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Template Policy Re: Access to Medical Assistance in Dying in Publicly-Funded Institutions

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TEMPLATE POLICY RE: ACCESS TO MEDICAL ASSISTANCE IN DYING IN PUBLICLY-FUNDED INSTITUTIONS

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<u>Patient access to Medical Assistance in Dying in publicly-funded institutions in [insert location]</u>

Limitation on scope

This policy does not address the issue of healthcare providers who have a religious or conscientious objection to MAiD. The conduct of such providers is governed by their professional regulatory bodies and employment arrangements with the institutions.

Terminology

"objecting institution" means a publicly-funded institution whose leadership has officially and publicly expressed an objection to MAiD in the name of the institution.

"harm" includes physical or psychological suffering, significant social dislocation, and risk of loss of capacity. Any dispute in the assessment of whether the consequences of patient transfer or refusal to admit a patient constitute harm must be taken by the objecting institution to the [title of clinical person in charge of] the [insert location] Medical Assistance in Dying Program ([insert location] MAiD Program) who must make a determination in writing sent to the patient and the objecting institution.

"undue delay" means a delay that is unreasonable in the circumstances of the patient. Any dispute in the assessment of whether a delay is undue must be taken by the objecting institution to the [title of clinical person in charge of] the [insert location] MAiD Program who must make a determination in writing sent to the patient and the objecting institution.

Process

1. If a religious or conscientious objection to medical assistance in dying (MAiD) has not been officially and publicly expressed by the leadership of a publicly-funded institution, that institution must allow eligibility assessments for, and the provision of, MAiD within its walls. The institution need not provide the staff for MAiD but must allow MAiD assessors and providers to enter the institution to discuss all end of life care options with the patient and, if desired by the patient, conduct assessments and, if the patient qualifies and so requests, provide MAiD. Transfer or refusal to admit the patient based on a patient's inquiries, wishes, or request for MAiD is not permitted by such institutions.

2. If a religious or conscientious objection to medical assistance in dying (MAiD) has been officially and publicly expressed by the leadership of a publicly-funded institution, that institution must follow the process outlined below:

    a. If the patient is within the catchment area for the objecting institution but is not yet an in-patient at the objecting institution, after receiving a request for admission, the objecting institution must contact the [insert location] MAiD Program and the [insert location] MAiD Program will determine whether the patient can be admitted to a non-objecting institution without undue delay or harm to the patient and

        i) if the patient can be admitted to a non-objecting institution without undue delay or harm to the patient, the Program will make arrangements for the patient to be admitted to that non-objecting institution; and
        ii) if the patient cannot be admitted to a non-objecting institution without undue delay or harm to the patient, the objecting institution must admit the patient.

    b. If the patient is an in-patient at the objecting institution, the objecting institution must contact the [insert location] MAiD Program and the [insert location] MAiD Program will determine whether the patient can be transferred to a non-objecting institution without undue delay or harm to the patient and

        i) if the patient can be transferred to a non-objecting institution without undue delay or harm to the patient, the Program will make arrangements for a transfer to that non-objecting institution;
        ii) if the patient cannot be transferred to a non-objecting institution without undue delay or harm to the patient, the objecting institution must allow MAiD assessors and providers to enter the objecting institution to discuss all end of life care options with the patient and, if desired by the patient, conduct assessments and, if the patient qualifies and so requests, provide MAiD.

Any objecting institution must contact the [insert location] MAiD Program whenever a patient makes inquiries about MAiD. The [insert location] MAiD Program will then ensure that all appropriate arrangements are made. The objecting institution is not required to provide resources for assessments for or provision of MAiD (e.g., the provider will bring the medications with them if providing MAiD).

Illustrative scenarios

Please note: In order to maintain patient confidentiality, the following scenarios are fictional.

Permissible refusal to admit

Michael Hutchins was diagnosed with ALS 4 years ago. Since that time, he has slowly lost motor function and now requires a motorized wheelchair. He is slowly losing the motor function for his speech. His cognitive facilities are completely intact. His greatest fear is losing the ability to breathe and requiring constant mechanical breathing support. He would like MAiD to occur before he loses his ability to breathe. Over the past few weeks he has noticed his breathing has become more laboured. A physician and a nurse practitioner have conducted the necessary assessments and have concluded that he meets the eligibility criteria for MAiD. He does not want to die at home. His local hospital has publically stated that it has religious objections to MAiD. He would prefer to be admitted to his local hospital. However, there is another hospital 50 km away which is supportive of patients requesting MAiD and has a bed available. Michael's family have all returned home to say their final farewells and have the ability to make the 50 km journey to the supportive hospital. Michael has no pressure sores or other reasons to expect the journey to be painful or to pose a risk to his decision-making capacity.

Permissible transfer

Fiona Horne was diagnosed with COPD ten years ago. Since that time, her ability to breathe has steadily declined. She has been on supplemental home oxygen over the past two years and her supplemental home oxygen demands have steadily increased. Following a recent bout of influenza, she suffered a severe acute exacerbation of her COPD which required admission to hospital for high flow supplemental oxygen demands. Even with supplemental oxygen, she becomes severely short of breath with any activity including washing, eating, or toileting. She is completely bedbound without two-person assistance. Years ago, she had said she would want MAiD once her breathing had become too difficult and she was completely bedbound. She has reaffirmed her desire for MAiD. The hospital where she is admitted has publically stated that is has religious objections to MAiD. Her physicians agree that the supplemental oxygen provided in ambulance would be sufficient to meet her current oxygen demands. She has no other medical issues that would cause pain or suffering associated with her transfer to the closest supportive hospital 100 km away. Her family live throughout [insert location] and can travel to the hospital to visit her while she goes through MAID assessments and, if she is found to be eligible, can travel to say their final farewells.

Impermissible refusal to admit

Sarah Knowles was diagnosed with breast cancer ten years ago. She has suffered through ten years of treatment with variable success. A year ago, her physicians informed her that her cancer was no longer curable and advised palliative treatment. She has metastases to the bone and lung. She also suffers with severe rheumatoid arthritis which causes her incredible pain.

She has requested MAiD and after two at home assessments, she has been found to be eligible. Her home has been in her family for generations and she wishes to leave her home to her only daughter. She does not want her daughter's memory of her mother's death to be associated with the home that her daughter will subsequently live in. She has requested MAiD at the local hospital less than a kilometer away. The local hospital is officially and publicly an objecting institution. The nearest supportive hospital is 100 km away. The supportive hospital does not have any available beds and likely won't for ten days. There is a serious risk that Sarah will lose her decision-making capacity sometime within that window.

Impermissible transfer

Bill Harvey was diagnosed with prostate cancer 5 years ago. Despite radical surgery, many rounds of chemotherapy and radiation, his cancer has metastasized and become incurable. He has metastases to bone and lung. His lung metastases have impaired his breathing. His bony metastases cause him incredible pain throughout his upper arms, ribs, spine and legs. He has suffered compression fractures throughout his spine as a result of his spine metastases. Due to his breathing problems and weakened state, he has been bedbound for nearly 4 months. During that time, he has developed a large bed sore is his sacral region (far lower back). This sore is about 4 centimetres in diameter and its depth is near to bone. Any friction over this area causes incredible burning pain to sear through Bill's body. Any pressure over the areas of bone metastasis cause Bill pain on par with a fracture. He was recently admitted to hospital due to sepsis arising from his bed sore. He has requested MAiD but the hospital where he is admitted has publically stated it is opposed to MAiD on religious grounds. The closest supportive hospital is 100 km away.

In order to transfer Bill, there were many required procedures that cause severe pain and suffering. First, the medical team needed to roll Bill onto his side causing pressure to shoulder and ribs with bone metastases. While painless for a healthy person, this felt like a breaking bone at the site of the metastases. He then had to have a transfer pad slid under his body and he was rolled back to his back on top of the transfer pad. He was then slid from his hospital bed to the paramedic's stretcher across the transfer pad. While the transfer pad reduced some friction, the remaining friction was still excruciating to his sacral bedsore. It was similar to running coarse sandpaper over a blistered burn. Bill then needed to be rolled onto his opposite side to remove the transfer pad. Again, this caused excruciating pain to his bony metastases.

Bill was then strapped to the paramedic stretcher. While the paramedics took all measures to be as gentle as possible, Bill still needed to be securely strapped to the stretcher to ensure safe transfer and minimize pain over the many bumps on the road. The pressure of these straps across his chest and hips felt like incredible tension across his weakened bones and severe gnawing pain at the sites of his bony metastases. This pain continued throughout the transfer.

The paramedics wheeled the stretcher to the elevator and then to the ambulance. They needed to collapse the stretcher down as it entered the ambulance. The inevitable motions of this positioning jarred Bill against the stretcher and straps. He felt a crack in his back and severe

shocks of pain throughout his spine. He had multiple compression fractures from his spine metastases. One of these compression fractures had shifted in the movement resulting in pain on par with an acute spinal fracture.

While Bill had access to titratable intravenous analgesics in hospital (patient controlled pain medication through a specialized IV pump), this was not available in the ambulance so his pain was not be able to be controlled at the same level as in hospital. While the paramedics had access to analgesics (pain-killers) and had training in pain relief, it did not compare to the specialized care that could have been delivered by palliative care nurses in hospital.

The paramedics provided some IV analgesic to Bill but they had to be sparing because the medications can cause respiratory depression (breathing problems) and Bill's lungs had already been weakened by his cancer and if they gave too much, the drugs could have caused him to stop breathing and thereby caused brain damage. A lot of care needed to be taken throughout the transfer to avoid brain damage. The paramedics worried that if Bill suffered brain damage he might lose the cognitive capacity to be able to consent to MAiD. If he lost capacity, he would be left suffering for many weeks while waiting for his cancer to slowly kill him. The IV medications helped a little but Bill's bed sore was still burning and the pain was radiating throughout his upper legs, abdomen and back. As well, the crushing pain of the stretcher straps still left him gasping for air.

The pain from the compression fractures resonated with every bump on the road. Every bump on the road also caused a worsening of the pain in every bony metastasis, the searing pain at his bed sore, and the crushing pressure from the stretcher straps.

After about 50 km over turns, bumps and jarring movements, the paramedics had trouble balancing the IV analgesics and Bill's oxygen levels. Despite their best efforts, Bill entered a pain crisis (when a combination of pain sensations overwhelm the sensory system) and was constantly screaming out in pain. The paramedics had no choice but to provide more IV pain medication. The increased pain meds stopped the screaming but Bill lost consciousness from the combination of extreme pain and sedating effects of the IV medications. His breathing slowed. The paramedics attempted various airway management techniques but Bill's oxygen levels dipped.

Throughout the rest of the journey Bill was in varying states of consciousness. When awake, he was in incredible pain, when unconscious his oxygen levels decreased. He arrived at the receiving hospital and had to repeat the same series of painful procedures all over again: removal from the ambulance, rolling to the side for placement of transfer pad, sliding from stretcher to bed, and rolling to remove the transfer pad. He was taken directly to the emergency department for airway assessment. After many hours, Bill's oxygen levels stabilized. His pain was still very severe but he was no longer screaming in pain. Unfortunately, he had suffered an anoxic brain injury (brain damage from low oxygen) and, while still conscious, did not have sufficient cognitive capacity to consent to MAiD. He lived the next six weeks suffering through the final stages of his cancer.