coordination Service for further exploratory discussion is required.

Covenant Health is morally and legally bound to work together with patients/residents, 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/resident and their records to their home or to a non-objecting institution which can support the provision of MAID.³ Consistent with Covenant Health's mission and values, our interaction in such patient/resident and external provider requested assessments or transfers should be conducted in a compassionate and respectful manner.

While Covenant Health will not participate in the formal eligibility determination or provision of MAID, it is recognized that various components of the determination phase undertaken by the Alberta Health Services Care Coordination Service of such medically fragile patients/residents will take place on Covenant sites (e.g., witnessing and signing of legal documents, assessments of eligibility, or transfer of care arrangements). That is a matter solely organized and arranged between the patient/resident and AHS personnel within the privileged relationship they share, for whom this aspect of care has been assumed by AHS within the mandate of the Care Coordination Service.

Similarly, in those instances when the patient/resident chooses to coordinate their own arrangements for determining eligibility and provision of MAID, this too is conducted within the privileged relationship the person has with the community assessor and/or provider. Timely and respectful access of community practitioners to Covenant Health sites would be expected to conduct assessments for eligibility, and potentially, to assume responsibility in transferring the patient/resident to another facility or home for provision of MAID. Covenant Health personnel would be required to ensure a written release of care is signed, and to support the patient/resident-initiated transfer, as per standard of practice.

Covenant Health, however, will not allow the provision of MAID on Covenant property at any time given the incompatibility of MAID with Covenant's mission and ethical tradition.

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 MAID therefore must be timely, compassionate and appropriate, while respecting 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 including the right to accept

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 care organization and the conscience rights of its personnel to not provide or directly refer explicitly for same.

- 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 MAID, 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 available options, but fully expects that patients/residents/caregivers and clinicians will respect 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:

See also the professional obligations of regulated members under each respective *body's Standard of Practice*.⁴

1. When a person verbalizes a request for MAID, the attending physician, and/or nurse practitioner will be promptly notified. The information and support provided will be guided by the patient/resident's or families' needs or explicit requests. In some settings, this may also require concurrent notification of other allied staff, including Social Work.
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:
 - a) The attending physician and/or nurse practitioner will discuss the full range of available options with the person, including all factually relevant information⁵ as would be expected with any end of life discussion. This may require responding to questions about MAID, as well as Covenant Health's relevant policy. It may also require other information sources being left with the person such as those available from AHS.
 - b) This response may require consultation with other health care personnel to assess the person's decision-making capacity, to be cognizant of particular circumstances of vulnerability that might motivate choices, and to provide emotional and spiritual support, as indicated.

⁴ <http://www.cpsa.ca/standardspractice/medical-assistance-dying/> and <http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/Standards/MAID-standards-for-NPs.pdf> (Accessed Nov. 27, 2018).

⁵ 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."

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 discuss 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 MAID, alternatives will be explored with clear communication that the actual provision of MAID is not done in Covenant Health facilities. The patient/resident 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).
6. Once a discussion 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 for further assessment of eligibility.

These arrangements will be made directly between such medically fragile individuals and the AHS Care Coordination Service and Navigator without Covenant Health participation, other than ensuring AHS access to the site and an appropriate location or means (e.g., telehealth) for conversations to take place and/or education materials to be left.

Personnel with joint privileges acting simultaneously on behalf of Covenant as well as an external provider which raises questions of perceived or actual conflicts of interest must be declared and managed appropriately among the clinical care team.

7. The AHS Care Coordination Service will assume responsibility for those aspects of the MAID process within their mandate and which are not otherwise able to be coordinated directly by the requesting individual and/or their family/supports. This includes witnessing and signing of the "Record of Request," and arrangements for conducting formal assessments of eligibility and potential transfers. It is understood that such activities may occur on Covenant Health sites but will not be arranged by Covenant staff.

It is expected that assessments conducted by the AHS Care Coordination Service on a Covenant Health site would be held in an appropriate setting, including, but not limited to the patient or resident's room, or a private meeting room at a Covenant Health facility if that is more appropriate for the assessment.

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 explicitly requested they are assuming total care of the person, and either:

- a) A transfer of the patient/resident and records has been completed to a non-objecting institution; or
 - b) The person is transferred home.
9. Responding to a person's clearly consented written request 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.
 10. Physicians and nurse practitioners are expected to comply with all federal and provincial regulatory reporting requirements that have been established when in receipt of a written request for MAID. For more information on these legal obligations, see the AHS website, MAID Reporting for Alberta Practitioners at: <https://www.albertahealthservices.ca/info/Page16124.aspx> as well as: <https://www.albertahealthservices.ca/assets/info/hp/maid/if-hp-maid-faq.pdf>

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 Chief Medical Officer or to the Chief Mission and Ethics Officer 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. Current internal reporting on date of known requests, location of and reason for transfers, and other supports provided to patient/residents will be reconciled quarterly with Alberta Health Services to ensure data integrity.

Nursing, Pharmacy, Allied Staff and other involved personnel:

1. Personnel will respond to inquiries about MAID 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, Allied Staff and other involved personnel, 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, including for the care team.
4. Pharmacy staff will not be involved in providing medications intended for MAID, 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 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 MAID 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 (e.g., the CPSA Standards of Practice). 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.

When MAID assessments are completed by AHS at a Covenant Health site, the AHS assessor is encouraged to make notes in the patient/resident chart to ensure continuity of care and good team communication. They may wish to indicate in the progress notes that the assessment was done, or to make suggestions to the most responsible practitioner about enhancements to the existing care that would improve the patient or resident's care.

The AHS Care Coordination Service will store all forms and assessments electronically within AHS systems on a secure drive, accessible only to the navigation teams and the AHS clinical lead for MAID.

D. Consultation Services

If situations arise that present further ethical and/or legal issues, the Chief Medical Officer or Chief Mission and Ethics Officer shall be contacted about questions around the application of this policy. After consulting Covenant Health, AHS and other relevant stakeholders, the Chief Medical Officer or Chief Mission and Ethics Officer may provide advice or direction concerning the interpretation or application of this policy.

Clinical Ethics, Legal Services, the Critical Incident Stress Management Team (CISM), Social Work, or the Employee Family Assistance Program (EFAP) can be contacted for additional individual or group support as needed.

Definitions⁶

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.⁷

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.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 improves⁹ 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 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,

⁶ 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> (Accessed November 27, 2018), 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.

⁷ 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."

⁸ 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.

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

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.

“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 November 27, 2018).

“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 November 27, 2018).

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“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 November 27, 2018).

“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 November 27, 2018).

“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 November 27, 2018).

“Medical Assistance in Dying – MAID,” Covenant Health CEO video interview series, November 2018. See: <http://www.compassionnet.ca/Page4921.aspx> (Accessed November 27, 2018).

“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 November 27, 2018).

“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 November 27, 2018).

“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 November 27, 2018).

“Order in Council O.C. 142/2016 June 10, 2016” Order respecting Medical Assistance in Dying Standard of Practice for Physicians. See: http://www.qp.alberta.ca/documents/orders/Orders_in_Council/2016/616/2016_142.html (Accessed November 27, 2018)

“Order in Council O.C. 320/2016 December 6, 2016” Order respecting Medical Assistance in Dying Standards of Practice for Nurse Practitioners. See: http://www.qp.alberta.ca/documents/orders/Orders_in_Council/2016/1216/2016_320.html (Accessed November 27, 2018).

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 (Accessed November 27, 2018).

“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 November 27, 2018).

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“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.

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“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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“Medical Assistance in Dying,” Standard of Practice, *College of Physicians and Surgeons of Alberta*, June 2016. See: <http://www.cpsa.ca/standardspractice/medical-assistance-dying/> (Accessed November 27, 2018).

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Revisions

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