Cliff # (John has already created the cliff #)

All Health Authority Chief Executive Officers

RE: Ministry of Health Policy Communiqué 2017-0_: Access to and Care Coordination of Medical Assistance in Dying.

In June 2016, medical assistance in dying became legal in Canada, as long as eligibility criteria are met and safeguards are followed. Since then, the provincial health sector has implemented this new health service in a manner that is respectful of patients and families, sensitive to the concerns of health care providers, and follows both federal and additional provincial protections.

As discussed and approved by Leadership Council on…, I am pleased to share with you *Ministry of Health Policy Communiqué 2017-0_: Access to and Care Coordination of Medical Assistance in Dying* (the policy) developed in collaboration with health authority and regulatory college representatives from the provincial Medical Assistance in Dying Working Group. This policy supports a provincially consistent and patient-centred approach to access to medical assistance in dying. The policy also builds on the direction provided to you by the Minister of Health, in his letter of June 3, 2016 (cliff # 1057216), which required health authorities to put a care coordination service in place to assist individuals and health care providers in navigating access to medical assistance in dying.

Leadership Council has approved a "soft-launch" approach to implementation of the policy, to ensure a short period of time is allocated to work with stakeholders (e.g. BC Hospice and Palliative Care Association, BC Centre for Palliative Care, and contracted residential care organizations) to communicate the policy and develop an implementation plan. Health authorities may need time to work with contracted organizations that receive the majority of their funding from a health authority, to ensure medical assistance in dying is accessible.

I encourage you to continue to closely monitor the implementation and delivery of medical assistance in dying in your health authority, and ask that you contact Ian Rongve, Assistant Deputy Minister, Hospital, Diagnostic and Clinical Services Division, should your health authority face challenges related to medical assistance in dying or compliance with this policy. Ian Rongve may be reached by telephone at: (250) 953-4504, or email: Ian.Rongve@gov.bc.ca.

Your continued support in implementing and monitoring this new service is appreciated.

Sincerely,

Ministry of Health Office of the Deputy Minister PO Box 9639 STN PROV GOVT
Victoria BC V8W 9P1

Steve Brown
Deputy Minister

Attachment

BRITISH COLUMBIA

MINISTRY OF HEALTH

POLICY COMMUNIQUÉ

COMMUNIQUÉ

TO:

TRANSMITTAL DATE:

COMMUNIQUÉ NUMBER:

CLIFF NUMBER:

SUBJECT: Access to and Care Coordination of Medical Assistance in Dying (MAiD)

DETAILS:

EFFECTIVE DATE:

MINISTRY CONTACT:

Stephen Brown
Deputy Minister
Ministry of Health

Ministry of Health
Access to and Care Coordination of Medical Assistance in Dying (MAiD)
2017

BRITISH COLUMBIA

Ministry of Health
Policy Instrument

Type:	**Specific Directive**
Policy Name	**Access to and Care Coordination of Medical Assistance in Dying**

Version	
Effective Date:	
Division/Branch:	**Hospital, Clinical and Diagnostic Services Division/Acute and Provincial Services Branch**
Ministry Contact:	**Executive Director, Acute and Provincial Services**
Document Number:	
Date:	**May 1, 2018**

Deputy Minister
Ministry of Health

BRITISH COLUMBIA

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

POLICY OBJECTIVE

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

In June 2016, the Ministry of Health informed all Health Authorities Chief Executive Officers of the Province's expectation that all health authorities have a care coordination service in place to provide an additional point of contact for patients who require assistance in navigating access to medical assistance in dying and to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

Expected Impact on Patient/Population Outcomes/Service Attributes

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery.

This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

1. To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.
2. To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.
3. To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Also referred to throughout this policy as a "Contracted Organization", refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code* of Canada, to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code* of Canada, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the Health Authorities Act, and the Provincial Health Services Authority established under the Society Act.

Opt-out: Refers to a decision that may be made by a contracted independent non-denominational facility or organization to not allow the provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

SCOPE

This policy applies to all health authorities. If health authority programs or services are provided through a contracted independent non-denominational facility or organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and staff to ensure

patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

POLICY DIRECTION

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MONITORING & EVALUATION

Performance Monitoring

Implementation, monitoring and progress evaluation will be ongoing to to ensure reasonable access to assessment and provision of MAiD. The Ministry of Health in collaboration with key stakeholders, will monitor and follow up on any barriers to implementation raised by health authorities and key stakeholders. Progress monitoring will be undertaken annually by Ministry of Health, health authorities, and key stakeholders.

In consultation with Ministry of Health and key stakeholders, indicators will be developed to allow for the monitoring and reporting of performance of this policy directive. These indicators will be limited in scope to the impacts to care and services outlined in the Policy Objectives.

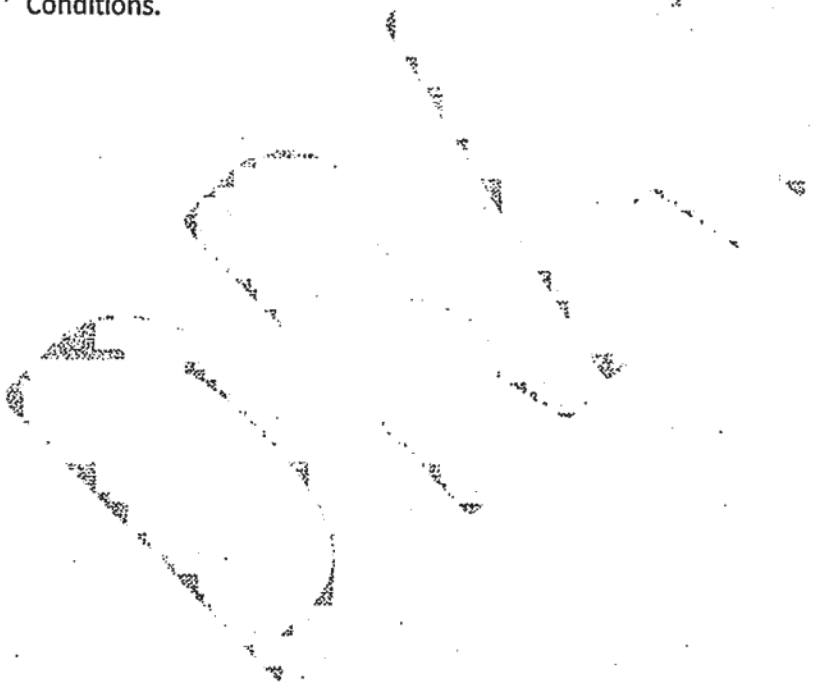
The performance indicators developed for this policy directive will include and/or complement indicators selected to undertake both implementation and outcome evaluations of the MAiD policy and provide insight on the measurable, expected outcomes stated in the Policy Objectives.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed one year from the date of implementation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.

REFERENCES & LINKAGES

- *The Criminal Code of Canada*
- *The Health Professions Act*
- The Master Agreement between the Province of BC and the Denominational Health Care Facilities Association
- Minister of Health direction to Health Authority Chief Executive Officers RE: Health Authority Coordination of Access to Medical Assistance in Dying (1057216)
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Scope of Practice Standards for Nurse Practitioners: Medical Assistance in Dying
- College of Pharmacists of British Columbia: Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.



BRITISH COLUMBIA

1057216

All Health Authority Chief Executive Officers

RE: Health Authority Coordination of Access to Medical Assistance in Dying

On February 6, 2015, the Supreme Court of Canada (SCC) in *Carter v. Canada* struck down the provisions in the *Criminal Code* prohibiting physician-assisted dying. On January 15, 2016 the SCC extended the suspension of its decision for an additional four months from February 6, 2016 to June 6, 2016. However, after June 6, the prohibition on physician assistance in dying will be lifted.

The Ministry of Health is committed to implementation of medical assistance in dying in a manner that is respectful and supportive of patients, families and providers. To facilitate reasonable, safe patient access to this service, all health authorities are expected to have a care coordination service in place.

The care coordination service will provide an additional point of contact for patients who require assistance in navigating access to medical assistance in dying. It will also serve to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

I encourage you to closely monitor the implementation and delivery of medical assistance in dying in your health authority, especially as the legal landscape continues to evolve. I ask that you contact Doug Hughes, Assistant Deputy Minister, Health Services Policy Division, should your health authority face challenges related to the implementation or provision of this service. Mr. Hughes may be reached by telephone at: (250) 952-1049, or by email at: Doug.Hughes@gov.bc.ca.

Your support in implementation of this new service is appreciated.

Sincerely,

Terry Lake
Minister of Health

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1073439

PREPARED FOR: Honourable Terry Lake, Minister - **FOR INFORMATION**

TITLE: Delivery of MAiD in BC

PURPOSE: To seek policy direction on where medical assistance in dying (MAiD) will and will not be required by policy to occur.

BACKGROUND:
Patient-centred care and reasonable access are the principles driving policy development for MAiD.

There is currently debate whether administration of MAiD ought to be offered in specific facilities. It is important to balance the needs and wishes of patients choosing to seek this legal health service, with conscience rights of practitioners, and the rights of various types of service delivery facilities who may be in a position to deliver MAiD.

Conscientious objection for health care providers is protected by federal law. No health care provider is compelled to provide MAiD.

Some health care delivery organizations have indicated an objection to delivering MAiD, including denominational organizations and some hospices operated by independent societies where palliative care is provided.

Following a recent Federal/Provincial/Territorial request for information from BC, provinces are taking different approaches in relation to where MAiD must be offered:

Ontario
- No restrictions on where MAiD may occur; e.g. it is permissible for MAiD to occur in a hospital, long-term care facility, at home, etc.
- No plans to require MAiD to be obligatory in any institution.

Nunavut
- Nunavut does not have policy related to where MAiD may or may not be delivered. There are no faith based or denominational facilities in Nunavut.

Manitoba
- Currently reviewing policy regarding the provision of MAiD in hospice and palliative care settings.
- Denominational and faith-based facilities will not be required to provide assessments or perform MAID.

New Brunswick
- No policy position on delivering MAiD in hospice or palliative care.
- Understand MAiD and residential hospice to be two distinct options, with little chance of interaction.
- MAiD is not provided in faith-based institutions, but assessments are expected to take place there.

Saskatchewan
- No policy requiring facilities to participate in assessments or provision of MAiD.

Alberta

- Not currently requiring all contracted service providers to offer MAiD

Quebec

- By legislation, hospices are able to opt-out of providing MAiD. Of 31 hospices, 26 have opted-out.

DISCUSSION:

Most acute/tertiary palliative care beds in the province are owned and operated by health authorities. There are clear accountabilities in place, allowing the Ministry of Health (the Ministry) to mandate assessments and provision of MAiD in health authority owned and operated acute/tertiary palliative care settings.

Community hospices, on the other hand, operate under a mix of funding and ownership models, including health authority owned and operated, and contracted not for profit and for profit models. Independent hospices that contract their services with health authorities are autonomous organizations with their own governance structures and accountabilities. Most contracted hospice societies do not receive 100 percent funding from health authorities; there is a wide range in the amount of funding they receive, with some receiving only a small portion of their operating costs, and others receiving a much higher proportion.

Hospices provide palliative care for people at end of life. Several hospice providers expressed that their main concern in regard to MAiD is the discord with their core principle to neither hasten nor prolong death. Other issues have been raised, including the potential for union conflict, liability concerns, risk of losing donors, and the notion that certain clinical procedures are typically not provided in a hospice setting. According to some hospice service providers, current practice is to ensure patients are informed prior to receiving care in hospice that if they wish to undergo certain procedures, the patient would have to be transferred to another care setting. While options exist to mitigate concerns about liability and union conflict, concerns are more difficult to mitigate regarding the culture of hospice, and appropriateness of providing the MAiD clinical procedure in hospice settings.

There is no consensus amongst palliative care providers regarding MAiD delivery in palliative and hospice settings, s.13 We have learned since MAiD was decriminalized in June that patient transfers can be hard on patients and their families. s.13

At least eight instances of MAiD have occurred in hospices in BC (seven in Victoria, one in the Interior) demonstrating some hospice palliative care providers have managed to work through the issues associated with their philosophy of care. A collaborative approach that seeks to mitigate concerns, while continuing to stress the importance of patient-centred care may be successful in achieving delivery of MAiD in hospice settings, when requested by individuals already receiving care in these settings. s.13

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RECOMMENDATIONS:

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FINANCIAL IMPLICATIONS:
None at this time

ADM/Division: Doug Hughes, ADM Health Services Policy Division
Telephone: 250 952-1049
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Derek Rains, Director, Medical Services
Date: December 5, 2016

Rationale

In February 2015, the Supreme Court of Canada (SCC) ruled in *Carter v. Canada (Carter)* that the blanket prohibition against assisted-dying set out in the *Criminal Code of Canada (Criminal Code)* was unconstitutional. In response to the ruling, the federal government amended the *Criminal Code* on June 17, 2016 to create exemptions from criminal prosecution for physicians and nurse practitioners to assess for eligibility and provide medical assistance in dying, as well as pharmacists who dispense medical assistance in dying drugs. The *Criminal Code* amendment also includes eligibility criteria which define who may access medical assistance in dying and procedural safeguards which must be observed before the service can be provided.

The federal legislation situates medical assistance in dying as an option to relieve the suffering of eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved under conditions acceptable to them. The Ministry of Health recognises that this is a significant shift in health care delivery, as well as societal norms.

A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to implementation and service delivery. The policy aligns with the *Criminal Code*, professional college standards related to medical assistance in dying, and the Minister of Health's June 2016 letter which formalised the expectation that health authorities establish a medical assistance in dying care coordination service.

Policy Objectives

To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province similar to the manner in which other health care services are delivered.

Scope

This policy applies to all heath authority, owned and operated, contracted and affiliated services and settings.

Policy[1]

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Accountability

Senior level health authority executives are accountable for compliance with this policy.

A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt patient care occur.

Patient and/or family complaints related to medical assistance in dying within scope of the Patient Care Quality Review Board Act will continue to be directed to the health authority's Patient Care Quality Office.

Review

This policy is subject to review on an annual basis, or as required to address operational challenges.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #

PREPARED FOR: Honourable Terry Lake, Minister - **FOR INFORMATION**

TITLE: MAiD Delivery – draft Policy

PURPOSE: To confirm policy direction on where medical assistance in dying (MAiD) will and will not be required by policy to occur.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of MAiD in palliative care and hospice settings.

Previous versions of the attached draft Policy were developed in collaboration with health authority representatives from the provincial MAiD Working Group and shared with the BC Hospice Palliative Care Association (BCHPA).

Attached is the draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* which gives health authorities the following direction:

1. **Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered** (e.g. palliative care). [#11 in draft Policy]

2. **The ability for contracted organizations to opt-out of allowing or providing MAiD.** Health authorities are directed to consider, at time of service level agreement renewal, whether a contracted organization (e.g. hospice, residential care) receives a substantial level of operating funds or services from a health authority, and to balance this with their mandate to ensure reasonable access to MAiD and the strategic priorities of the BC Government (e.g. increasing hospice beds). [#12]

3. **Confirms the ability for faith-based organizations to decide not to allow provision of MAiD.** [#13]

4. **Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access**, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#14]

DISCUSSION:
There are both risks and benefits associated with implementing a Ministry policy that clarifies expectations regarding the delivery of MAiD.

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Benefits

s.13

ADVICE:

s.13

Program ADM/Division: Doug Hughes, Health Services Policy Division
Telephone: 250-952-1049
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: January 20, 2017
File Name with Path:
NOTES:

MINISTRY OF HEALTH

POLICY COMMUNIQUÉ

COMMUNIQUÉ

TO: All Health Authorities

TRANSMITTAL DATE:

COMMUNIQUÉ NUMBER:

CLIFF NUMBER:

SUBJECT: Medical Assistance in Dying: Access and Care Coordination

DETAILS: The objective of this policy is to clarify expectations related to access to this new health care service and to support a consistent approach to service delivery across the province.

EFFECTIVE DATE: July 2018

MINISTRY CONTACT: Executive Director, Hospital Services Branch, Provincial, Hospital and Laboratory Health Services Division

Stephen Brown
Deputy Minister
Ministry of Health

MINISTRY OF HEALTH POLICY:
MEDICAL ASSISTANCE IN DYING: ACCESS AND CARE COORDINATION

Background

In June 2016, amendments to the *Criminal Code of Canada* (CCC) to allow medical assistance in dying (MAiD) for capable adults in certain circumstances came into effect. The CCC sets out criteria that medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for MAiD. The CCC provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The CCC contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in MAiD and this is permitted, provided the assistance is in accordance with the specific circumstances described in the CCC.

The Ministry of Health informed all Health Authorities Chief Executive Officers of the Province's expectation that all health authorities have a care coordination service in place to provide an additional point of contact for patients who require assistance in navigating access to MAiD and to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

Definitions

- **Contracted Organization:** A contracted organization (or facility) with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.
- **Eligible:** According to the CCC, to be eligible for MAiD a person must meet all of the following criteria:
  a. Be eligible for health services funded by a government in Canada;
  b. Be at least 18 years of age and capable of making decisions with respect to their health;
  c. Have a grievous and irremediable medical condition (defined below);
  d. Have made a voluntary request for MAid that, in particular, was not made as a result of external pressure; and,
  e. Have given informed consent to receive medical MAiD after having been informed of the means that are available to relieve their suffering, including palliative care.
- **Faith-based Organization:** An organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.
- **Grievous and Irremediable Medical Condition:** According to the CCC, a person has a grievous and irremediable medical condition if they meet all of the following criteria:
  a. They have a serious and incurable illness, disease, or disability;
  b. They are in an advanced state of irreversible decline in capability;
  c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
  d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
- **Health Authority:** Refers to regional health authorities (established under the *Health Authorities Act*) and the Provincial Health Services Authority (established under the *Society Act*).
- **Opt-out:** Refers to a decision that may be made by a Contracted Organization to not allow the provision of MAiD in their setting(s).

- **Transfer of Care:** At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

Policy Objective

The Ministry of Health recognizes that the provision of medical assistance in dying is a significant shift in health care delivery. The objective of this policy is to clarify expectations related to access to this new health care service and to support a consistent approach to service delivery across the province. This will include:

1. Establishing a provincial policy framework that supports reasonable access across the province to medical assistance in dying, in a manner similar to other health care services.
2. Supporting a consistent approach to delivery of medical assistance in dying that complies with the CCC.
3. Recognizing that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities in British Columbia. If health authority programs or services are provided through a Contracted Organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

Policy

Health authorities/hospital societies must ensure the policy direction below is followed:

Access

1) Health authorities are responsible for ensuring that medical assistance in dying is reasonably available in a manner similar to other end-of-life health care services. This may require collaboration with community-based services and health care providers to ensure care is effectively sequenced in a patient-centred manner across settings, programs and services.
2) No individual should be denied admission or access to a program or service for which they would otherwise be eligible, due to a request or potential request for medical assistance in dying.

Health Care Provider Participation

3) Medical assistance in dying must be available in a manner that is respectful of the requesting individual's personal autonomy and the conscience[1] of individual health care providers.
4) Regulated health care providers must adhere to their professional standards of practice. Health authorities must not establish operating procedures that put the health care provider in a direct conflict with their professional standards.
5) Health authorities must ensure that information about how to access medical assistance in dying within each health authority is available to the public, individuals who may request medical assistance in dying, health care providers and staff.
6) Nothing in this policy compels an individual to provide or assist in providing medical assistance in dying.
7) In the event that a health care provider declares a conscientious objection to participating in the assessment or provision of medical assistance in dying, health authorities must ensure that qualified staff are available

[1] References to objections of conscience throughout are intended to also include objections based on religion.

to provide information to individuals requesting medical assistance in dying, in order to enable the requesting individual to connect with a health care provider willing to assist the requesting individual to explore their request. Individual health providers declaring conscientious objection will ensure compliance with regulatory standards as related to effective transfer of care (see #4)

Location and Availability

8) Health authorities must make reasonable efforts to facilitate assessment and provision of medical assistance in dying in the appropriate location of the requesting individual's choosing[2], irrespective of whether the interdisciplinary care team in that setting is involved in the assessment or provision.
   a. When distributing or reallocating resources, Health authorities must consider their populations' health needs and existing access to medical assistance in dying in communities throughout their regions. This may include new or expanded partnerships with contracted organizations.
   b. If the interdisciplinary care team involved in providing the requesting individual's health care is not involved in the assessment or provision of medical assistance in dying, they are expected to continue to meet those care needs unrelated to medical assistance in dying, unless a transfer of care is enacted at the individual's request.
9) A physical transfer of an admitted patient, resident or client from one facility or setting to another, as a result of a request for medical assistance in dying, should be avoided unless:
   a. the request for transfer originates with the individual; or,
   b. the individual is receiving care at a non-participating Faith-based Organization (see #12) or a Contracted Organization that refuses to allow provision of medical assistance in dying (see #11b).

Health Authority Managed Services and Facilities

10) The assessment and provision of medical assistance in dying are expected to be reasonably accessible in all health authority owned and operated settings where end-of-life services are normally offered. This is inclusive of hospitals, hospices, long term care facilities, assisted living residences and other settings.

Contracted Organizations (eg. long term care facility, hospices, assisted living residences and other settings)

11)
   a. Health Authorities will ensure that a Contracted Organization that receives greater than 50% of their beds funded by the health authority, the contracted facility will allow the assessment and provision of medical assistance in dying in settings where end-of-life services are normally offered.
      i. Where the Contracted Organization does not have staff willing or able to participate in assessment and/or provision of medical assistance in dying, the health authority will ensure that qualified staff are available.
   b. Health Authorities will permit that a Contracted Organization that receives less than or equal to 50% of their beds funded from the health authority may decide to refuse to allow the provision of medical assistance in dying. Contracted Organizations that refuse to allow the provision of medical assistance in dying, must:
      i. Provide a notification of the Contracted Organization's confirmation of refusal to allow the provision of medical assistance in dying in their facility, including all Board of Directors signatures, to the applicable Health Authority;

[2] This may include the individual's home, but does not include non-participating faith-based organizations.

ii. Provide a copy of the Contracted Organization's most recent fiscal year financial statement, and any other additional required financial information requested, to the applicable Health Authority;
iii. Inform individuals of their policy prior to consent to admission; and,
iv. Clearly post their policy(ies) related to MAiD on their website.

c. Health authorities must work with Contracted Organizations that refuse to allow provision of medical assistance in dying (11b) to ensure that requesting individuals are provided with information to support decision making, including the role of health authorities in care coordination.
d. Health Authorities will only allocate new health authority funding to:
   i. Contracted Organizations that will allow the assessment and provision of medical assistance in dying in settings where end-of-life services are normally offered; or,
   ii. Contracted Faith-based Organizations (see 12).

Faith-Based Organizations

12) Faith-based Organizations may decide not to allow the provision of medical assistance in dying in their facilities operated by the organization. Health authorities must consult with their affiliate Faith-based Organizations who opt out to develop policies and procedures that outline how faith-based organizations will work with the health authority or with community-based health care providers (e.g. physician in private practice), to ensure that patient-centred pathways are in place to support an effective connection with another health care provider or organization willing to explore the request for information, transfer of care or physical transfer, as required.
Health authorities must work with non-participating Faith-based Organizations opting out to ensure the following:

a. the requesting individual has full information regarding the services and treatment options available to them;
b. the requesting individual is aware of available information resources, including information regarding the health authority's role in care coordination;
c. the non-participating Faith-based Organization will respect and not impede the individual's request for information concerning medical assistance in dying; and,
d. the non-participating Faith-based Organization will minimize harm to medically frail patients, working with the health authority to meet patients needs; and,
e. the non-participating Faith-based Organization will continue to provide comprehensive care for the requesting individual, to ensure care needs unrelated to medical assistance in dying are met.
f. the health authority is reasonably assured that the non-participating Faith-based Organization meets the definition of faith-based organization as noted in definitions section.

Care Coordination

13) To ensure reasonable, safe access and coordination of care for medical assistance in dying, each health authority will establish the appropriate mechanisms that are acceptable to the Ministry of Health to fulfil the following functions:
   a. Support individuals requesting medical assistance in dying to understand available services and to navigate access;
   b. Support and provide advice regarding the coordination of care and other matters related to medical assistance in dying - to health care administrators, members of the interdisciplinary health care team,

Faith-based Organizations, Contracted Organizations, as well as organizations and providers not affiliated with the health authority. This may include the development of appropriate patient pathways, resource materials, and consultation services;

c. Coordinate with the individual requesting medical assistance in dying, the most responsible practitioner, and/or administrator, to assist the individual in exploring their request when care is being provided at a non–participating Faith-based or opted-out Contracted Organization, or when the most responsible provider has an objection of conscience;
d. Maintain the capacity to receive and respond to public requests for information related to medical assistance in dying, by telephone, email and fax. Provide contact information for the care coordination service, as well as general information on eligibility criteria and procedural safeguards online and in print; and,
e. Support activities related to monitoring, reporting and oversight of medical assistance in dying.

Other

14) This policy should be reflected, where relevant, in operational policies and procedures related to medical assistance in dying.
15) A member of the health authority's senior executive team must be notified should a dispute or significant operational challenge arise related to medical assistance in dying.
16) Patient or family complaints related to medical assistance in dying will be directed to the health authority's Patient Care Quality Office.

Human Resources

Medical assistance in dying may only be assessed and provided by a physician or nurse practitioner through the health authority or in the community. Depending on the setting, interdisciplinary care teams must provide wrap-around, person-centered care using available human resources and optimized scopes of practice, whenever possible. Interdisciplinary care teams may be comprised of, but not limited to, the following health care providers:

- Physicians
- Nurse Practitioners
- Registered Nurses
- Unregulated Care Providers

Organizational Capacity

Health authorities are expected to establish the appropriate mechanisms that are acceptable to the Ministry of Health to ensure reasonable, safe access and coordination of care for medical assistance in dying. See Section 13 of Policy Direction above for detail.

Accountabilities

Senior level health authority executives are accountable for their health authority's compliance with this policy.

Data Analytics and Reporting

Reporting of medical assistance in dying will be consistent with federal and provincial requirements.

Monitoring and Evaluation

Implementation, monitoring and progress evaluation will be ongoing to ensure reasonable access to assessment and provision of MAiD. The Ministry of Health, in collaboration with key stakeholders, will monitor and follow up on any barriers to implementation raised by health authorities and key stakeholders. Progress monitoring will be undertaken annually by Ministry of Health, health authorities, and key stakeholders.

In consultation with Ministry of Health and key stakeholders, indicators will be developed to allow for the monitoring and reporting of performance of this policy directive. These indicators will be limited in scope to the impacts to care and services outlined in the policy objective.

The performance indicators developed for this policy will include and/or complement indicators selected to undertake both implementation and outcome evaluations of the MAiD policy and provide insight on the measurable, expected outcomes stated in the Policy Objectives.

Implementation

This policy is effective as of July 2018.

References/Linkages

- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Scope of Practice Standards for Nurse Practitioners: Medical Assistance in Dying
- *Criminal Code of Canada*
- *Health Professions Act*
- Master Agreement between the Province of BC and the Denominational Health Care Facilities Association
- Minister of Health direction to Health Authority Chief Executive Officers re: Health Authority Coordination of Access to Medical Assistance in Dying (1057216)

Review

- This policy will be reviewed one year from the date of implementation.
- The policy is also subject to additional review, as required (based on consultations between Ministry and external stakeholders, etc.).

Contacts

For information on this policy, please contact the Executive Director, Hospital Services Branch, Provincial, Hospital and Laboratory Health Services Division, Ministry of Health.

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MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff #

PREPARED FOR: Stephen Brown, Deputy Minister **- FOR DECISION**

TITLE: MAID Access and Care Coordination Policy Communique 2016-08

PURPOSE: To seek approval for the Ministry of Health's Policy Communique 2016-08: *Access to and Care Coordination for Medical Assistance in Dying*.

BACKGROUND:

- In February 2015, the Supreme Court of Canada (SCC) ruled in *Carter v. Canada* (*Carter*) that the blanket prohibition against assisted-dying set out in the *Criminal Code* was unconstitutional.
- On April 14, 2016, the federal government introduced *Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts*, (medical assistance in dying). The Bill, which received Royal Assent on June 17, created *Criminal Code* exemptions, and established eligibility criteria and procedural safeguards that must be adhered to in order for medical assistance in dying (MAID) to be legally provided.
- Provinces have traditionally been responsible for hospitals, health care delivery and the regulation of health care providers. As such, the federal legislation does not place conditions on the institution or location where MAID may be provided, nor does it set out obligations for institutions in providing access to MAID. Apart from Quebec, no other Canadian jurisdiction has implemented comprehensive MAID legislation.
- The legalization of MAID is a significant change in health care delivery, as well as societal norms. As expected, there has been opposition to this shift within British Columbia's (BC) health sector, particularly in *some* hospice and faith-based settings.
- Ministry of Health (the Ministry) and health authority senior executives have expressed interest in the creation of a provincial policy to address matters related to access to MAID and assist in addressing this resistance.

DISCUSSION:

- Policy Communique 2016-08 (the Policy) has been developed to support a provincially consistent approach to service delivery by setting standards for health authorities regarding their role in ensuring access to MAID.
- s.13

- The Provincial MAID Working Group (which includes representatives from relevant professional colleges, health authorities and the Ministry) is supportive of the Policy, while at the same time acknowledging that full compliance may take time.

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- The Policy is directed toward health authorities but also sets out an expectation that they work with contracted services, programs and providers to adhere to minimum standards. s.13

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- Health Authority Care Coordination Function - The Minister of Health had previously required health authorities to take on a care coordination role in relation to MAID. The Policy additional provides clarity regarding this function.

OPTIONS:

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RECOMMENDATION:

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Approved/Not Approved
(Enter Name)
(Enter Title)

Date Signed

ADM/Division: Doug Hughes, ADM Health Services Policy Division
Telephone: 250 952-1049
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Leah Smith, Policy Analyst, Acute and Provincial Services
Date: August 19, 2016

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 1061807 (x-ref 1057216)

PREPARED FOR: Stephen Brown, Deputy Minister **- FOR DECISION**

TITLE: Access and Care Coordination Policy - MAID

PURPOSE: To seek approval for the Ministry of Health Policy Communique *Access to and Care Coordination for Medical Assistance in Dying* (MAID).

BACKGROUND:

- In February 2015, the Supreme Court of Canada ruled in *Carter v. Canada* that the blanket prohibition against assisted-dying set out in the *Criminal Code* was unconstitutional.
- On April 14, 2016, the Federal government introduced *Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts*, (medical assistance in dying). The Bill, which received Royal Assent on June 17, created *Criminal Code* exemptions, and established eligibility criteria and procedural safeguards that must be adhered to in order for MAID to be legally provided.
- In early June 2016, the Minister of Health formally communicated to health authority chief executive officers his expectation regarding health authorities role in providing assistance in the public in navigating access to MAID, as well as supporting health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing MAID providers.

DISCUSSION:

- Prior to the introduction of federal legislation several reports advocated for a comprehensive access to MAID; albeit with varying recommendations on how this should be achieved.
- The Provincial and Territorial Expert Advisory Group recommended in late 2015 that "[p]rovinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying." This recommendation is reflective of the regional service delivery model used in most Canadian jurisdictions.
- On February 25, 2016 the Parliamentary Special Joint Committee on Physician Assisted Dying (the Joint Committee) recommended establishment of a process that respects an individual health care practitioner's freedom of conscience while ensuring patient access to MAID. Citing difficulties associated with patient transfers, the Joint Committee also recommended that MAID be available in "all publicly funded health care institutions" and did not support institutional-level conscience protections.
- The legalization of MAID represents a significant shift in
- The policy attempts to the balance the autonomy of individuals requesting MAID with the ethical obligations of health care providers and their right to freedom conscience and religion.

- In July 2016 the senior Ministry and health authority executives agreed that to ensure a provincial policy was required to support a provincial approach to implementation and access to this service.

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- Support

Recommendations related to Access & Care Coordination

- Within BC, the Master Agreement with Denominational Health Care Facilities Association (the Agreement) obligates faith-based facilities to plan and deliver health care services in collaboration with other health bodies, including health authorities. This relationship between the faith-based organization and the regional health authorities ensures availability of an appropriate range of health services within each health region.
- National and local catholic health care organizations have publicly stated that they will not provide MAID at their facilities as per the Catholic Health Alliance of Canada's Health Ethics Guide.

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- Despite the coming into force of federal legislation, the debate surrounding MAID will continue as evidenced by the constitutional challenge of the federal legislation in BC Supreme Court on June 27 by the BC Civil Liberties Association and Julia Lamb, and the constitutional challenge brought forward by the Christian Medical and Dental Society of Canada against the College of Physicians and Surgeons of Ontario regarding their "effective referral" policy.

[This section should outline the Division/Ministry perspective on the issue, including relevant policy and program implications/precedence and who is affected. Use same writing style as the BACKGROUND section, usually one third of a page in length.]

OPTIONS:

[Probably the most valuable part of the document. Usually 3 options, the first of which is often not to do anything. Outline the implications of (evaluate) each option. Traditional evaluation criteria are:

- effect on Ministry outcomes (maybe with reference to our service plan);
- summary financial implications (see next section); and
- who (individuals or groups or organizations) is impacted and whether they might support/not support the option.

Sometimes regional or federal provincial implications are important and can be added.

Sentences or bullets can be used to outline the implications.]

FINANCIAL IMPLICATIONS:

[While the options section provides summary financial implications, in this section provide more financial details of the recommended option. These could include:

- Operating and capital costs on a three year basis,
- Whether the money is in the current budget, and
- Whether the money will be in the form of a grant to a health authority or other organisation.]

RECOMMENDATION:
[Put down the option you recommend]

_____	_____
Approved/Not Approved	Date Signed
(Enter Name)	
(Enter Title)	

Program ADM/Division: [enter info in this section unbolded]
Telephone:
Program Contact (for content):
Drafter:
Date:
File Name with Path:

NOTES:

Briefing documents are limited to 2 pages; font must be 12 point Times New Roman; left and right margins are to be 1.25".

All briefing documents containing financial and data information must be approved by Finance or Planning & Innovation staff as appropriate. ADM approval must be in place prior to forwarding to Finance and PID.

Briefing documents containing data elements must be sourced in endnote format; the endnotes **must be included as "Appendix A"**, and be the third page of the briefing document.

Briefing documents may contain appendices, making the entire document over 2 pages. Appendices can be used for large tables (usually outlining financial implications if they are complicated), for legislative references (for large sections) or for items like terms of references if you are writing for approval of such terms.

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 1080633

PREPARED FOR: Honourable Terry Lake, Minister - **FOR DECISION**

TITLE: MAiD Delivery – Draft Policy

PURPOSE: To confirm policy direction on where medical assistance in dying will, and will not, be required by policy to occur.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of medical assistance in dying (MAiD) in palliative care and hospice settings.

The draft Policy has been developed in collaboration with health authority and regulatory college representatives from the provincial MAiD Working Group, and discussions about the draft Policy were held with the BC Hospice Palliative Care Association (BCHPCA) and the BC Centre for Palliative Care (BCCPC).

The draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* gives health authorities the following direction:

1. **Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered** (e.g. palliative care). [#11 in draft Policy]

2. **The ability for contracted organizations to opt-out of allowing the provision of MAiD.** Health authorities are directed to consider, at time of service level agreement renewal, whether a contracted organization (e.g. hospice, residential care) receives a substantial level of operating funds from a health authority, and to balance this with their mandate to ensure reasonable access to MAiD. [#12]

3. **Confirms the ability for faith-based organizations to decide not to allow the provision of MAiD.** [#13]

4. **Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access**, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#14]

DISCUSSION:
Given a range of stakeholder views, the Ministry can expect that there will be mixed views on the implementation of the drafted policy. The benefits and risks of approving versus not approving the policy are outlined below.

OPTIONS:

1. **Approve the draft Policy.**

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FINANCIAL IMPLICATIONS:
N/A

RECOMMENDATION:

Recommend Option 1, with the following plan for policy implementation:

s.13

Program ADM/Division: Ian Rongve, Hospital, Diagnostic and Clinical Services Division
Telephone: 250-953-4504
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: March 14, 2017

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 1080633

PREPARED FOR: Honourable Terry Lake, Minister - **FOR DECISION**

TITLE: MAiD Delivery – Draft Policy

PURPOSE: To request policy direction on where medical assistance in dying will, and will not, be required by policy to be made accessible.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of medical assistance in dying (MAiD) in palliative care and hospice settings.

The draft Policy has been developed in collaboration with health authority and regulatory college representatives from the provincial MAiD Working Group, and discussions about the draft Policy were held with the BC Hospice Palliative Care Association (BCHPCA) and the BC Centre for Palliative Care (BCCPC).

The draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* gives health authorities the following direction:

1. Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered (e.g. palliative care). [section #12 in draft Policy]

2. Contracted organizations that receive the majority of their operating funds from a health authority must ensure the assessment and provision of MAiD are accessible in settings where end-of-life services are normally offered. [#13a]

3. Contracted organizations that do not receive the majority of their operating funds from a health authority may opt-out of allowing the provision of MAiD. This includes hospices and residential care facilities. [#13b]

4. Confirms the ability for faith-based organizations to decide not to allow the provision of MAiD. [#14]

5. Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#15]

DISCUSSION:
Given a range of stakeholder views, the Ministry can expect that there will be mixed views on the implementation of the drafted policy. The benefits and risks of approving versus not approving the policy are outlined below.

OPTIONS:

1. **Approve the draft Policy.**

s.13

RECOMMENDATION:

Recommend Option 1, with the following plan for policy implementation:

s.13

s.13

Program ADM/Division: Ian Rongve, Hospital, Diagnostic and Clinical Services Division
Telephone: 250-953-4504
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: March 2017~~7~~, 2017

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 1080633

PREPARED FOR: Honourable Terry Lake, Minister - **FOR DECISION**

TITLE: MAiD Delivery – Draft Policy

PURPOSE: To request policy direction on where medical assistance in dying will, and will not, be required by policy to be made accessible.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of medical assistance in dying (MAiD) in palliative care and hospice settings.

The draft Policy has been developed in collaboration with health authority and regulatory college representatives from the provincial MAiD Working Group, and discussions about the draft Policy were held with the BC Hospice Palliative Care Association (BCHPCA) and the BC Centre for Palliative Care (BCCPC).

The draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* gives health authorities the following direction:

1. Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered (e.g. palliative care). [section #12 in draft Policy]

2. Contracted organizations that receive >50% of their operating funds from a health authority must ensure the assessment and provision of MAiD are accessible in settings where end-of-life services are normally offered. [#13a]

3. Contracted organizations that receive ≤50% of their operating funds from a health authority may opt-out of allowing the provision of MAiD. This includes hospices and residential care facilities. [#13b]

4. Confirms the ability for faith-based organizations to decide not to allow the provision of MAiD. [#14]

5. Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#15]

DISCUSSION:
Given a range of stakeholder views, the Ministry can expect that there will be mixed views on the implementation of the drafted policy. The benefits and risks of approving versus not approving the policy are outlined below.

OPTIONS:

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FINANCIAL IMPLICATIONS:

N/A

RECOMMENDATION:

Recommend Option 1, with the following plan for policy implementation:

s.13

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Program ADM/Division: Ian Rongve, Hospital, Diagnostic and Clinical Services Division
Telephone: 250-953-4504
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: March 20, 2017

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 1080633

PREPARED FOR: Honourable Terry Lake, Minister - **FOR DECISION**

TITLE: MAiD Delivery – Draft Policy

PURPOSE: To request~~confirm~~ policy direction on where medical assistance in dying will, and will not, be required by policy to ~~occur~~be made accessible.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of medical assistance in dying (MAiD) in palliative care and hospice settings.

The draft Policy has been developed in collaboration with health authority and regulatory college representatives from the provincial MAiD Working Group, and discussions about the draft Policy were held with the BC Hospice Palliative Care Association (BCHPCA) and the BC Centre for Palliative Care (BCCPC).

The draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* gives health authorities the following direction:

1. Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered (e.g. palliative care). [section #12~~1~~ in draft Policy]

2. Contracted organizations that receive the majority of their operating funds from a health authority must ensure the assessment and provision of MAiD are accessible in settings where end-of-life services are normally offered. [#13a]

~~2.~~3. ~~**The ability for c**~~Contracted organizations that do not receive the majority of their operating funds from a health authority may~~to~~ opt-out of allowing the provision of MAiD. This includes hospices and residential care facilities. ~~Where a significant portion of funding comes from the health authority, expectations with respect to MAiD should be reviewed and agreed upon at service agreement renewal.~~ [#13~~2~~b]

~~3.~~4. Confirms the ability for faith-based organizations to decide not to allow the provision of MAiD. [#14~~3~~]

~~4.~~5. Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#15~~4~~]

DISCUSSION:

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Given a range of stakeholder views, the Ministry can expect that there will be mixed views on the implementation of the drafted policy. The benefits and risks of approving versus not approving the policy are outlined below.

OPTIONS:

1. **Approve the draft Policy.**
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FINANCIAL IMPLICATIONS:
N/A

RECOMMENDATION:

Recommend Option 1, with the following plan for policy implementation:

s.13

Program ADM/Division: Ian Rongve, Hospital, Diagnostic and Clinical Services Division
Telephone: 250-953-4504
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: March 174, 2017

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through a contracted independent non-denominational facility or organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

Policy

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Also referred to throughout this policy as a "Contracted Organization", refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Opt-out: Refers to a decision that may be made by a contracted independent non-denominational facility or organization to not allow the provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through a contracted independent non-denominational facility or organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

Policy

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Opt-out: Refers to a decision that may be made by a contracted independent non-denominational facility or organization to not allow the provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1080633

PREPARED FOR: Honourable Terry Lake, Minister - **FOR INFORMATION**

TITLE: MAiD Delivery – Draft Policy

PURPOSE: To confirm policy direction on where medical assistance in dying will and will not be required by policy to occur.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of medical assistance in dying (MAiD) in palliative care and hospice settings.

Previous versions of the attached draft Policy were developed in collaboration with health authority and regulatory college representatives from the provincial MAiD Working Group, and discussions about the draft Policy were held with the BC Hospice Palliative Care Association (BCHPCA) and the BC Centre for Palliative Care (BCCPC).

The draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* gives health authorities the following direction:

1. **Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered** (e.g. palliative care). [#11 in draft Policy]

2. **The ability for contracted organizations to opt-out of allowing the provision of MAiD.** Health authorities are directed to consider, at time of service level agreement renewal, whether a contracted organization (e.g. hospice, residential care) receives a substantial level of operating funds or services from a health authority, and to balance this with their mandate to ensure reasonable access to MAiD and the strategic priorities of the BC Government (e.g. increasing hospice beds). [#12]

3. **Confirms the ability for faith-based organizations to decide not to allow the provision of MAiD.** [#13]

4. **Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access**, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#14]

DISCUSSION:
There are both risks and benefits associated with implementing a Ministry policy that clarifies expectations regarding the delivery of MAiD.

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ADVICE:

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Program ADM/Division: Ian Rongve, Hospital, Diagnostic and Clinical Services Division
Telephone: 250-953-4504
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: February 28, 2017

Ministry of Health
Policy Instrument

Type:	**Specific Directive**
Policy Name	**Access to and Care Coordination of Medical Assistance in Dying**

Version	
Effective Date:	
Division/Branch:	**Hospital, Clinical and Diagnostic Services Division/Acute and Provincial Services Branch**
Ministry Contact:	**Executive Director, Acute and Provincial Services**
Document Number:	
Date:	**May 1, 2018**

Deputy Minister
Ministry of Health

BRITISH COLUMBIA

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

POLICY OBJECTIVE

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

In June 2016, the Ministry of Health informed all Health Authorities Chief Executive Officers of the Province's expectation that all health authorities have a care coordination service in place to provide an additional point of contact for patients who require assistance in navigating access to medical assistance in dying and to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

Expected Impact on Patient/Population Outcomes/Service Attributes

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery.

This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

1. To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.
2. To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.
3. To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Also referred to throughout this policy as a "Contracted Organization", refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code* of Canada, to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code* of Canada, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the Health Authorities Act, and the Provincial Health Services Authority established under the Society Act.

Opt-out: Refers to a decision that may be made by a contracted independent non-denominational facility or organization to not allow the provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

SCOPE

This policy applies to all health authorities. If health authority programs or services are provided through a contracted independent non-denominational facility or organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and staff to ensure

patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

POLICY DIRECTION

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MONITORING & EVALUATION

Performance Monitoring

Implementation, monitoring and progress evaluation will be ongoing to to ensure reasonable access to assessment and provision of MAiD. The Ministry of Health, in collaboration with key stakeholders, will monitor and follow up on any barriers to implementation raised by health authorities and key stakeholders. Progress monitoring will be undertaken annually by Ministry of Health, health authorities, and key stakeholders.

In consultation with Ministry of Health and key stakeholders, indicators will be developed to allow for the monitoring and reporting of performance of this policy directive. These indicators will be limited in scope to the impacts to care and services outlined in the Policy Objectives.

The performance indicators developed for this policy directive will include and/or complement indicators selected to undertake both implementation and outcome evaluations of the MAiD policy and provide insight on the measurable, expected outcomes stated in the Policy Objectives.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed one year from the date of implementation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.

REFERENCES & LINKAGES

- *The Criminal Code of Canada*
- *The Health Professions Act*
- The Master Agreement between the Province of BC and the Denominational Health Care Facilities Association
- Minister of Health direction to Health Authority Chief Executive Officers RE: Health Authority Coordination of Access to Medical Assistance in Dying (1057216)
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Scope of Practice Standards for Nurse Practitioners: Medical Assistance in Dying
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

In June 2016, the Ministry of Health informed all Health Authorities Chief Executive Officers of the Province's expectation that all healthauthorities have a care coordination service in place to provide an additional point of contact for patients who require assistance in navigating access to medical assistance in dying and to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through a contracted independent non-denominational facility or organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and

staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

Policy

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*

- The Master Agreement between the Province of BC and the Denominational Health Care Facilities Association
- Minister of Health direction to Health Authority Chief Executive Officers RE: Health Authority Coordination of Access to Medical Assistance in Dying (1057216)
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners: Medical Assistance in Dying~~Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.~~
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Also referred to throughout this policy as a "Contracted Organization", refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Opt-out: Refers to a decision that may be made by a contracted independent non-denominational facility or organization to not allow the provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

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The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

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2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through a contracted independent non-denominational facility or organization (i.e. publicly funded), or contracted staff, health authorities are required to work with these organizations and

staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

Policy

s.13

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Withheld pursuant to/removed as

s.13

Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- The Master Agreement between the Province of BC and the Denominational Health Care Facilities Association
- Minister of Health direction to Health Authority Chief Executive Officers RE: Health Authority Coordination of Access to Medical Assistance in Dying (1057216)
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners: Medical Assistance in DyingCollege of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

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d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

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c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

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Opt-out: Refers to a decision that may be made by a contracted independent non-denominational facility or organization to not allow the provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

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Withheld pursuant to/removed as

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MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 1112207

PREPARED FOR: Deputy Minister Stephen Brown**- FOR DECISION**

TITLE: Access to and Care Coordination of Medical Assistance in Dying Policy

PURPOSE: To provide clear direction to health authorities in establishing a provincial framework to ensure reasonable access to medical assistance in dying.

BACKGROUND:

A 2016 amendment to the *Criminal Code of Canada* allowed medical assistance in dying (MAiD) in Canada. The amendment outlines criteria for medical and nurse practitioners to apply while assessing eligibility and provision of MAiD.

Following the amendment, the Ministry of Health informed each health authority (HA's) of the Provincial expectations to set up care coordination services to assist patients and care providers, to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

The Access to and Care Coordination of Medical Assistance in Dying Policy (Policy) reflects the current position of the Ministry and provides HA's with useful tools for implementation across the province. The Ministry of Health recognises that the provision of MAiD is a significant shift in health care delivery. This Policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

DISCUSSION:

Ministry of Health staff worked conjointly with HA's to develop the Policy. It is the expectation of the Ministry that all eligible persons wishing to access MAiD have reasonable access to the assessment and provision of MAiD. The Policy applies to all HA's and any programs or services provided through a contracted independent non-denominational facility or organization (ie. publically funded) to ensure patient centred pathways are in place to provide access to MAiD.

The objectives of the policy are:

1. To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.
2. To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.
3. To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

The policy outlines expectations for:

- health care providers about a patient's right to access care coordination;
- health authority managed locations and availability of assessment and provision; and
- contracted (including faith based) organization services.

OPTIONS:

s.13

RECOMMENDATION:

s.13

_____ _____

Approved/Not Approved
(Enter Name)
(Enter Title)

Date Signed

Program ADM/Division: Ian Rongve/Hospital, Diagnostic and Clinical Services Division
Telephone: 250-952-3008
Program Contact (for content): Derek Rains, Director, Acute Care Access
Drafter: Genevieve Stainton, A/Policy Analyst
Date: April 13, 2018
File Name with Path:

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Withheld pursuant to/removed as

s.13

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1129094

PREPARED FOR: Honourable Adrian Dix, Minister **- FOR INFORMATION**

TITLE: Medical Assistance in Dying in Hospice and Long Term Care

PURPOSE: Analysis of position paper regarding Medical Assistance in Dying (MAiD) in hospice and long-term care (LTC).

BACKGROUND:
Since 2016, the Ministry of Health (Ministry), Health Authorities (HAs), regulatory colleges and Coroners Service have developed and implemented a patient centred service delivery model for MAiD in BC. As part of that model, each HA has a MAiD Care Coordination Service (MCCS) to assist patients, providers and organizations to provide seamless access to MAiD. As of November 2018, the Ministry has taken responsibility for oversight and monitoring of MAiD, which includes ensuring patients have been informed of all treatment options available to them, including palliative care.

In December 2017, the Fraser Health Authority (FHA) issued a directive indicating MAiD would be available in all FHA palliative care units, hospitals and LTC facilities. Denominational facilities were exempt, since the Denominational Health Agreement allows faith-based organizations to opt-out of allowing for the assessment and/or provision of MAiD. Some non-denominational, private and not-for-profit contracted organizations have requested a similar exemption.

In response to concerns from a number of organizations, Dr. Darryl Plecas, Speaker and MLA for Abbotsford South, commissioned a White Paper (the Paper) titled *Implementing Medical Assistance in Dying (MAiD) in British Columbia: Should a hospice or long term care facility be allowed to opt out of MAiD?* The Paper advocates for a separation between palliative care services and MAiD, suggesting a model where hospices can opt for one of three service delivery options: 1) palliative care only; 2) palliative care and MAiD; or, 3) MAiD only. In support of this argument, a number of issues and recommendations are raised in the Paper and in an accompanying briefing note for consideration by the Minister of Health.

A meeting is scheduled between the Minister of Health and MLA Plecas on February 13, from 3:00-3:30 pm.

DISCUSSION:
The Paper argues for a model that meets the needs of providers and organizations that oppose MAiD. The model developed and implemented in BC is a patient-centred program that puts the needs of patients first, rather than providers.

Conscientious Objection
The Paper argues that conscientious objection, afforded to individual health care providers, should also apply to organizations.
s.13

Centralization of Specialized Services:
The Paper equates MAiD with centralized, specialized services, such as trauma, suggesting MAiD be delivered in a centralized model.
s.13

Concerns about Capacity in Palliative Care Beds
The Paper suggests MAiD could unduly add burden to the province's limited number of palliative care beds.
s.13

Legislative and/or Regulatory Framework
The Paper generalizes about conflicts between allowing MAiD and requirements in the *Community Care and Assisted Living Act* and Accreditation Canada Standards.
s.13

-

Legal exposure/liability/risk
The Paper raises concerns that privately owned hospices have regarding their lack of legal protection, particularly around malpractice.
s.13

Lack of organizational capacity
The Paper raises concerns with hospices having capacity to provide MAiD.
s.13

Systemic Coercion
The paper argues a request for MAiD cannot be truly voluntary without appropriate access to palliative care. They argue that requests for MAiD are a result of patients being unable to access palliative care.
s.13

ADVICE:
s.13

Program ADM/Division: Ian Rongve, ADM, Provincial, Hospital, and Laboratory Health Services
Telephone: 250-953-4504
Program Contact (for content): Derek Rains, Director, Acute Care Access and Policy
Drafter: Nancy Blythe, Acute and Provincial Services Branch, MoH
Date: February 12, 2019

Appendix A – Advice on Recommendations

	Recommendation	Ministry Position
1	Advise Fraser Health to allow a service delivery model that allows hospices and long-term care facilities that operate with a Palliative Care approach to opt-out of MAiD. Do not limit this only to organizations linked with a religious denomination; provide this option to any service provider whose organizational mandates, beliefs, policies, and ethics of care prohibit the intentional ending of human life through MAiD.	s.13
2	Ensure robust dialogue and consultation regarding MAiD with long term care facilities and hospice societies that represent local communities.	
3	Designate appropriate sites owned and operated by Fraser Health as MAiD sites, thereby ensuring reasonable access to MAiD throughout the Fraser Health region.	
4	Allow private facilities and those run by not-for-profit societies or religious organizations to determine their own philosophical stance, and to opt-in or opt-out accordingly. Some may choose to opt-in when policies and procedures are in place and their licensing, accreditation and insurance concerns have been addressed; others may continue to opt-out for ethical reasons.	
5	Provide and inform all site personnel of the mechanism to accommodate Charter rights for workers who may not be able to participate in MAiD for reasons of conscience, belief or religion, to ensure their Charter rights are protected, and the intent of Bill C-14 section 241.2(9) is upheld.	

6	Develop robust monitoring systems that will track data to support evidence-based policy decisions. (Track cases that move from a palliative care approach to MAiD, and from MAiD to palliative.)	s.13
7	Ensure appropriate training on best practices for patient transfers to enable patients to have the comfort and dignity they require within a seamless, painless approach.	
8	Support allocation of space within facilities that offer both MAiD and palliative care to adopt a parallel but separate approach, not an integrated approach. This protects the ethics and ethos of palliative care that prohibit hastening death, while also ensuring access to MAiD.	

From:	Archibald, Karen HLTH:EX
To:	Greenaway, Shelley E HLTH:EX; Acker, Kelly HLTH:EX; Prescott, Julia HLTH:EX; Wingrove, Scott HLTH:EX
Subject:	Additional requirements that relate to hospitals for the LTC Access Policy
Date:	March 12, 2019 7:39:01 PM
Attachments:	HCCPM Chapter 2D 20190312 page 2.docx LTC Access Guidelines 20190311.docx

Hi all, I have made some further draft changes to the Guidelines, 3.4, fourth bullet and then to Policy 2.D, based on some information we received today from Alberta s.13; s.16
s.13; s.16

I ran these by Kiersten and she supports them, but Shelley, I know you need to run them by Derek to see if the acute care folks might have any issues with these additional expectations. I think the only concern they may have is it might slow down some processes. I want to let you know first, before we send out to the HA's – which I would like to have done tomorrow or Thursday.
I have saved these versions on the LAN as well…
Thanks,
Karen

Karen Archibald

Director, Strategic Initiatives | Seniors Services | Ministry of Health

Tel: 250-952-1162 | *Email*: Karen.Archibald@gov.bc.ca

From: Greenaway, Shelley E HLTH:EX
To: Blythe, Nancy HLTH:EX
Subject: Bullet from Long Term Care Access Guidelines
Date: March 11, 2019 3:03:00 PM

Hello Nancy;
If you have any objections to the highlighted bullet below, please send your suggested edits to me and I will forward them to Kelly. Thank you.

2.2 - Care home-specific information

Care home-specific information about care and services (differs between care homes), including:

- location, and contact information for care home;
- approximate wait time for admission for each care home;
- types of accommodation (shared occupancy, single occupancy);
- availability of other services (such as hair dressing, foot care and nail care);
- availability of spiritual/denominational/pastoral services and activities;
- frequency and type of social and recreational activities;
- if the care home is one where the assessment and provision of medical assistance in dying (MAiD) services, are or are not available on site;
- what additional services are available for a fee, and the amount of these fees;
- security at the care home; and
- accessibility of the care home.

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

CPX0000: Responding to Requests for Medical Assistance in Dying

Approved Date: _____

Reviewed/Revised Date: _____

1.0 Introduction

Description

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 Providence Health Care ("PHC") who requests Medical Assistance in Dying, either through medically assisted suicide, where the patient is provided assistance in intentionally ending his or her own life, or voluntary euthanasia, where a physician directly administers a lethal dose of medication to end the patient's life. The procedure further outlines the steps for a safe and timely transfer of the patient to another facility in accordance with their wishes.

Scope

This policy applies to all PHC staff, physicians, volunteers, students and any other persons acting on behalf of PHC and caring for PHC patients ("Personnel").

2.0 Policy

As a Catholic health care organization, PHC is committed to the inherent dignity of every human being throughout the entire continuum of life from conception to natural death. PHC has an institutional obligation as a Catholic health care provider to uphold the principles of Catholic moral teaching as set out in the Health Ethics Guide (3rd ed. 2012) approved by the Canadian Conference of Catholic Bishops (the "Guide"). Given the incompatibility of Catholic teaching with actions intended to terminate human life, PHC Personnel will not enable the provision of Medical Assistance in Dying.

PHC 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 advance directives, advance care planning and/or options for care designation, including clear recognition of the role of substitute decision-makers;
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;
3. Delivering effective and timely pain and symptom management.

2.1 Principles

2.1.1 A request from a person in our care for Medical Assistance in Dying must be received in a compassionate and respectful manner.

2.1.2 The patient will be provided support in a non-judgmental way to ensure they are aware of all of the care options available to them, and they are provided with the appropriate physical, psychological and spiritual supports to help address the person's needs that may underlie their expressed request.

2.1.3 Personnel are morally and legally bound to work together with patients and families to resolve potential conflict around the goals of care and to find proactive solutions that respect the wishes of the patient and the integrity of all.

2.1.4 In response to a patient's informed request, the proactive solution may require a safe and timely transfer of the patient and their records to a non-objecting institution for continued exploratory discussion and assessment.

2.1.5 While it is our responsibility to provide care in accordance with the Guide, we must do so without abandoning those who may be impacted by such conscientious or professional decisions, or pressuring patients/residents and their families to justify their own beliefs.

2.2 Responsibilities

2.2.1 All Staff (including Physicians)

Maintain strict confidentiality concerning a request for Medical Assistance in Dying and any other aspect of a patient's personal information.

2.2.2 Direct Care Staff

Respond as able to patient's requests for information on Medical Assistance in Dying, and inform the Most Responsible Physician of the request.

2.2.3 Operations Leadership

Ensure all staff are aware of this policy.

Consider impact of requests for Medical Assistance in Dying on care teams and provide support to staff as may be appropriate.

2.2.4 All Physicians

Ensure compliance with the College of Physicians and Surgeons of BC ("CPSBC") Standard concerning Medical Assistance in Dying.

Ensure that patients requesting Medical Assistance in Dying have had the opportunity to consider all alternative services which may alleviate their suffering.

2.2.5 Most Responsible Provider

Determine capacity of a patient requesting Medical Assistance in Dying.

Arrange for transfer of a capable patient, who wishes to pursue Medical Assistance in Dying after exploration of all other possible options, to a non-objecting centre/setting for continued exploratory discussion and assessment.

2.3 Compliance

Personnel who have concerns about care provided in relation to this policy are asked to contact Risk Management for follow-up.

3.0 References

Covenant Health Policy – Responding to Requests for Medical Assistance in Dying, May 24, 2016

Health Ethics Guide 3rd Ed. Catholic Health Alliance, 2012

CPSBC Professional Standards and Guidelines – Medical Assistance in Dying. June 6, 2016

Tools, Forms and Guidelines

- None at this time

Related Policies

- Consent to Health Care
- Abuse
- Advance Care Planning

Keywords

Assisted suicide, death, euthanasia, Medical Assistance in Dying, PAD, suicide

4.0 Definitions

Advance Care Planning The process of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions.

Advance Directive An Advance Directive provides written consent to (or refusal of) health care to a health care provider in advance of a decision being required about that care. Advance directives must be written, signed by a capable adult, and be witnessed by two witnesses (or one witness who is a lawyer or notary public). Advance Directives are considered to be legally binding in British Columbia.

"**Medical assistance in dying**" (sometimes referred to as "MAiD") is used to describe the assistance provided to a person with the aim of intentionally ending his/her life, as well as voluntary euthanasia, where a legally recognized health professional directly administers a lethal dose of medication (or equivalent) in accordance with the wishes of the patient.

Options for Care – PHC policy CPF1100 sets out four "Options for Care" in the event of a serious illness or sudden collapse during admission in a PHC facility. Options for Care provides a framework for patients/residents and their families to decide their treatment or care preferences during a current admission or episode of care.

Patient For the sake of readability, reference is made to the "patient" throughout this document. Unless otherwise directed, any reference to "patient" should be interpreted to mean patient, client and/or resident.

Substitute Decision Maker If a decision is made that an adult is incapable of making a consent decision, consent must be obtained from a properly executed Advance Directive or from someone on the patient's behalf. The person making decisions on behalf of a patient is called a "substitute decision maker".

5.0 Procedure

1. If a patient makes a request to any of his or her providers for Medical Assistance in Dying, this matter will be brought to the attention of the Most Responsible Provider (MRP).
2. The MRP will explore with the patient their concerns with the current situation and prognosis, and ensure the patient is made aware of all possible standard end-of-life care and treatment options, including adjustments to the current treatment plan, and palliative and comfort care.
    a. If the patient accepts these services, they will be provided to every extent possible.
    b. If, despite the provision of these treatments and interventions, the patient determines that his or her needs and concerns have not been adequately met, and remains interested in Medical Assistance in Dying, the MRP will consider whether there is any indication that the patient is incapable of making a decision concerning Medical Assistance in Dying.
    c. If the MRP determines the patient to be incapable of decision-making regarding health care in general, or Medical Assistance in Dying in particular, the request for Medical Assistance in Dying will not be pursued. Subsequent decisions about health care will be made either by a substitute decision maker, and/or with the aid of an advance directive if one exists.
    d. If the patient requests a second opinion regarding his or her capacity, this will be provided.
3. If there is no concern about the patient's decisional capability, the MRP will initiate a transfer to a non-objecting centre/ setting by contacting medicalassistanceindying@vch.ca **or by phone at 1-844-550-5556** for continued exploratory discussion and assessment.
4. Patients may be transferred to another facility of their choice in accordance with their wishes at any time if there is an admitting provider willing to assume care.
5. If at any time the patient abandons interest in Medical Assistance in Dying, and seeks to return to PHC for care, re-engagement with PHC services will be expedited. If it is the wish of the patient to return to PHC during a waiting time , PHC will accept the patient back if appropriate to their ongoing care needs.

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff #

PREPARED FOR: Honourable Adrian Dix, Minister of Health **- FOR DECISION**

TITLE: Access to and Care Coordination of Medical Assistance in Dying Policy

PURPOSE: To seek approval for the draft Policy, Access to and Care Coordination of Medical Assistance in Dying.

BACKGROUND:
Following legalization of medical assistance in dying (MAiD) in Canada in 2016, the Ministry of Health (the Ministry) informed all health authorities (HA) of the provincial expectations to establish care coordination services to assist patients and care providers, to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

In 2017, Minister Terry Lake approved a draft (Cliff 1080633) of the Access to and Care Coordination of Medical Assistance in Dying Policy (the Policy). The Policy directed the HAs to ensure reasonable access to assessment and provision of MAiD in all HA owned and operated settings, and in contracted organizations where more than 50% of their operating funds are from the HA.

A policy position paper (Cliff 1110185) to clarify current Ministry direction on policy was developed and approved in April 2018. Following that direction, the Policy was updated to reflect the current position of the Ministry (see Appendix A: Access to and Care Coordination of Medical Assistance in Dying Policy). s.13

DISCUSSION:
The Ministry of Health recognises that the provision of MAiD is a significant shift in health care delivery. This Policy has been developed to clarify expectations related to access to this health service and to support a consistent approach to service delivery across the province. It is the expectation of the Ministry that all eligible persons wishing to access MAiD have reasonable access to the assessment and provision of MAiD, across the continuum of care. While the Ministry supports patient choice, it also recognizes the right of individual health providers to conscientiously object to participation in MAiD.

The Policy applies to all HAs and any programs or services including, but not limited to, hospitals, long term care, assisted living residences and hospices. The Policy covers both the HA owned and operated facilities and contracted organizations:

- The Policy recognizes that faith-based organizations may decide not to allow the provision of MAiD in facilities operated by the organization.
- HAs will ensure that for a contracted organization, such as a long term care facility or hospice, that receives greater than 50% of their beds funded by the HA, the contracted facility will allow MAiD assessments and provision. A contracted organization that receives less than or equal to 50% of their beds funded from the health authority may decide to refuse to allow the provision of MAiD.

- HAs must work with contracted organizations, including faith-based organizations that refuse to allow provision of MAiD to ensure that individuals requesting MAiD are provided with information to support decision making (as a part of the role of health authorities in care coordination).
- s.13; s.17

s.13

-

OPTIONS:
Option 1: Approve the Policy.
Pro:
s.13

RECOMMENDATION:
Option 1: Approve the policy

_____ _____
Approved/Not Approved Date Signed
Honourable Adrian Dix
Minister

Program ADM/Division: Ian Rongve/Hospital, Diagnostic and Clinical Services Division
Telephone: 778-974-2554
Program Contact (for content): Darlene Therrien, Executive Director, Hospital Services
Drafter: Genevieve Verite
Date: June 6, 2018
File Name with Path:

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff #

PREPARED FOR: Honourable Adrian Dix, Minister of Health **- FOR DECISION**

TITLE: Medical Assistance in Dying: Access and Care Coordination Policy

PURPOSE: To seek approval for the draft Medical Assistance in Dying: Access and Care Coordination Policy.

BACKGROUND:
Following legalization of medical assistance in dying (MAiD) in Canada in 2016, the Ministry of Health (the Ministry) informed all health authorities (HA) of the provincial expectations to establish care coordination services to assist patients and care providers, to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

In 2017, Minister Terry Lake approved a draft (Cliff 1080633) of the Medical Assistance in Dying: Access and Care Coordination Policy (the Policy). The Policy directed the HA to ensure reasonable access to the assessment and provision of MAiD in all HA owned and operated settings, and in contracted organizations where more than 50% of their beds funded are from the HA. Minor updates to the Policy have been since made to clarifying the Ministry's direction on access to MAiD (see Appendix A: Access to and Care Coordination of Medical Assistance in Dying Policy).

DISCUSSION:
The Ministry of Health recognises that the provision of MAiD is a significant shift in health care delivery. This Policy has been developed to clarify expectations related to access to this health service and to support a consistent approach to service delivery across the province. It is the expectation of the Ministry that all eligible persons wishing to access MAiD have reasonable access to the assessment and provision of MAiD, across the continuum of care. While the Ministry supports patient choice, it also recognizes the right of individual health providers to conscientiously object to participation in MAiD.

The Policy applies to all HAs and any programs or services including, but not limited to, hospitals, long-term care, assisted living residences and hospices. The Policy covers both the HA owned and operated facilities and contracted organizations:

- The Policy recognizes that faith-based organizations may decide not to allow the provision of MAiD in facilities operated by the organization.
- HAs will ensure that for a contracted organization, such as a long-term care facility or hospice, that receives greater than 50% of their beds funded by the HA, the contracted facility will allow MAiD assessments and provision. A contracted organization that receives less than or equal to 50% of their beds funded from the HA may decide to refuse to allow the provision of MAiD.
- HAs must work with contracted organizations, including faith-based organizations that refuse to allow provision of MAiD to ensure that individuals requesting

MAiD are provided with information to support decision making (as a part of the role of HA in care coordination).

s.13; s.17

OPTIONS:
Option 1: Approve the Policy.

s.13

RECOMMENDATION:
Option 1: Approve the policy

_____ _____

Approved/Not Approved
Honourable Adrian Dix
Minister

Date Signed

Program ADM/Division: Ian Rongve/Hospital, Diagnostic and Clinical Services Division
Telephone: 778-974-2554
Program Contact (for content): Darlene Therrien, Executive Director, Hospital Services
Drafter: Genevieve Verite
Date: June 6, 2018
File Name with Path:

From:	Cairns, Leann HLTH:EX
To:	Therrien, Darlene HLTH:EX
Cc:	Diacu, Razvan HLTH:EX; Bergen, Sara J HLTH:EX
Subject:	Department of Justice Canada Statement on Institutional Objection to Provide MAID
Date:	December 12, 2019 4:32:32 PM

Would institutions be able to decline to provide medical assistance in dying?

> Under our constitution, it would be up to individual provinces and territories to determine whether some medical institutions would be allowed to decline to provide medical assistance in dying. Nothing in Bill C-14 addresses this issue.

https://www.justice.gc.ca/eng/cj-jp/ad-am/faq.html

Leann Cairns

Manager, Acute Care Access and Policy

BC Ministry of Health |Provincial, Hospital and Laboratory Health Services Division|

PO Box 9638 Stn Prov Govt, Victoria BC V8W 9P1

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MINISTRY OF HEALTH POLICY DRAFT

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria ~~which~~that medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

~~The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery.~~ This policy has been developed to clarify Ministry of Health (Ministry) expectations related to access to this new health service and to support a consistent approach to service delivery across the province. The policy reflects the Ministry's priority of providing patient-centred care, given the precarious medical condition of individuals who request medical assistance in dying (i.e. a grievous and irremediable medical condition accompanied by intolerable suffering).

Policy Objectives

1) To establish a provincial policy framework that supports patient-centred, safe~~reasonable~~ access to medical assistance in dying across the province.~~, in a manner similar to other health services~~.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through contracted independent non-denominational facilities or organizations, or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Opt-out: Refers to a decision that may be made by a contracted publicly-funded independent non-denominational facility or organization to not allow and/or provide the assessment and provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

Rationale

In February 2015, the Supreme Court of Canada (SCC) ruled in *Carter v. Canada (Carter)* that the blanket prohibition against assisted-dying set out in the *Criminal Code of Canada (Criminal Code)* was unconstitutional. In response to the ruling, the federal government amended the *Criminal Code* on June 17, 2016 to create exemptions from criminal prosecution for physicians and nurse practitioners to assess for eligibility and provide medical assistance in dying, as well as pharmacists who dispense medical assistance in dying drugs. The *Criminal Code* amendment also includes eligibility criteria which define who may access medical assistance in dying and procedural safeguards which must be observed before the service can be provided.

The federal legislation situates medical assistance in dying as an option to relieve the suffering of eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved under conditions acceptable to them. The Ministry of Health recognises that this is a significant shift in health care delivery, as well as societal norms.

A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to implementation and service delivery. The policy aligns with the *Criminal Code*, professional college standards related to medical assistance in dying, and the Minister of Health's June 2016 letter which formalised the expectation that health authorities establish a medical assistance in dying care coordination service.

Policy Objectives

To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province similar to the manner in which other health care services are delivered.

Scope

This policy applies to all heath authority, owned and operated, contracted and affiliated services and settings.

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Accountability

Senior level health authority executives are accountable for compliance with this policy.

A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt patient care occur.

Patient and/or family complaints related to medical assistance in dying within scope of the Patient Care Quality Review Board Act will continue to be directed to the health authority's Patient Care Quality Office.

Review

This policy is subject to review on an annual basis, or as required to address operational challenges.

DRAFT Access and Care Coordination Policy

Confidential – Not for Redistribution

Rationale

On June 17, 2016, the Government of Canada amended the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying in certain circumstances. The *Criminal Code* sets out criteria to determine who is **Eligible** for medical assistance in dying and includes procedural safeguards that must be observed before this service can be provided. The *Criminal Code* also includes exemptions from criminal liability for those involved in the ~~provision and~~ assessment of individuals and provision of ~~for~~ medical assistance in dying, dispensing of the required drugs, as well as those aiding in this process.

The Ministry of Health recognises that this is a significant shift in health care delivery, as well as societal norms. A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to implementation and service delivery.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code* and British Columbia professional college standards.

3) To recognise that medical assistance in dying is an option available to Eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authority, owned and operated, as well as contracted and affiliated services, programs and settings.

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DRAFT Access and Care Coordination Policy

Confidential – Not for Redistribution

Rationale

On June 17, 2016, the Government of Canada amended the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying in certain circumstances. The *Criminal Code* sets out criteria to determine who is **Eligible** for medical assistance in dying and includes procedural safeguards that must be observed before this service can be provided. The *Criminal Code* also includes exemptions from criminal liability for those involved in the provision and assessment of individuals for medical assistance in dying, dispensing of the required drugs, as well as those aiding in this process.

The Ministry of Health recognises that this is a significant shift in health care delivery, as well as societal norms. A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to implementation and service delivery.

Policy Objectives

To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province similar to the manner in which other health care services are delivered.

To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code* and professional college standards.

To recognise that medical assistance in dying is an option available to Eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authority, owned and operated, contracted and affiliated services, programs and settings.

Policy

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Senior level health authority executives are accountable for compliance with this policy.

A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt patient care occur.

Patient and/or family complaints related to medical assistance in dying within scope of the *Patient Care Quality Review Board Act* will continue to be directed to the health authority's Patient Care Quality Office.

Review
This policy is subject to review on an annual basis, or as required to address operational challenges.

Definitions

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and if authorized by the patient, transferring the medical records as required.

Eligible: To be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada

b. Be at least 18 years of age and capable of making decisions with respect to their health

c. Have a grievous and irremediable medical condition (see below)

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care

Faith-based Organization: an organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion, spirituality, or culture.

Grievous and Irremediable Medical Condition: A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability

b. In an advanced state of irreversible decline in capability

c. Have an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable

d. their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily

Transfer of Care: At the request of the individual, a health care professional must agree to transfer the individual's medical records to another health care professional who will assume responsibility for the patient's care.

DRAFT Access and Care Coordination Policy

Confidential – Not for Redistribution

Rationale

On June 17, 2016, the Government of Canada amended the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying in certain circumstances. The *Criminal Code* sets out criteria to determine who is **Eligible** for medical assistance in dying and includes procedural safeguards that must be observed before this service can be provided. The *Criminal Code* also includes exemptions from criminal liability for those involved in the assessment of individuals and provision of medical assistance in dying, dispensing of the required drugs, as well as those aiding in this process.

The Ministry of Health (the Ministry) recognises that this is a significant shift in health care delivery, as well as societal norms. A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying for eligible individuals across the province similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code* and the standards of British Columbia's professional college.

3) To recognise that medical assistance in dying is an option available to eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authority owned, operated, contracted, and affiliated facilities, programs, settings, and services.

Policy

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Accountability

a. Senior level health authority executives are accountable for compliance with this policy.

b. A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt care arise.

c. Patient or family complaints related to medical assistance in dying will be directed to the health authority's Patient Care Quality Office.

Review
This policy is subject to review on an annual basis, or as required to address operational challenges.

Definitions

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and, if authorized by the patient, transferring the medical records as required.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion, spirituality, or culture.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Transfer of Care: At the request of the individual, a health care professional must agree to transfer the individual's medical records to another health care professional who will assume responsibility for the patient's care.

DRAFT Access and Care Coordination Policy

Confidential – Not for Redistribution

Rationale

On June 17, 2016, the Government of Canada amended the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying in certain circumstances. The *Criminal Code* sets out criteria to determine who is **Eligible** for medical assistance in dying and includes procedural safeguards that must be observed before this service can be provided. The *Criminal Code* also includes exemptions from criminal liability for those involved in the assessment of individuals and provision of medical assistance in dying, dispensing of the required drugs, as well as those aiding in this process.

The Ministry of Health (the Ministry) recognises that this is a significant shift in health care delivery, as well as societal norms. A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying for eligible individuals across the province similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code* and the standards of British Columbia's professional college.

3) To recognise that medical assistance in dying is an option available to eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authority owned, operated, contracted and affiliated facilities, programs, settings and services.

Policy

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Accountability

a. Senior level health authority executives are accountable for compliance with this policy.

b. A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt care arise.

c. Patient or family complaints related to medical assistance in dying will be directed to the health authority's Patient Care Quality Office.

Review
This policy is subject to review on an annual basis, or as required to address operational challenges.

Definitions

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and, if authorized by the patient, transferring the medical records as required.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion, spirituality, or culture.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Transfer of Care: At the request of the individual, a health care professional must agree to transfer the individual's medical records to another health care professional who will assume responsibility for the patient's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, the Government of Canada amended the *Criminal Code of Canada* (the Criminal Code) to allow medical assistance in dying in certain circumstances. The Criminal Code sets out criteria to determine who is eligible for medical assistance in dying and includes procedural safeguards that must be observed before this service can be provided. The Criminal Code also includes exemptions from criminal liability for those involved in the assessment of individuals and provision of medical assistance in dying, dispensing of the required drugs, as well as those aiding in this process.

The Ministry of Health (the Ministry) recognises that this is a significant shift in health care delivery, as well as societal norms. A provincial policy has been developed ~~is required~~ to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

The objective of this policy is three-fold:

- To establish a provincial policy framework that supports reasonable access to medical assistance in dying for eligible individuals across the province similar to the manner in which other health care services are delivered
- To support a consistent approach to delivery of medical assistance in dying that aligns with the Criminal Code and the standards of British Columbia's professional college.
- To recognise that medical assistance in dying is an option available to eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authority funded facilities and programs in British Columbia, including health authority owned, operated, contracted and affiliated facilities, programs, settings and services.

Policy

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References/Related Policies

- *Criminal Code of Canada*
- HPA
- xxxx (other legislation, etc)

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Accountability

- Senior level health authority executives are accountable for their health authority's compliance with this policy.

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- A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt care arise.
- Patient or family complaints related to medical assistance in dying will be directed to the health authority's Patient Care Quality Office.

Review

This policy is subject to review on an annual basis, or as required. ~~to address operational challenges.~~

APPENDIX 1: DEFINITIONS

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and, if authorized by the patient, transferring the medical records as required.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion, spirituality, or culture.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;
b. Is in an advanced state of irreversible decline in capability;
c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Transfer of Care: At the request of the individual, a health care professional must agree to transfer the individual's medical records to another health care professional who will assume responsibility for the patient's care.

DRAFT Access and Care Coordination Policy

Confidential – Not for Redistribution

Rationale

On June 17, 2016, ~~the Government of Canada~~ amendments to the ~~ed the~~ *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to ~~to~~ determine who is **Eligible** for medical assistance in dying. The Criminal Code provisions ~~and~~ includes procedural safeguards that must be observed before this service may lawfully ~~can~~ be provided. The *Criminal Code* also permits other persons to provide assistance, under specific circumstances described in the Code. ~~includes exemptions from criminal liability for those involved in the assessment of individuals and provision of medical assistance in dying, dispensing of the required drugs, as well as those aiding in this process~~.

The Ministry of Health (the Ministry) recognises that the provision of medical assistance in dying ~~this~~ is a significant shift in health care delivery, as well as societal norms. A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying for eligible individuals across the province similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code* and ~~the standards of British Columbia's professional college~~.

3) To recognise that medical assistance in dying is an option available to eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved through another means acceptable to them.

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Scope

This policy applies to all heath authority owned, operated, contracted, and affiliated facilities, programs, settings, and services.

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Accountability

a. Senior level health authority executives are accountable for compliance with this policy.

b. A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt care arise.

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c. Patient or family complaints related to medical assistance in dying will be directed to the health authority's Patient Care Quality Office.

Review

This policy is subject to review on an annual basis, or as required to address operational challenges.

Definitions

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and, if authorized by the patient, transferring the medical records as required.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality. ~~, or culture.~~

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Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Transfer of Care: At the request of the individual, a health care professional must agree to transfer the individual's medical records to another health care professional who will assume responsibility for the patient's care.

MINISTRY OF HEALTH POLICY DRAFT

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine who is eligible for medical assistance in dying. The Criminal Code provisions include procedural safeguards that must be observed before this service may lawfully be provided. The *Criminal Code* also permits other persons to provide assistance, under specific circumstances described in the Code.

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The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

The objective of this policy is three-fold:

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authorities. If health authority programs or services are provided through contracted facilities or organizations (e.g. private residential care facilities), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways to access medical assistance in dying are in place that meet or exceed the measures described in this policy.

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Accountability
Senior level health authority executives are accountable for their health authority's compliance with this policy.

Review
This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and, if authorized by the patient, transferring the medical records as required (to be revised).

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Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Transfer of Care: At the request of the individual, a health care provider must agree to transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine who is eligible for medical assistance in dying. The *Criminal Code* provisions include procedural safeguards that must be observed before this service may lawfully be provided. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in medical assistance in dying and this is permitted provided this assistance is provided, under the specific circumstances described in the *Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

The objective of this policy is three-fold:

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authorities. If health authority programs or services are provided through contracted facilities or organizations (e.g. private residential care facilities), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways to access medical assistance in dying are in place that meet or exceed the measures described in this policy.

Policy

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada* (add sections)
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia. Professional Standards and Guidelines: Medical Assistance in Dying
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Nurse Practitioners.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying. Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine who is eligible for medical assistance in dying. The *Criminal Code* provisions include procedural safeguards that must be observed before this service may lawfully be provided. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in medical assistance in dying and this is permitted provided this assistance is provided, under the specific circumstances described in the *Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

The objective of this policy is three-fold:

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authorities. If health authority programs or services are provided through contracted facilities or organizations (e.g. private residential care facilities), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways to access medical assistance in dying are in place that meet or exceed the measures described in this policy.

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Policy

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia. Professional Standards and Guidelines: Medical Assistance in Dying
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Nurse Practitioners.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying. Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine ~~who~~whether an individual is eligible for medical assistance in dying. ~~-~~The *Criminal Code* provisions also include procedural safeguards that must be observed ~~before~~for this service ~~may~~to be lawfully ~~be~~ provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, and this is permitted, provided the~~is~~ assistance ~~is provided, under~~ is in accordance with the specific circumstances described in the *Criminal Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. ~~-~~This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

~~The objective of this policy is three-fold:~~

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through ~~an~~other means acceptable to them.

Scope

This policy applies to all health authorities. ~~-~~If health authority programs or services are provided through contracted independent non-denominational facilities or organizations ~~(e.g. private residential care facilities)~~, or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, ~~are in place~~ that meet or exceed the measures described in this policy.

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, ~~Medical Assistance in Dying.~~ Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

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Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying~~,~~ a~~n individual~~ person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement, or otherwise in its constitution declares itself as being an organization based on religion or~~,~~ spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria ~~are met~~:

a. Have~~s~~ a serious and incurable illness, disease, or disability;

b. Be~~Is~~ in an advanced state of irreversible decline in capability;

c. That~~Has an~~ illness, disease or~~,~~ disability or that state of decline ~~that~~ causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. ~~A~~Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Opt-out: Refers to a decision that may be made by a contracted publicly-funded independent non-denominational facility or organization to not allow and/or provide the assessment and provision of medical assistance in dying in their setting(s).

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Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine who is eligible for medical assistance in dying. The *Criminal Code* provisions include procedural safeguards that must be observed before this service may lawfully be provided. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in medical assistance in dying and this is permitted provided this assistance is provided, under the specific circumstances described in the *Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

The objective of this policy is three-fold:

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authorities. If health authority programs or services are provided through contracted facilities or organizations (e.g. private residential care facilities), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways to access medical assistance in dying are in place that meet or exceed the measures described in this policy.

Policy

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia. Professional Standards and Guidelines: Medical Assistance in Dying
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Nurse Practitioners.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying. Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, and this is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through contracted independent non-denominational facilities or organizations, or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Opt-out: Refers to a decision that may be made by a contracted publicly-funded independent non-denominational facility or organization to not allow and/or provide the assessment and provision of medical assistance in dying in their setting(s).

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine who is eligible for medical assistance in dying. The Criminal Code provisions include procedural safeguards that must be observed before this service may lawfully be provided. The *Criminal Code* also permits other persons to provide assistance, under specific circumstances described in the Code.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

The objective of this policy is three-fold:

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying for eligible individuals across the province similar to the manner in which other health care services are delivered.

2) To support a consistent approach to delivery of medical assistance in dying that aligns with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authorities. If health authority programs or services are provided through contracted facilities or organizations (e.g. private residential care facilities), or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways to access medical assistance in dying are in place that meet or exceed the measures described in this policy.

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Effective Connection: Individuals should be provided with information on the options available to alleviate their suffering. This includes advising the requesting individual that other healthcare professionals may be available to see them, suggesting the requesting individual visit another healthcare professional or service, and, if authorized by the patient, transferring the medical records as required (to be revised).

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Transfer of Care: At the request of the individual, a health care provider must agree to transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT

ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine who is eligible for medical assistance in dying. The *Criminal Code* provisions include procedural safeguards that must be observed before this service may lawfully be provided. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in medical assistance in dying and this is permitted provided this assistance is provided, under the specific circumstances described in the *Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery.

Policy Objectives

~~The objective of this policy is three-fold:~~

1) To establish a provincial patient-centred policy framework that supports reasonable access to medical assistance in dying across the province in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through another means acceptable to them.

Scope

This policy applies to all heath authorities and all health authority owned and operated facilities.

~~If h~~Health authorities~~y programs or services are provided through~~ are expected to work with contracted facilities or organizations (e.g. private residential care facilities)~~, or contracted staff, health authorities are required to work with these organizations and staff~~ to ensure patient-centred pathways to access medical assistance in dying are in place. ~~that meet or exceed the measures described in this policy.~~

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia. Professional Standards and Guidelines: Medical Assistance in Dying
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia. Medical Assistance in Dying. Scope of Practice Standards for Nurse Practitioners.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying. Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying, an individual must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;

b. Be at least 18 years of age and capable of making decisions with respect to their health;

c. Have a grievous and irremediable medical condition (defined below);

d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,

e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement or otherwise in its constitution declares itself as being an organization based on religion or, spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if all of the following criteria are met:

a. Has a serious and incurable illness, disease, or disability;

b. Is in an advanced state of irreversible decline in capability;

c. Has an illness, disease, disability or state of decline that causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d. A natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

MINISTRY OF HEALTH POLICY DRAFT
ACCESS TO AND CARE COORDINATION OF MEDICAL ASSISTANCE IN DYING

Background

On June 17, 2016, amendments to the *Criminal Code of Canada* (the *Criminal Code*) to allow medical assistance in dying for capable adults in certain circumstances came into effect. The *Criminal Code* sets out criteria which medical practitioners and nurse practitioners must apply in order to determine whether an individual is eligible for medical assistance in dying. The *Criminal Code* provisions also include procedural safeguards that must be observed for this service to be lawfully provided, and the standards of British Columbia's professional regulatory colleges include additional safeguards that must be adhered to in this province. The *Criminal Code* contemplates that other health care providers (such as nurses and pharmacists) may be involved in aiding in medical assistance in dying, which is permitted, provided the assistance is in accordance with the specific circumstances described in the *Criminal Code*.

The Ministry of Health recognises that the provision of medical assistance in dying is a significant shift in health care delivery. This policy has been developed to clarify expectations related to access to this new health service and to support a consistent approach to service delivery across the province.

Policy Objectives

1) To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province, in a manner similar to other health services.

2) To support a consistent approach to delivery of medical assistance in dying that complies with the *Criminal Code*.

3) To recognise that medical assistance in dying is an option available to eligible adults at the end of life, whose suffering cannot be relieved through other means acceptable to them.

Scope

This policy applies to all health authorities. If health authority programs or services are provided through contracted independent non-denominational facilities or organizations, or contracted staff, health authorities are required to work with these organizations and staff to ensure patient-centred pathways are in place to access medical assistance in dying, that meet or exceed the measures described in this policy.

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Accountability

Senior level health authority executives are accountable for their health authority's compliance with this policy.

References/Related Policies

- *The Criminal Code of Canada*
- *The Health Professions Act*
- College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, Medical Assistance in Dying
- College of Registered Nurses of British Columbia, Medical Assistance in Dying (MAiD), Scope of Practice Standards for Registered Nurses.
- College of Registered Nurses of British Columbia, Scope of Practice Standards for Nurse Practitioners, Part 2: Standards, Limits and Conditions, Section D. Medical Assistance in Dying.
- College of Pharmacists of British Columbia. Health Profession Act Bylaws, Schedule F, Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying, Standards, Limits and Conditions.

Review

This policy is subject to review on an annual basis, or more frequently as required.

APPENDIX 1: DEFINITIONS

Contracted Independent Non-Denominational Facility or Organization: Refers to a contracted facility or organization with an independent board that receives public funding from a health authority, for operating setting(s) where end-of-life services are normally offered.

Eligible: According to the *Criminal Code of Canada,* to be eligible for medical assistance in dying a person must meet all of the following criteria:

a. Be eligible for health services funded by a government in Canada;
b. Be at least 18 years of age and capable of making decisions with respect to their health;
c. Have a grievous and irremediable medical condition (defined below);
d. Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
e. Have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Faith-based Organization: An organization that is a party to the Master Denominational Health Agreement, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

Grievous and Irremediable Medical Condition: According to the *Criminal Code of Canada*, a person has a grievous and irremediable medical condition if they meet all of the following criteria:

a. Have a serious and incurable illness, disease, or disability;
b. Be in an advanced state of irreversible decline in capability;
c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Health Authority: Refers to regional health authorities established under the *Health Authorities Act*, and the Provincial Health Services Authority established under the *Society Act.*

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Transfer of Care: At the request of the individual, a health care provider must transfer the individual's medical records to another health care provider who will assume responsibility for the individual's care.

Rationale

In February 2015, the Supreme Court of Canada (SCC) ruled in *Carter v. Canada (Carter)* that the blanket prohibition against assisted-dying set out in the *Criminal Code of Canada (Criminal Code)* was unconstitutional. In response to the ruling, the federal government amended the *Criminal Code* on June 17, 2016 to create exemptions from criminal prosecution for physicians and nurse practitioners to assess for eligibility and provide medical assistance in dying, as well as pharmacists who dispense medical assistance in dying drugs. The *Criminal Code* amendment also includes eligibility criteria which define who may access medical assistance in dying and procedural safeguards which must be observed before the service can be provided.

The federal legislation situates medical assistance in dying as an option to relieve the suffering of eligible adults nearing the end of their natural life, who have decided that their suffering cannot be relieved under conditions acceptable to them. The Ministry of Health recognises that this is a significant shift in health care delivery, as well as societal norms.

A provincial policy is required to clarify expectations related to access to this new health service and to support a consistent approach to implementation and service delivery. The policy aligns with the *Criminal Code*, professional college standards related to medical assistance in dying, and the Minister of Health's June 2016 letter which formalised the expectation that health authorities establish a medical assistance in dying care coordination service.

Policy Objectives

To establish a provincial policy framework that supports reasonable access to medical assistance in dying across the province similar to the manner in which other health care services are delivered.

Scope

This policy applies to all heath authority, owned and operated, contracted and affiliated services and settings.

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Accountability

Senior level health authority executives are accountable for compliance with this policy.

A member of the senior executive team must be notified should a dispute or significant operational challenge with the potential to disrupt patient care occur.

Patient and/or family complaints related to medical assistance in dying within scope of the Patient Care Quality Review Board Act will continue to be directed to the health authority's Patient Care Quality Office.

Review

This policy is subject to review on an annual basis, or as required to address operational challenges.

Care Facility Information for Client – June 11, 2018
For Discussion Only

Information to be provided to adults eligible for publicly-funded residential care and considering their preferred care facilities, or to their substitute decision maker.

Standard information about care and services that applies to all residential care facilities:

- clients are required to pay the income-based, assessed rate ~~assessed, based on income~~
- benefits are provided at no extra charge, including:
  - accommodation
  - meals
  - care plan development and monitoring
  - social and recreational activities
  - most prescription medication
  - basic laundry services (bed linens, towels, wash cloths, clothing)
  - general hygiene and medical supplies
  - basic wheelchairs, including basic cleaning and maintenance
- there are some services for which a charge may be applied, including
  - personal cable and telephone connection and services
  - personal transportation
  - purchase/rental of any equipment for exclusive use of client (such as walker, crutches, canes, or other devices)
  - companion services
  - personal dry cleaning or laundry services for items needing special attention
- clients are allowed to receive visitors at times designated by the facility
- clients' rights are set out in the Residents' Bill of Rights, which is required to be posted in every facility
- how to make a complaint (internal complaint process, Community Care Facilities Licensing, and Patient Care Quality Office)

Facility - specific information about care and services (differs between facilities):

- location and contact information for facility
- ~~average~~ approximate wait time for admission into each facility
- types of accommodation available (shared occupancy, single occupancy)
- availability and cost of services, such as:
  - hair dressing
  - oral care
  - nail care
  - foot care
- availability of allied health supports, such as physiotherapy, occupational therapy, social work

- availability of spiritual/denominational/pastoral services and activities
- frequency and type of social and recreational activities
- if the facility is one where ~~a person would be unable to access~~ Medical Assistance in Dying (MAiD) services are not supported **(NOTE: WORDING TO BE CONFIRMED BY MINISTRY)**
- what additional services are available for a fee, and the amount of these fees
- security of the facility
- accessibility of the facility

Information about initial admission and transfers into facilities

- Updated version of *MoH Guide: Planning for Your Care Needs: Help in Selecting a Residential Care Facility*. February 2013. https://www.health.gov.bc.ca/library/publications/year/2013/planning-for-your-care-needs.pdf
- Updated version of *MoH HCC Policy, 6 Residential Care Services, 6.D, Access to Services*. https://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter-6.pdf
- Outline of any health authority-specific processes for initial admission and transfer, including waitlist management.

Care Facility Information for Client – July 6, 2018
For Discussion Only

Information to be provided to adults eligible for publicly-funded residential care and considering their preferred care facilities, or to their substitute decision maker.

Standard information about care and services that applies to all residential care facilities:

- clients are required to pay the income-based, assessed rate
- benefits are provided at no extra charge, including:
  - accommodation
  - meals
  - 24-hour care and supervision is provided by nurses and health care assistants
  - clinical support services such as rehabilitation and social work services consistent with the client's care plan
  - care plan development and monitoring
  - social and recreational activities
  - ~~most~~ prescription medication covered by Pharmacare/Plan B
  - basic laundry services (bed linens, towels, wash cloths, clothing)
  - general hygiene and medical supplies
  - basic wheelchairs, including basic cleaning and maintenance
- there are some services for which a charge may be applied, including
  - personal cable and telephone connection and services
  - personal transportation
  - purchase/rental of any equipment for exclusive use of client (such as walker, crutches, canes, or other devices)
  - companion services
  - personal dry cleaning or laundry services for items needing special attention
  - some non-prescription medications (in facilities licensed under the *Community Care and Assisted Living Act)*
- clients can access other medical and dental services though these services may not be provided onsite and will involve a fee (if not covered by the Medical Services Plan)
- ~~clients are allowed to receive~~ visitors are welcome at times designated by the facility
- clients' rights are set out in the Residents' Bill of Rights, which is required to be posted in every facility
- all facilities are required to comply with the health authority's "least restraint policy" (more information can be provided upon request)
- how to make a complaint (internal complaint process, Community Care Facilities Licensing, and Patient Care Quality Office)

Facility - specific information about care and services (differs between facilities):

- location and contact information for facility
- approximate wait time for admission into each facility

- types of accommodation available (shared occupancy, single occupancy)
- availability of other services (such as hair dressing, foot care and nail care)
- availability of spiritual/denominational/pastoral services and activities
- frequency and type of social and recreational activities
- if the facility is one where Medical Assistance in Dying (MAiD) services are not supported **(NOTE: WORDING TO BE CONFIRMED BY MINISTRY)**
- what additional services are available for a fee, and the amount of these fees
- security of the facility
- accessibility of the facility

Information about initial admission and transfers into facilities **(not mandatory to be provided)**

- Updated version of *MoH Guide: Planning for Your Care Needs: Help in Selecting a Residential Care Facility*. February 2013. https://www.health.gov.bc.ca/library/publications/year/2013/planning-for-your-care-needs.pdf
- Updated version of *MoH HCC Policy, 6 Residential Care Services, 6.D, Access to Services*. https://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter-6.pdf
- Outline of any health authority-specific processes for initial admission and transfer, including waitlist management.

Care Facility Information for Client – July 6, 2018
For Discussion Only

Information to be provided to adults eligible for publicly-funded residential care and considering their preferred care facilities, or to their substitute decision maker.

Standard information about care and services that applies to all residential care facilities in accordance with the provincial Home and Community Care~~CC~~ Policy Manual Chapter: 6.F Residential Care Services - Benefits And Allowable Charges:

- clients are required to pay the income-based, assessed rate
- benefits are provided at no extra charge, including:
  - accommodation
  - meals
  - 24-hour care and supervision is provided by nurses and health care assistants
  - clinical support services such as rehabilitation and social work services consistent with the client's care plan
  - development and maintenance of a care plan, ~~development and monitorin~~in collaboration with client/substitute decision maker and family
  - social and recreational activities
  - prescription medication covered by Pharmacare/Plan B
  - basic laundry services (bed linens, towels, wash cloths, clothing)
  - general hygiene and medical supplies (such as, oral care, basic incontinence supplies and others)
  - basic wheelchairs, including basic cleaning and maintenance
- there are some services for which a charge may be applied, including
  - personal cable and telephone connection and services
  - personal transportation
  - purchase/rental of any equipment for exclusive use of client (such as walker, crutches, canes, specialized wheelchairs or other devices)
  - companion services
  - personal dry cleaning or laundry services for items needing special attention
  - some non-prescription medications (in facilities licensed under the *Community Care and Assisted Living Act*)
- clients can access other medical and dental services though these services may not be provided onsite and will involve a fee (if not covered by the Medical Services Plan)
- information about on-site end-of-life and palliative care services
- visitors are welcome at times designated by the facility
- clients' rights are set out in the Residents' Bill of Rights, which is required to be posted in every facility
- all facilities are required to comply with the health authority's "least restraint policy" (more information can be provided upon request)

- how to make a complaint (internal complaint process, Community Care Facilities Licensing, and Patient Care Quality Office)

Facility - specific information about care and services (differs between facilities): s.13

- location and contact information for facility
- approximate wait time for admission into each facility
- types of accommodation available (shared occupancy, single occupancy)
- availability of other services (such as hair dressing, foot care and nail care)
- availability of spiritual/denominational/pastoral services and activities
- frequency and type of social and recreational activities
- if the facility is one where the assessment and provision of medical assistance in dying (MAiD) services, are or are not available on site ~~if the facility is one where Medical Assistance in Dying (MAiD) services are not supported~~ ~~**(NOTE: WORDING TO BE CONFIRMED BY MINISTRY)**~~

Commented [KLA2]: Wording provided by Genevieve Stanton

- what additional services are available for a fee, and the amount of these fees
- security of the facility
- accessibility of the facility

Information about initial admission and transfers into facilities (not mandatory to be provided)

- Updated version of *MoH Guide: Planning for Your Care Needs: Help in Selecting a Residential Care Facility*. February 2013. https://www.health.gov.bc.ca/library/publications/year/2013/planning-for-your-care-needs.pdf
- Updated version of *MoH HCC Policy, 6 Residential Care Services, 6.D, Access to Services*. https://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter-6.pdf
- Quick Facts Directory. Developed by the Office of the Seniors Advocate. https://www.seniorsadvocatebc.ca/quickfacts/
- Outline of any health authority-specific processes for initial admission and transfer, including waitlist management.

Care Facility Information for Client – September 19, 2018
For Discussion Only

Information to be provided to adults eligible for publicly-funded residential care and considering their preferred care facilities, or to their substitute decision maker.

Standard information about care and services that applies to all residential care facilities, in accordance with the provincial Home and Community Care Policy Manual Chapter: 6.F Residential Care Services - Benefits And Allowable Charges, including that:

- clients are required to pay the income-based, assessed rate
- benefits are provided at no extra charge, including:
    - accommodation
    - meals
    - 24-hour care and supervision is provided by nurses and health care assistants
    - clinical support services such as rehabilitation and social work services consistent with the client's care plan
    - development and maintenance of a care plan, in collaboration with client/substitute decision maker and family
    - social and recreational activities
    - prescription medication covered by Pharmacare/Plan B
    - basic laundry services (bed linens, towels, wash cloths, clothing)
    - general hygiene and medical supplies (such as, oral care, basic incontinence supplies and others)
    - basic wheelchairs, including basic cleaning and maintenance
- there are some services for which a charge may be applied, including
    - personal cable and telephone connection and services
    - personal transportation
    - purchase/rental of any equipment for exclusive use of client (such as walker, crutches, canes, specialized wheelchairs or other devices)
    - companion services
    - personal dry cleaning or laundry services for items needing special attention
    - some non-prescription medications (in facilities licensed under the *Community Care and Assisted Living Act*)
- clients can access other medical and dental services though these services may not be provided onsite and will involve a fee (if not covered by the Medical Services Plan)
- on-site end-of-life and palliative care services are available
- visitors are welcome at times designated by the facility
- clients' rights are set out in the Residents' Bill of Rights, which is required to be posted in every facility
- all facilities are required to comply with the health authority's "least restraint policy" (more information can be provided upon request)

- there are ways to make a complaint (internal complaint process, Community Care Facilities Licensing, and Patient Care Quality Office)

Facility - specific information about care and services (differs between facilities):

- location, distance from closest acute care facility, and contact information for facility
- approximate wait time for admission for each facility
- types of accommodation (shared occupancy, single occupancy)
- availability of other services (such as hair dressing, foot care and nail care)
- availability of spiritual/denominational/pastoral services and activities
- frequency and type of social and recreational activities
- if the facility is one where the assessment and provision of medical assistance in dying (MAiD) services, are or are not available on site
- what additional services are available for a fee, and the amount of these fees
- security at the facility
- accessibility of the facility

Additional information available to the public about initial admission and transfers into facilities (not mandatory to be provided)

- Ministry of Health *Guide: Planning for Your Care Needs: Help in Selecting a Residential Care Facility*. February 2013. https://www.health.gov.bc.ca/library/publications/year/2013/planning-for-your-care-needs.pdf
- Ministry of Health *Home and Community Care Policy Manual, 6 Residential Care Services, 6.D, Access to Services*. https://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter-6.pdf
- Quick Facts Directory. Office of the Seniors Advocate. https://www.seniorsadvocatebc.ca/quickfacts/
- Outline of any health authority-specific processes for initial admission and transfer, including waitlist management.

1091415

Ian Bushfield
Executive Director
British Columbia Humanist Association
PO Box 400 - 3381 Cambie Street
Vancouver, BC V5Z 4R3

Dear Ian Bushfield:

I am writing in response to your email to the Honorable Adrian Dix, Minister of Health, received on August 15, 2017. Thank you for taking the time to congratulate the Minister of Health on his appointment and for raising issues important to the British Columbia Humanist Association (BCHA). Responses to the two issues raised in your email are provided below:

1. The BCHA is seeking recognition of Humanist Officiants under the *Marriage Act.*

A decision of the Registrar General of the Vital Statistics Agency, in response to an application for authority to solemnize marriage, is restricted to criteria outlined in the *Marriage Act*. The *Act* pertains to the registration of religious representatives, marriage commissioners, and treaty first nations members designated under the laws of the treaty first nation to solemnize marriages.

The Registrar General provided the BCHA with a letter of response dated January 28, 2013, to the BCHA's application for recognition as a religious body under the *Marriage Act* for the purpose of seeking the registration of religious representatives for solemnizing marriage. The BCHA application was denied based on a review of the application and supporting materials as well as the *Marriage Act.* The letter pointed out that the Constitution of the BCHA explicitly states that the purpose of secular humanism is to provide a valid alternative to existing religions and that humanism has no official dogma. The Registrar General concluded that the BCHA is not a religious body for the purposes of the *Marriage Act*, and that for all intents and purposes the sample wedding ceremony in the application was a civil rather than a religious ceremony.

The Registrar General recommended that BCHA members make application under the *Marriage Act* to become marriage commissioners in the communities in which they reside, and indicated that Section 5 of the *Marriage Act* provided for an appeal of his decision, on a question of law, to the Supreme Court of British Columbia within 3 months of the date of decision.

2. The BCHA wants to ensure British Columbians have protected access to healthcare services, including medical assistance in dying and abortion.

Medical assistance in dying is now a legal service in Canada, with federal legislation in place since June 17, 2016. In British Columbia, each health authority has a care coordination service

Ministry of Health Acute and Provincial Services Branch PO Box 9638 STN PROV GOVT Victoria BC V8W 9P1

in place to assist patients and health care providers in navigating access to this service, including linking patients with medical practitioners who are willing and trained to conduct an eligibility assessment or provide medical assistance in dying. The federal legislation does not compel individuals to provide or assist in providing medical assistance in dying; however, the standards of British Columbia's regulatory colleges require health care professionals to provide an effective transfer of care for their patients.

Under the 1995 *Master Agreement* between the Minister of Health and the Denominational Health Association (DHA), faith-based organizations are not compelled to allow or provide medical assistance in dying in owned facilities. However, health authorities have worked with faith-based and non-faith-based organizations to ensure procedures are in place for the effective transfer of patient care or transfer to service when necessary.

Regarding access to abortion services in British Columbia, the *Hospital Act* and *Hospital Act Regulation* specify a Schedule of hospitals that must provide the facilities and services that allow a qualified person to receive abortion services. Similar to the above response on access to medical assistance in dying, the *Master Agreement* between the Minister of Health and the DHA does not compel faith-based organizations to provide abortion services.

Sincerely,

Brendan Abbott
Executive Director

Key Messages: End of Life Care and Medical Assistance in Dying (MAiD)

(November 2019)

CAMAP | ACEPA

Canadian Association of MAiD Assessors and Providers

Association canadienne des évaluateurs et prestataires de l'AMM

End-of-Life Law & Policy in Canada

HEALTH LAW INSTITUTE, DALHOUSIE UNIVERSITY

Copyright

Page 233 of 359 to/à Page 236 of 359

Withheld pursuant to/removed as

Copyright

From:	Kopetsky, Darren
To:	Heathcote, Susan; McKenzie, Michael (RO VCC); Bergen, Sara J HLTH:EX
Subject:	FW: CAMAP statement on EOL care and MAiD
Date:	December 9, 2019 10:41:19 AM
Attachments:	EOL and MAiD Statement Nov2019.pdf

Hi all
You may already have seen
D

Darren Kopetsky
Corporate Director, Risk Management, PHSA
Desk: 604-675-7425
Cell: 604-317-2742

From: CAMAP [mailto:camap.office@gmail.com]
Sent: Monday, December 09, 2019 7:35 AM
To: Kopetsky, Darren
Subject: CAMAP statement on EOL care and MAiD

Dear CAMAP member,

Attached you will find CAMAP's draft statement of Key Messages on End of Life Care and MAiD.

As a membership organization, we believe it is important to seek your input on our statement before publishing more widely. Our goal was to be clear and concise and focus on the larger picture.

Since drafting this statement, CHPCA and CSPCP have jointly released a somewhat divisive position statement involving MAiD and palliative care. Our statement is not meant as a retort and does not specifically address any concerns arising from their publication (although it could).

If you have comments or constructive feedback we ask you to send them directly to Kim Wiebe at:

KLWiebe@sharedhealthmb.ca

We have delayed the release of our statement until we have a sense of membership support and we remain open to hearing your thoughts.

CAMAP Team

***And as a reminder, if you haven't already done so, please DO fill in our engagement survey at:
https://docs.google.com/forms/d/e/1FAIpQLSf4B8KJdD1z7tT4Ef6_GVFu6H3m4gjYL9rdY7EuXhQAokVkxA/viewform
CAMAP Team

Page 239 of 359 to/à Page 240 of 359

Withheld pursuant to/removed as

s.14

From: Therrien, Darlene HLTH:EX
To: Diacu, Razvan HLTH:EX; Bergen, Sara J HLTH:EX
Subject: FW: MAiD Policy letter
Date: January 20, 2020 12:34:01 PM
Attachments: image001.jpg

Sharing

Darlene

From: Chang, Daniele L HLTH:EX **On Behalf Of** PHLHS Document Coordinator HLTH:EX
Sent: January 20, 2020 11:59 AM
To: Therrien, Darlene HLTH:EX; PHLHS Document Coordinator HLTH:EX; Henwood, Tannis L HLTH:EX
Cc: Schuster, Michelle M HLTH:EX; Patterson, Catherine M HLTH:EX
Subject: RE: MAiD Policy letter

Good morning everyone,

MAiD Policy letters and attachment were distributed to the HA CEOs this date and uploaded to cliff # 1152978.

Tannis - Please refer to cliff to save finals to the branch LAN as needed.

Thank you,

Dani Chang
Documents Coordinator
Provincial, Hospital and Laboratory Health Services Division
Ministry of Health
PO Box 9639 Stn Prov Govt, Victoria BC, V8W 9P1
Tel: 778-698-7193
Email: daniele.chang@gov.bc.ca

From: Therrien, Darlene HLTH:EX
To: Diacu, Razvan HLTH:EX; Bergen, Sara J HLTH:EX
Cc: Skeels, Carley HLTH:EX
Subject: FW: MAID provisions VIHA
Date: December 18, 2019 4:33:31 PM
Attachments: image001.gif
image002.jpg

Confirmation follow up from our bilateral phone call.

Darlene

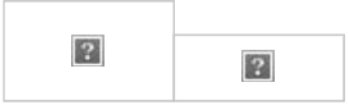
From: Peljhan, Marko [mailto:Marko.Peljhan@viha.ca]
Sent: Wednesday, December 18, 2019 9:51 AM
To: Therrien, Darlene HLTH:EX
Cc: Robertson, David W (Dr)
Subject: FW: MAID provisions

Hi Darlene,
In response to the question you raised last week related to MAID access in Hospices on Vancouver Island, please see below notes. Let myself or Dr. David Robertson know if you have more questions. Dr. Robertson is the Executive Medical Director lead for MAID in Island Health.

- MAiD is supported in all of our Hospice beds (community) and Palliative care units (acute), except "Hospice at The Views" in Comox. These beds are contracted with St. Josesph's. Their refusal to provide MAiD on site is based on the current agreement between the Province and the Denominational Health care Association.
- Because of its commitment to MAiD access, Island Health has decided to relocate the contracted Comox Valley Hospice beds to a new location (done as part of RFP), but this new location won't open until spring 2021.
- For now, MAiD assessments are allowed on site at The Views and the small number of transfers out (4 in 2019) have gone smoothly.

Thank you,
Marko

Marko Peljhan
Executive Director Geography 4
Sooke Region, West Shore and Urban Greater Victoria
Office: 250-370-8111, 13169
Mobile: 778-678-2485



Page 244 of 359 to/à Page 249 of 359

Withheld pursuant to/removed as

s.14

From:	Rains, Derek HLTH:EX
To:	Smith, Leah M HLTH:EX
Cc:	Greenaway, Shelley E HLTH:EX
Subject:	FW: Urgent MAID fees proposal
Date:	July 27, 2016 1:01:17 PM
Attachments:	Urgent Proposal to Medical Services Commission and Tariff Committee - MA....pdf

FYI - Leah this may come up while I'm away.

Shelley, FYI, this might just be interesting given the amount work we do regarding MSP.

-----Original Message-----
From: Rains, Derek HLTH:EX
Sent: Wednesday, July 27, 2016 1:00 PM
To: s.22
Cc: Louie, Betty HLTH:EX; XT:HLTH Crow, Richard Dr.
Subject: RE: Urgent MAID fees proposal

Good afternoon Dr. Reggler,

Thank you for taking the time to bring this important matter to our attention.

We have reviewed your proposal and have determined the appropriate process for your request.

For matters pertaining to developing a new fee code, proposals need to be submitted to the Section. Doctors of BC will be able to move the proposal through the proper channels.

Please feel free to contact me with any questions you may have.

Regards,

Derek

Derek Rains

Director, Medical Services
Health Services Policy | Acute & Provincial Services Branch | Ministry of Health Main floor, 1515 Blanshard Street, Victoria, BC | PO Box 9638 Stn Prov Govt V8W 9P1
Office: 250-952-3008
Cell: 250-896-9748

From: Jonathan Reggler <s.22
Sent: July-12-16 12:49 AM
To: Abbott, Brendan HLTH:EX
Cc: XT:HLTH Crow, Richard Dr.

Subject: Urgent MAID fees proposal

Dear Mr Abbott

I am a member of the Island Health Medical Assistance in Dying (MAID) Working Group. I have been asked by Dr Richard Crow, the Group's Chair, to send you a copy of the proposal that has been written by the eight current MAID providers in BC regarding the fees that should be paid for the provision of MAID. I am one of these providers.

Interim guidance regarding fees has been published for physicians. Unfortunately the fees within the guidance are completely inadequate and will prove to be a major inhibition to the involvement of physicians in providing MAID especially if they form the basis for established fees in the future.

Our proposal is detailed and contains within it a system of fees that will allow the development of a comprehensive MAID service throughout BC.

From: Therrien, Darlene HLTH:EX
To: Bergen, Sara J HLTH:EX
Subject: Fwd: FYI CHPCA and CSPCP - Joint Call to Action
Date: November 27, 2019 2:11:38 PM

Sharing... very topical...

Darlene

Begin forwarded message:

From: "Adams, Alix HLTH:EX" <Alix.Adams@gov.bc.ca>
Date: November 27, 2019 at 12:02:47 PM PST
To: "Fisher, Kiersten D HLTH:EX" <Kiersten.Fisher@gov.bc.ca>, "Therrien, Darlene HLTH:EX" <Darlene.Therrien@gov.bc.ca>
Subject: FYI CHPCA and CSPCP - Joint Call to Action

Hi Kiersten and Darlene,

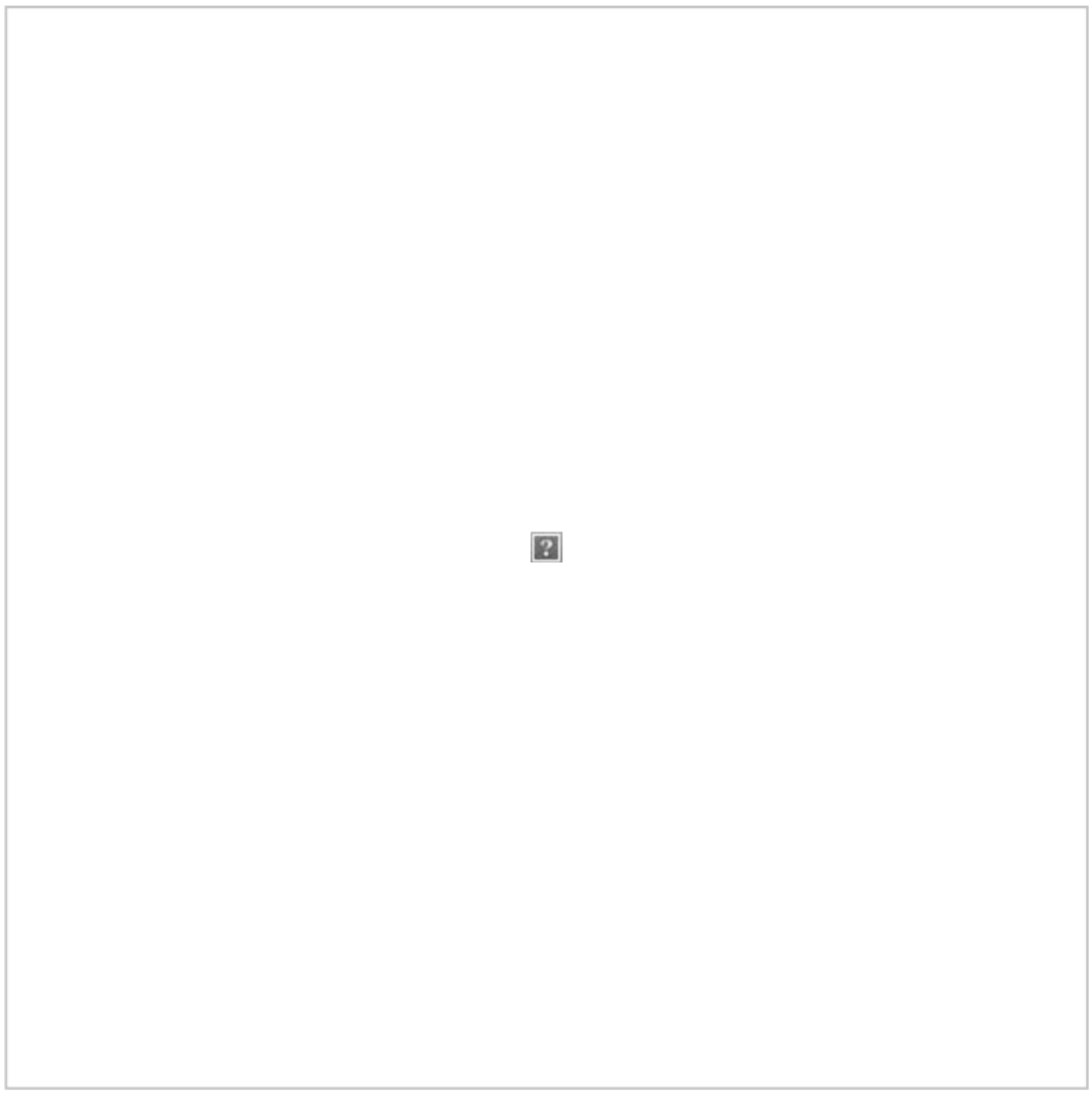
FYI, looping you in to this communication about MAID and Palliative Care – from two national palliative care organizations.

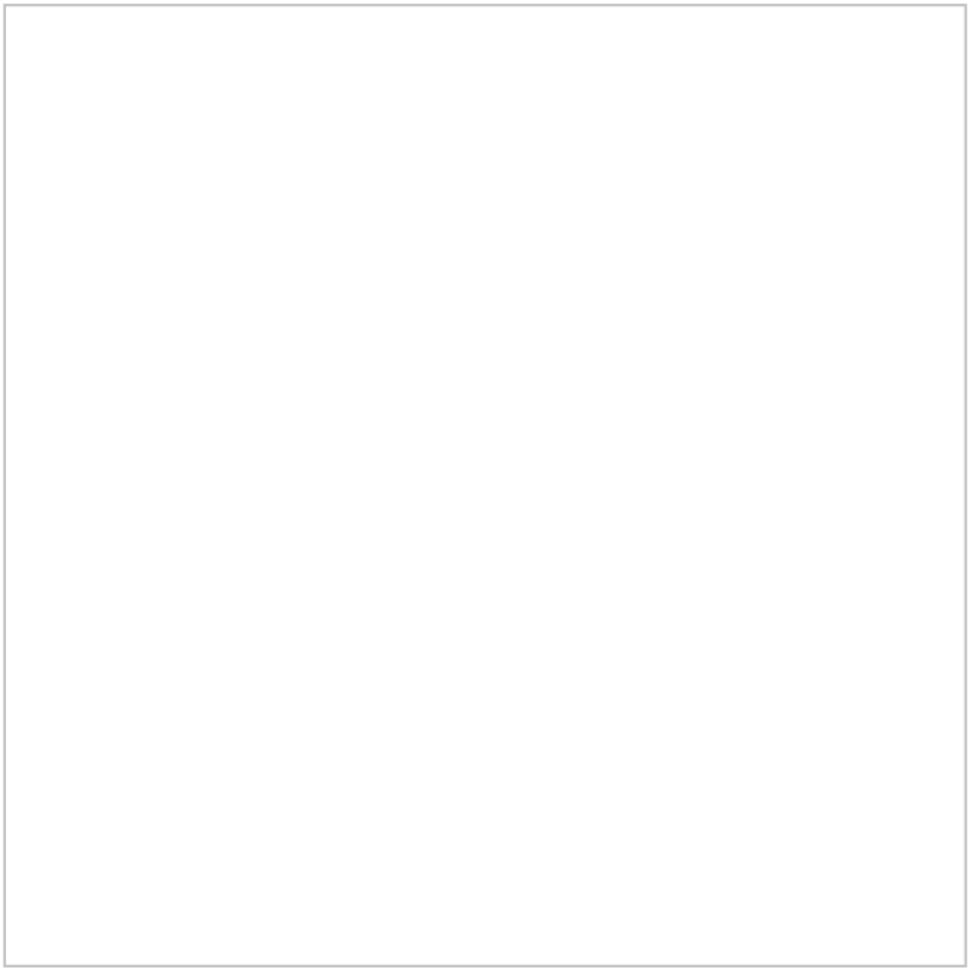
I am received the Call to Action as a result of being on the CHCPA distribution list.

Alix Adams
Director, Palliative and Dementia Care
Specialized Services Division
BC Ministry of Health
Office: (250) 952-2857
Mobile: (250) 896-8471

From: Canadian Hospice Palliative Care Association <info@chpca.net>
Sent: November 27, 2019 9:04 AM
To: Adams, Alix HLTH:EX <Alix.Adams@gov.bc.ca>
Subject: CHPCA and CSPCP - Joint Call to Action

View this email in your browser | Cliquez ici pour la version française.





CHPCA and CSPCP Joint Call to Action

Due to ongoing confusion amongst the general public regarding Hospice Palliative Care (HPC) and Medical Assistance in Dying (MAiD), the Canadian Hospice Palliative Care Association (CHPCA) and the Canadian Society of Palliative Care Physicians (CSPCP) would like to clarify the relationship of hospice palliative care and MAiD.

Healthcare articles and the general media continue to conflate and thus misrepresent these two fundamentally different practices. MAiD is not part of hospice palliative care; it is not an "extension" of palliative care [i] nor is it one of the tools "in the palliative care basket".[ii] National and international hospice palliative care organizations are unified in the position that MAiD is not part of the practice of hospice palliative care.[iii] [iv] [v] [vi] [vii] [viii] [ix] [x]

Hospice palliative care and MAiD substantially differ in multiple areas including in philosophy, intention and approach.[xi] Hospice palliative care focuses on improving quality of life and symptom management through holistic person-centered care for those living with life threatening conditions. Hospice palliative care sees dying as a normal part of life and helps people to live and die well. Hospice palliative care does not seek to hasten death or intentionally end life. In MAiD, however, the intention is to address suffering by ending life through the administration of a lethal dose of drugs at an eligible person's request.

Less than 30% of Canadians have access to high quality hospice palliative care, yet more than 90% of all deaths in Canada would benefit from it.[xii] [xiii] Despite this startling discrepancy, access to hospice palliative care is not considered a fundamental healthcare right for Canadians. In contrast, MAiD has been deemed a right through the Canada Health Act, even though deaths from MAiD account for less than 1.5% of all deaths in Canada.[xiv]

We call on the federal and provincial governments to prioritize funding and improve access to hospice palliative care in Canada, and to support the implementation and action plan of the National Framework for Palliative Care in Canada.[xv] Canadians must have a right to assistance in living with hospice palliative care, and not just a right to termination of life.

Sincerely,

Sharon Baxter, MSW
Executive Director
Canadian Hospice Palliative Care Association (CHPCA)
Annex D, Saint-Vincent Hospital
60 Cambridge Street, North
Ottawa, Ontario K1R 7A5
SBaxter@chpca.net

Leonie Herx MD PhD FCFP (PC)
President

Canadian Society of Palliative Care Physicians (CSPCP)
Suite 584
1A – 12830 – 96th Avenue
Surrey, British Columbia V3V 0C2
Leonie.Herx@kingstonhsc.ca

---

[i] Buchman, Dr. Sandy. "Bringing Compassion to Medicine and to the CMA." *Canadian Medical Association*, 12 Oct. 2019, https://www.cma.ca/dr-sandy-buchman.
[ii] Kutcher, Dr. Matt. "Navigating MAiD on PEI." *Canadian Medical Association*, 19 Nov. 2018, https://www.cma.ca/dr-matt-kutcher.
[iii] World Health Organization (WHO). "WHO Definition of Palliative Care." *World Health Organization (WHO)*, https://www.who.int/cancer/palliative/definition/en/.
[iv] De Lima L, Woodruff R, et al, International Association for Hospice and Palliative Care "Position Statement Euthanasia and Physician-Assisted Suicide." JPM Vol 20, 1:1 -7.
[v] Radbruch, Lukas, et al. "Euthanasia and Physician-Assisted Suicide: A White Paper from the European Association for Palliative Care." *Palliative Medicine*, vol. 30, no. 2, 2015, pp. 104–116., doi:10.1177/0269216315616524.
[vi] Australia and New Zealand Society of Palliative Medicine (ANZSPM) *"Position Statement on the Practice of Euthanasia and Physician Assisted Suicide."* 31 Mar. 2017
[vii] Canadian Hospice Palliative Care Association *"Policy on Hospice Palliative Care and Medical Assistance in Dying (MAiD)."* Jun. 2019
[viii] Canadian Society of Palliative Care Physicians *"Key Messages: Palliative Care and Medical Assistance in Dying (MAID)."* May 2019.
[ix] "Statement on Physician-Assisted Dying." *American Academy of Hospice and Palliative Medicine (AAHPM)*, 24 Jul. 2016, http://aahpm.org/positions/pad.
[x] Canadian Medical Association. "Palliative Care (Policy)." 2016
[xi] Shariff M & Gingerich M. "Endgame: Philosophical, Clinical and Legal Distinctions between Palliative Care and Termination of Life." Vol. 85, Second Series Supreme Court Law Review 225. 2018
[xii] Quality End-of-Life Care Coalition of Canada and Canadian Hospice Palliative Care Association. "The Way Forward National Framework; a Roadmap for an Integrated Palliative Approach to Care." Mar. 2015.
[xiii] Canadian Society of Palliative Care Physicians . "How to Improve Palliative Care in Canada - A Call to Action for Federal, Provincial, Territorial, Regional and Local Decision-Makers." Nov. 2016.
[xiv] "Fourth Interim Report on Medical Assistance in Dying in Canada." Government of Canada, Health Canada, Apr. 2019, https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019.html.
[xv] "Framework on Palliative Care in Canada." *Government of Canada*, Health Canada, 4 Dec. 2018, https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html.

From:	Rains, Derek HLTH:EX
To:	Greenaway, Shelley E HLTH:EX; Archibald, Karen HLTH:EX; Wingrove, Scott HLTH:EX
Subject:	Fwd: Revised DRAFT Guidelines for LTC Access
Date:	March 15, 2019 1:18:38 PM
Attachments:	LTC Access Guidelines 20190314 - JH.docx ATT00001.htm

---

I'm in Vancouver today, so can't see the comments.

Sending you all since is of the essence on this one.

Thnx

Sent from my iPhone

Begin forwarded message:

From: "Harrison, Joanna" <Joanna.Harrison@interiorhealth.ca>
Date: March 15, 2019 at 8:30:33 AM PDT
To: "Rains, Derek HLTH:EX" <Derek.Rains@gov.bc.ca>
Subject: RE: Revised DRAFT Guidelines for LTC Access

Hello Derek,
Thank you so much for the opportunity to see this. I made a couple of comments in track changes.
Thanks,
Jo.
Joanna Harrison, MscM, Bsc
Director – Access and Flow, Hospitals and Communities Integrated Services
9th Floor, Royal Inland Hospital
311 Columbia street
Kamloops, BC, V2C 2T1
Cell: 250 215-8585
I acknowledge that my work place is within the ancestral, traditional, and unceded territory of the Secwepemc Nation.

From: Rains, Derek HLTH:EX [mailto:Derek.Rains@gov.bc.ca]
Sent: Thursday, March 14, 2019 3:12 PM
To: 'O'Callaghan, Teresa'; Seeman, Susan [VA]; Ruby Syropiatko; Harrison, Joanna; Hobbs, Brent; XT:Schmid, Jonathan EHS:IN; Partridge, Colin (Dr); Derksen, Beth Ann [NHA]; marietjieslabbert@gmail.com; Oliver, Jordan [NHA]; Taverner, Tarnia [PHSA]; 'Friess, Claudia'; Elzinga, Don EHS:EX; Lilley, Neil EHS:EX
Cc: Greenaway, Shelley E HLTH:EX
Subject: FW: Revised DRAFT Guidelines for LTC Access
Importance: High
Hello AFWG;
Please review the Guidelines, especially section 3.4 (which is on page 6) as it includes an edit that affects acute care hospitals.

If any, concerns about the edit, or the document in general, could be sent to Derek by the morning of Tuesday, March 19th, that would be good.

Thank you,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

From: Archibald, Karen HLTH:EX
Sent: March 14, 2019 1:56 PM
To: 'dee.chatha@fraserhealth.ca' <dee.chatha@fraserhealth.ca>; 'Lisa.Maxfield@interiorhealth.ca' <Lisa.Maxfield@interiorhealth.ca>; 'Mary.herauf@northernhealth.ca' <Mary.herauf@northernhealth.ca>; 'Dawn.Connolly@northernhealth.ca' <Dawn.Connolly@northernhealth.ca>; 'Gina.Gaspard@fnha.ca' <Gina.Gaspard@fnha.ca>; 'Shelina.meghji@vch.ca' <Shelina.meghji@vch.ca>; 'Sarah.jordan@vch.ca' <Sarah.jordan@vch.ca>; 'Jillian.Fisher@viha.ca' <Jillian.Fisher@viha.ca>; 'Caitlin.Davies@viha.ca' <Caitlin.Davies@viha.ca>; 'Elizabeth.Pearce@fnha.ca' <Elizabeth.Pearce@fnha.ca>; XT:Coughlin, Kevin JAG:EX <kcoughlin@trustee.bc.ca>; XT:Leaney, Alison AG:IN <aleaney@trustee.bc.ca>; 'eprice_edencare@telus.net' <eprice_edencare@telus.net>; s.22 ; 'A.Berndt@gmx.net' <A.Berndt@gmx.net>; 'leigh.hayes@fraserhealth.ca' <leigh.hayes@fraserhealth.ca>; 'Davidson, Monique [VC]' <Monique.Davidson@vch.ca>; 'Armstrong, Barbara' <Barbara.Armstrong@northernhealth.ca>
Cc: McLachlan, Debbie HLTH:EX <Debbie.McLachlan@gov.bc.ca>; Greenaway, Shelley E HLTH:EX <Shelley.Greenaway@gov.bc.ca>; Flagg, Jackson HLTH:EX <Jackson.Flagg@gov.bc.ca>; de Aquino, Alexa HLTH:EX <Alexa.deAquino@gov.bc.ca>; Saric, Anthony HLTH:EX <Anthony.Saric@gov.bc.ca>; Acker, Kelly HLTH:EX <Kelly.Acker@gov.bc.ca>; Wingrove, Scott HLTH:EX <Scott.Wingrove@gov.bc.ca>; Prescott, Julia HLTH:EX <Julia.Prescott@gov.bc.ca>
Subject: Revised DRAFT Guidelines for LTC Access

Hi all, please find attached a copy of the revised Guidelines document based on input from our last meeting.

s.13

s.13

s.13 We will discuss this further at Monday's meeting.

We are hoping to finalize the Guidelines at that meeting and get them into our approval processes.

Thanks,

Karen

Karen Archibald

Director, Strategic Initiatives | Seniors Services | Ministry of Health

Tel: 250-952-1162 | *Email*: Karen.Archibald@gov.bc.ca

From: Therrien, Darlene HLTH:EX
To: Diacu, Razvan HLTH:EX; Bergen, Sara J HLTH:EX
Subject: Fwd: Signed MAID Policy
Date: December 18, 2019 3:27:44 PM
Attachments: MAID Policy July 2018.pdf
ATT00001.htm

Sharing

Darlene

Begin forwarded message:

> **From:** "Rongve, Ian HLTH:EX" <Ian.Rongve@gov.bc.ca>
> **Date:** December 18, 2019 at 3:12:37 PM PST
> **To:** "Patterson, Catherine M HLTH:EX" <Catherine.Patterson@gov.bc.ca>, "Therrien, Darlene HLTH:EX" <Darlene.Therrien@gov.bc.ca>
> **Subject: Fwd: Signed MAID Policy**
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Brown, Stephen R HLTH:EX" <Stephen.Brown@gov.bc.ca>
> > **Date:** December 18, 2019 at 3:09:44 PM PST
> > **To:** "XT:Lee, Victoria HLTH:IN" <Victoria.lee@fraserhealth.ca>
> > **Cc:** "Rongve, Ian HLTH:EX" <Ian.Rongve@gov.bc.ca>
> > **Subject: Signed MAID Policy**
> >
> > Good afternoon Victoria,
> >
> > Please find attached the MAID policy. In using this policy there are a couple of points to make clear.
> >
> > s.13

Regards,

Stephen Brown
Deputy Minister

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #

PREPARED FOR: Honourable Terry Lake, Minister - **FOR INFORMATION**

TITLE: MAiD Delivery – draft Policy

PURPOSE: To confirm policy direction on where medical assistance in dying (MAiD) will and will not be required by policy to occur.

BACKGROUND:
There have been ongoing concerns regarding the assessment and provision of MAiD in palliative care and hospice settings.

Previous versions of the attached draft Policy were developed in collaboration with health authority representatives from the provincial MAiD Working Group and shared with the BC Hospice Palliative Care Association (BCHPA).

Attached is the draft Policy titled *Access To and Care Coordination of Medical Assistance in Dying* which gives health authorities the following direction:

1. **Assessment and provision of MAiD be reasonably accessible in all health authority owned and operated settings where end of life services are normally offered** (e.g. palliative care). [#11 in draft Policy]

2. **The ability for contracted organizations to opt-out of allowing or providing MAiD.** Health authorities are directed to consider, at time of service level agreement renewal, whether a contracted organization (e.g. hospice, residential care) receives a substantial level of operating funds or services from a health authority, and to balance this with their mandate to ensure reasonable access to MAiD and the strategic priorities of the BC Government (e.g. increasing hospice beds). [#12]

3. **Confirms the ability for faith-based organizations to decide not to allow provision of MAiD.** [#13]

4. **Formalizes the expectation and role of the health authority MAiD Care Coordination Service to ensure reasonable, safe access**, as directed by the Minister in the June, 2016 letter to health authorities (CLIFF#1057216). [#14]

DISCUSSION:
There are both risks and benefits associated with implementing a Ministry policy that clarifies expectations regarding the delivery of MAiD.

Risks
s.13

s.13

Benefits

s.13

ADVICE:

s.13

Program ADM/Division: Doug Hughes, Health Services Policy Division
Telephone: 250-952-1049
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: January 20, 2017
File Name with Path:
NOTES:

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #

PREPARED FOR: Lynn Stevenson **- FOR INFORMATION**

TITLE: Medical Assistance in Dying (MAID) and Providence Health Care Policy

PURPOSE: To provide information relevant to a patient transfer from Providence Health Care to Vancouver Coastal Health for MAID assessment.

BACKGROUND:

- On August 27, Vancouver Coastal Health (VCH) notified the Ministry that a patient at St. Paul's Hospital (SPH) has requested medical assistance in dying (MAID).
- The Providence Health Care (PHC) Policy on *Responding to Requests for Medical Assistance in Dying*, Section 2.1.2, requires that patients be provided with all possible supports (physical, psychological and spiritual) and care options (including quality palliative care) to address the needs that may underlie a person's request for MAID.

  (Note: This complies with the Bill C-14 requirement that patients give informed consent after having been informed of the means available to relieve their suffering.)
- The incompatibility of Catholic teaching with actions intended to terminate human life does not allow PHC Personnel to "enable" the provision of MAID (beyond receiving and documenting a formal request for MAID). Therefore, Principle 2.1.4 of the PHC Policy stipulates that:

  > "In response to a patient's informed request, the proactive solution may require a safe and timely transfer of the patient and their records to a non-objecting institution for continued exploratory discussion and assessment."

  (Note: Principle 2.1.4 mirrors the content in Alberta's Covenant Health Policy on MAID, and both policies are reflective of the Catholic *Health Ethics Guide*.)
- Section 2.2.5 of the PHC Policy requires that the Most Responsible Provider (MRP) will assess a patient's decisional capacity and arrange for transfer of a capable patient to a non-objecting centre/setting for continued exploratory discussion and assessment.

  (Note: This complies with the CPSBC Standards that require a physician who conscientiously objects to provide an effective transfer of care.)
- The patient's Most Responsible Provider (MRP) at SPH is now on service at Vancouver General Hospital (VGH), as of August 29.
- VCH and the MRP are arranging for the patient's transfer to VGH. This will be the first patient transferred from PHC to VCH for a MAID assessment.
- The MRP conducted an informal assessment of the patient's eligibility while at SPH, to ensure a high likelihood of eligibility, to minimize disruption and optimize care.
- The PHC Policy enables the patient to return to PHC in the following circumstances:

  > "If at any time the patient abandons interest in Medical Assistance in Dying, and seeks to return to PHC for care, re-engagement with PHC services will be

expedited. If it is the wish of the patient to return to PHC during a waiting time, PHC will accept the patient back if appropriate to their ongoing care needs."

(This includes the option of returning to PHC if a patient is ineligible for MAID.)

DISCUSSION:

- VCH has indicated that the PHC Policy to transfer a patient for assessment is consistent with the working model developed earlier, and that both organizations will strive to not transfer a patient unless there is a high likelihood of eligibility for MAID.

s.13

ADVICE:

s.13

Program ADM/Division: Doug Hughes, ADM, Health Services Policy Division
Telephone: 250 952-1049
Program Contact (for content): Brendan Abbott, Executive Director, Acute and Provincial Services
Drafter: Nancy Blythe, Policy Analyst, Acute and Provincial Services
Date: August 30, 2016
File Name with Path: Y:\HSD General\Programs\QA\Quality Assurance\Projects\2015\Physician Assisted Dying\BN\IBN MAID and PHC Policy

Ministry of Health draft Policy: *Access To and Care Coordination of Medical Assistance in Dying*

Implementation Plan

s.13

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s.13

Ministry of Health

Long-Term Care Access

Guidelines

Supplement to Policy 6.A, General Description and Definitions, and Policy 6.D, Access to Services in the Home and Community Care Policy Manual

March 11, 2019

Page 272 of 359 to/à Page 281 of 359

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Ministry of Health

Long-Term Care Access

Guidelines

Supplement to Policy 6.A, General Description and Definitions, and Policy 6.D, Access to Services in the Home and Community Care Policy Manual

March 14, 2019

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s.13

BRITISH COLUMBIA

Cliff # (John has already created the cliff #)

All Health Authority Chief Executive Officers
Name
Title
Address
Address

RE: Ministry of Health Policy Communique 2016-08: Access to and Care Coordination for Medical Assistance in Dying.

As you are aware, on April 14, 2016, the federal government introduced *Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts,* which received Royal Assent on June 17, 2016. Over the last two months, the provincial health sector has continued to implement medical assistance in a manner that is respectful of patient and families, and sensitive to the concerns of providers.

I am pleased to share with you *Ministry of Health Policy Communique 2016-08: Access to and Care Coordination for Medical Assistance in Dying,* which was developed with feedback from the Provincial Medical Assistance in Dying Working Group. This policy is intended to underpin a provincially consistent, patient-centred approach to access to medical assistance in dying. The policy also builds on the direction provided to you by the Minister of Health, in his letter of June 3, 2016 (cliff # 1057216), which required health authorities to put a care coordination service in place to assist individuals and health care providers in navigating access to medical assistance in dying.

The legalization of MAID is a significant change in health care delivery. I encourage you to continue to closely monitor the implementation and delivery of medical assistance in dying in your health authority. I ask that you contact Doug Hughes, Assistant Deputy Minister, Health Services Policy Division, should your health authority face challenges related to medical assistance in dying or compliance with this policy. Mr. Hughes may be reached by telephone at: (250) 952-1049, or by email at: Doug.Hughes@gov.bc.ca.

Your continued support in implementation of this new service is appreciated.

Sincerely,

Steve Brown

Ministry of Health Office of the Deputy Minister PO Box 9639 STN PROV GOVT
Victoria BC V8W 9P1

Deputy Minister

From:	Therrien, Darlene HLTH:EX
To:	Gow, Fiona S AG:EX; Falconer, Mary AG:EX
Cc:	Bergen, Sara J HLTH:EX
Subject:	MAiD - confirming this statement is true.
Date:	December 4, 2019 8:30:33 AM
Attachments:	2031695.docx

Hi

In this BN from earlier in the year there is a paragraph that says… just looking to confirm it. thanks.
Thanks☺

Conscientious Objection
The Paper argues that conscientious objection, afforded to individual health care providers, should also apply to organizations.
s.13

Kind Regards,
Darlene

Darlene Therrien
Executive Director,
Hospital Services Branch
Provincial, Hospital, Laboratory Health Services Division
Ministry of Health
778-974-2554

From: Greenaway, Shelley E HLTH:EX
To: Acker, Kelly HLTH:EX
Subject: MAID Bullet
Date: March 11, 2019 4:06:00 PM

Hello Kelly;
Derek and Nancy would like the bullet below to replace the current MAID bullet in the Guidelines.
Thank you,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

From: Blythe, Nancy HLTH:EX
Sent: March 11, 2019 3:31 PM
To: Greenaway, Shelley E HLTH:EX
Subject: RE: Bullet from Long Term Care Access Guidelines

Thanks Shelley – I think it should be more clearly worded – my suggestion below (have run it past Derek Rains):

- Whether the care home allows eligibility assessment and the provision of medical assistance in dying (MAiD) on site;

Nancy Blythe
Senior Policy Analyst
Acute & Provincial Services | Provincial, Hospital and Laboratory Services Division
Ministry of Health | 250 952-1529 | Fax: 250 952-2970
Main floor, 1515 Blanshard Street, Victoria, BC | PO Box 9638 Stn Prov Govt V8W 9P1

From: Greenaway, Shelley E HLTH:EX
Sent: March 11, 2019 3:04 PM
To: Blythe, Nancy HLTH:EX <Nancy.Blythe@gov.bc.ca>
Subject: Bullet from Long Term Care Access Guidelines

Hello Nancy;
If you have any objections to the highlighted bullet below, please send your suggested edits to me and I will forward them to Kelly. Thank you.

2.2 - Care home-specific information

Care home-specific information about care and services (differs between care homes), including:

- location, and contact information for care home;
- approximate wait time for admission for each care home;

- types of accommodation (shared occupancy, single occupancy);
- availability of other services (such as hair dressing, foot care and nail care);
- availability of spiritual/denominational/pastoral services and activities;
- frequency and type of social and recreational activities;
- if the care home is one where the assessment and provision of medical assistance in dying (MAiD) services, are or are not available on site;
- what additional services are available for a fee, and the amount of these fees;
- security at the care home; and
- accessibility of the care home.

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

PROVINCE OF BRITISH COLUMBIA

Options to Regulate Medical Assistance in Dying

Analysis of Options under the Health Professions Act

Ministry of Health

6/23/2016

Medical Assistance in Dying

Purpose: To set out options under the *Health Professions Act* (HPA) to regulate medical assistance in dying (MAID).

Background

In February 2015, the Supreme Court of Canada (SCC) ruled in *Carter v. Canada* (*Carter*) that the blanket prohibition against physician assisted-dying set out in the *Criminal Code* was unconstitutional. In its decision, the SCC indicated that the risks associated with an exemption to the blanket prohibition on assisted dying could be mitigated through a carefully designed and managed system of safeguards.

The effect of the ruling was originally suspended for one year; however, following a petition to the SCC, federal, provincial and territorial governments were granted an additional four months to develop a regulatory regime. The extension came with the exception that from February 6, 2016 until June 6, 2016, individuals could access assisted-dying via court application.

On April 14, 2016, the Federal government introduced Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts,* (medical assistance in dying). The Bill creates *Criminal Code* exemptions, and establishes eligibility criteria and procedural safeguards that must be followed in order for MAID to be legally provided. Federal legislation was not in force as of June 6, 2016 at which time the *Carter* decision became the law governing MAID. Bill C-14 subsequently received Royal Assent on June 17, 2016.

Phase 1: *Carter* in effect - no federal legislation
June 6 to 17, 2016

As of June 6, 2016, provincial and territorial governments were faced with the challenge of regulating and providing MAID without federal legislation. While the *Carter* decision sets out broad eligibility criteria for access to MAID, it did not include procedural safeguards to limit the risks to vulnerable individuals (e.g. require assessment by two medical practitioners, a mandatory waiting period, written request etc.). To address this gap, the College of Physicians and Surgeons of British Columbia (CPSBC) implemented professional practice Standards that included a robust system of safeguards and a clear assessment process. The Minister of Health (the Minister) amended the Medical Practitioners regulation pursuant to the *Health Professions Act* (HPA) to give the Standards the force of law, making non-adherence to the Standards a provincial offence. The interim regulatory framework came into effect on June 6, 2016 and remains in force.

Phase 2: Federal legislation in force
June 17, 2016 – Onward

The eligibility criteria for MAID set out in federal legislation is more narrow than the *Carter* decision's eligibility criteria. MAID is now only available to individuals already approaching the end of their natural life. As a result, some of the procedural safeguards required during the interim period are no longer necessary. For example, a procedural safeguard to address instances where the individual's sole diagnosis contributing to a request for MAID is a psychiatric or psychological condition is no longer required as this group of individuals is no longer eligible for MAID. CPSBC intends to update the existing standards to reflect the new eligibility criteria and procedural safeguards.

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Medical Assistance in Dying
Travel and Training Assistance Program
(MAiDTTAP)

Policy

Ministry of Health

Effective date: November 2017

Updated: November 2018

1.1 Description:

The Medical Assistance in Dying Travel and Training Assistance Program (MAiDTTAP) provides funding to assist Health Authorities (HAs) in the provision of MAiD services to residents in Rural Subsidiary Agreement (RSA) communities. MAiDTTAP funds compensate visiting physicians for travel time and travel related costs, including lodging, incurred in conducting an eligibility assessment or providing MAiD when no local medical practitioner (i.e. physician or nurse practitioner) is available, willing and trained to provide the service. MAiDTTAP also compensates local physicians, via a mentorship training payment, for training with a visiting physician in eligibility assessment or the provision of MAiD, and compensates the visiting physician for travel time/costs and mentorship when attending a local physician's (or nurse practitioner's) provision of MAiD.

1.2 Guidelines:

HAs are expected to integrate MAiD services into regional health service delivery, with the objective of increasing capacity to provide service and improving access to MAiD for residents in RSA communities. HAs are expected to follow sound financial practices in their requests for MAiDTTAP funding and, where possible, to combine physician travel with mentorship training opportunities for local physicians willing to learn about eligibility assessment or the provision of MAiD.

Each HA has a MAiD Care Coordination Service (MCCS) in place to connect residents with available medical practitioners who are willing and trained to assess eligibility and/or provide MAiD. If no local practitioner is available in the resident's community, the MCCS will contact the nearest available physician who is able to travel to assess eligibility or provide MAiD. The MCCS will determine whether travel requirements meet the criteria for MAiDTTAP funding, including whether a mentored training opportunity exists for a local physician, and will submit the *MAiDTTAP Funding Request* form with supporting information for consideration and approval by Rural Programs, Physician Compensation Branch, Ministry of Health. Rural Programs will provide the MCCS with an indication of approval within 48 hours of receipt of the funding request, in consideration of MAiD timelines. The visiting physician will submit travel time and travel related cost receipts to Rural Programs using the *MAiDTTAP Application for Expenses* form. A local physician participating in mentored training, and a visiting physician attending and mentoring a local physician's (or nurse practitioner's) provision of MAiD, will submit the *Application for Mentorship Training Payment* form to Rural Programs.

1.3 Program Funding:

MAiDTTAP funding (i.e. physician travel expenses and travel time honorariums, and physician mentorship training payments) is a reserved amount of $100,000 allocated from one-time funding. Funding allocation will be reviewed ~~one~~ yearly from the effective date of this policy. As self-sufficiency in RSA communities is attained, the need for physician travel and training assistance is expected to diminish.

2.1 Visiting Physician Eligibility:

All RSA communities are eligible for MAiDTTAP funding if there is no local practitioner who is available, willing and trained to assess eligibility or provide MAiD in the resident's community, and if one-way travel time for the nearest available MAiD practitioner is >30 minutes. There is no maximum number of MAiD visits per RSA community per year; however, each *MAiDTTAP Funding Request* must include supporting information to indicate that the conditions for funding (see a-f below) have been met or adequately addressed. If approved, MAiDTTAP funding includes compensation for the visiting physician's travel time and travel related costs incurred in the pick-up and return of MAiD medications from/to the dispensing pharmacy, and for the visiting physician's travel time/costs and mentorship when attending a local physician's (or nurse practitioner's) provision of MAiD.

For each *MAiDTTAP Funding Request*, the MCCS will ensure that the following conditions have been met or adequately addressed, with supporting information:

a) Telemedicine will be used, if possible, for one of the two eligibility assessments to determine a resident's eligibility for MAiD.
b) There is no local practitioner who is available, willing and trained to conduct an eligibility assessment or provide MAiD in the resident's community.
c) Every effort is being made to recruit and support local practitioners, to enable self-sufficiency for MAiD in RSA communities.
d) Every effort has been made to identify whether a training opportunity exists that can be combined with the physician's travel, including communicating to local physicians the availability of a mentorship training payment for attending an eligibility assessment or provision of MAiD.
e) Allowable compensation is only up to the distance of the nearest MAiD provider able to travel.
f) Health care providers participating in the MAiD event, including local providers who attended as a mentored training opportunity, will be offered the opportunity to participate in any planned debrief following the MAiD event.

2.2 Training Physician Eligibility:

All RSA communities are eligible for MAiDTTAP funding, in the form of a mentorship training payment, for a local physician who participates in a mentored training session with a visiting physician in eligibility assessment or the provision of MAiD.

2.3 Rural Retention Premiums:

When a visiting physician provides services in a community that is eligible for Rural Retention Premiums, the visiting physician is entitled to the FFS retention premium in that community but is not entitled for the flat sum retention amount, which is only for resident physicians. Visiting physicians must ensure the Rural Retention Program Service Clarification Code is on all FFS billings to receive the FFS premium.

3.1 Travel Expenses: Visiting Physician

Reimbursement will be made directly to the visiting physician upon receipt and approval of their *MAiDTTAP Application for Expenses* form and applicable original receipts for eligibility assessment or provision of MAiD, or for attending and mentoring a local physician's (or nurse practitioner's) provision of MAiD. Acceptable expenses relate to direct costs of physician travel and lodging only, including travel expenses for the pick-up and return of prescribed MAiD medications from/to the dispensing pharmacy.

3.2 Travel Time: Visiting Physician

Physicians are also entitled to a travel time honorarium for eligibility assessment or provision of MAiD, or for attending and mentoring a local physician's (or nurse practitioner's) provision of MAiD. Travel time is calculated based on the time the physician leaves his/her residence/office and arrives in the community (including, if applicable, travel time to pick-up MAiD medications from the dispensing pharmacist) and the time the physician leaves the community to the time s/he returns to his/her residence/office (including, if applicable, travel time to return unused medications to the dispensing pharmacy), to a maximum of $1,500 per return trip (i.e. a total maximum of $3,000 for eligibility assessment and provision, and a maximum of $3000 for attending up to two MAiD provisions by each mentored local physician (or nurse practitioner)).

3.4 Travel Time Honorariums: Visiting Physician

Effective September, 2017:

Less than 2.5 hours	$ 250
2.5 to 4 hours	$ 500
4 to 10 hours	$1,000
Over 10 hours	$1,500

3.3 Mentorship Training Payment: Local Physician

Reimbursement will be made directly to the local physician upon receipt and approval of their *MAiDTTAP Application for Mentorship Training Payment* form. The local physician can claim a total of two mentorship training payments for training received in both eligibility assessment and the provision of MAiD (i.e. a total maximum of $265.14).

Mentorship Training Payment $ 132.57

Chapter:	MAiD Travel and Training Assistance Program (MAiDTTAP)	**Page:**	7 of 8
Section: 3	Reimbursement	**Effective:**	November 2017

3.4 Mentorship Training Payment: Visiting Physician

Reimbursement will be made directly to the visiting physician upon receipt and approval of their *MAiDTTAP Application for Mentorship Training Payment* form. The visiting physician can claim up to two mentorship training payments for attending up to two provisions of MAiD by each mentored local physician (or nurse practitioner) (i.e. a maximum of $265.14 for attending the MAiD provisions of each local provider).

Mentorship Training Payment $ 132.57

3.5 Retroactive Payment

MAiDTTAP **does not** compensate for travel/training prior to effective date of policy.

4.1 Joint Standing Committee on Rural Issues (JSC)

The Joint Standing Committee on Rural Issues (JSC) is the governing body for MAiDTTAP. The JSC reports to the Medical Services Commission on the funding and administration of MAiDTTAP and will provide policy direction, evaluate exceptional circumstance requests, and resolve appeals in relation to MAiDTTAP.

4.2 Appeal Process

If the JSC has deemed a community or physician ineligible, the MCCS may submit an appeal or register exceptional circumstances, in writing, to the JSC for consideration. The JSC will attempt to respond to an appeal promptly, in consideration of MAiD timelines.

4.3 Reporting, Monitoring, and Evaluation

4.3.1 Health Authority Responsibility

The MCCS will collect and retain information on MAiDTTAP funding requests, physician visits for eligibility assessment and provision of MAiD, and mentored training sessions, and will provide this information to Rural Programs or the JSC as requested for program review or audit.

4.3.2 Ministry Responsibility

The Ministry will monitor MAiDTTAP service delivery and expenses, perform program evaluation, and forward unresolved program issues to the JSC, as needed.

Medical Assistance in Dying
Travel and Training Assistance Program
(MAiDTTAP)

Policy

Ministry of Health

November 2017

1.1 Description:

The Medical Assistance in Dying Travel and Training Assistance Program (MAiDTTAP) provides funding to assist Health Authorities (HAs) in the provision of MAiD services to residents in Rural Subsidiary Agreement (RSA) communities. MAiDTTAP funds compensate visiting physicians for travel time and travel related costs, including lodging, incurred in conducting an eligibility assessment or providing MAiD when no local medical practitioner (i.e. physician or nurse practitioner) is available, willing and trained to provide the service. MAiDTTAP also compensates local physicians, via a mentorship training payment, for training with a visiting physician in eligibility assessment or the provision of MAiD.

1.2 Guidelines:

HAs are expected to integrate MAiD services into regional health service delivery, with the objective of increasing capacity to provide service and improving access to MAiD for residents in RSA communities. HAs are expected to follow sound financial practices in their requests for MAiDTTAP funding and, where possible, to combine physician travel with mentorship training opportunities for local physicians willing to learn about eligibility assessment or the provision of MAiD.

Each HA has a MAiD Care Coordination Service (MCCS) in place to connect residents with available medical practitioners who are willing and trained to assess eligibility and/or provide MAiD. If no local practitioner is available in the resident's community, the MCCS will contact the nearest available physician who is able to travel to assess eligibility or provide MAiD. The MCCS will determine whether travel requirements meet the criteria for MAiDTTAP funding, including whether a mentored training opportunity exists for a local physician, and will submit the *MAiDTTAP Funding Request* form with supporting information for consideration and approval by Rural Programs, Physician Compensation Branch, Ministry of Health. Rural Programs will provide the MCCS with an indication of approval within 48 hours of receipt of the funding request, in consideration of MAiD timelines. The visiting physician will submit travel time and travel related cost receipts to Rural Programs using the *MAiDTTAP Application for Expenses* form. A local physician participating in mentored training will submit the *Application for Mentorship Training Payment* form to Rural Programs.

1.3 Program Funding:

MAiDTTAP funding (i.e. physician travel expenses and travel time honorariums, and physician mentorship training payments) is a reserved amount of $100,000 allocated from one-time funding. Funding allocation will be reviewed one year from the effective date of this policy. As self-sufficiency in RSA communities is attained, the need for physician travel and training assistance is expected to diminish.

2.1 Visiting Physician Eligibility:

All RSA communities are eligible for MAiDTTAP funding if there is no local practitioner who is available, willing and trained to assess eligibility or provide MAiD in the resident's community, and if one-way travel time for the nearest available MAiD practitioner is >30 minutes. There is no maximum number of MAiD visits per RSA community per year; however, each *MAiDTTAP Funding Request* must include supporting information to indicate that the conditions for funding (see a-f below) have been met or adequately addressed. If approved, MAiDTTAP funding includes compensation for the visiting physician's travel time and travel related costs incurred in the pick-up and return of MAiD medications from/to the dispensing pharmacy.

For each *MAiDTTAP Funding Request*, the MCCS will ensure that the following conditions have been met or adequately addressed, with supporting information:

a) Telemedicine will be used, if possible, for one of the two eligibility assessments to determine a resident's eligibility for MAiD.
b) There is no local practitioner who is available, willing and trained to conduct an eligibility assessment or provide MAiD in the resident's community.
c) Every effort is being made to recruit and support local practitioners, to enable self-sufficiency for MAiD in RSA communities.
d) Every effort has been made to identify whether a training opportunity exists that can be combined with the physician's travel, including communicating to local physicians the availability of a mentorship training payment for attending an eligibility assessment or provision of MAiD.
e) Allowable compensation is only up to the distance of the nearest MAiD provider able to travel.
f) Health care providers participating in the MAiD event, including local providers who attended as a mentored training opportunity, will be offered the opportunity to participate in any planned debrief following the MAiD event.

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2.3 Rural Retention Premiums:

When a visiting physician provides services in a community that is eligible for Rural Retention Premiums, the visiting physician is entitled to the FFS retention premium in that community but is not entitled for the flat sum retention amount, which is only for resident physicians. Visiting physicians must ensure the Rural Retention Program Service Clarification Code is on all FFS billings to receive the FFS premium.

3.1 Travel Expenses: Visiting Physician

Reimbursement will be made directly to the visiting physician upon receipt and approval of their *MAiDTTAP Application for Expenses* form and applicable original receipts for eligibility assessment or provision of MAiD. Acceptable expenses relate to direct costs of physician travel and lodging only, including travel expenses for the pick-up and return of prescribed MAiD medications from/to the dispensing pharmacy.

3.2 Travel Time: Visiting Physician

Physicians are also entitled to a travel time honorarium for eligibility assessment or provision of MAiD. Travel time is calculated based on the time the physician leaves his/her residence/office and arrives in the community (including, if applicable, travel time to pick-up MAiD medications from the dispensing pharmacist) and the time the physician leaves the community to the time s/he returns to his/her residence/office (including, if applicable, travel time to return unused medications to the dispensing pharmacy), to a maximum of $1,500 per return trip (i.e. a total maximum of $3,000 for eligibility assessment and provision).

3.4 Travel Time Honorariums: Visiting Physician

Effective September, 2017:

Less than 2.5 hours	$ 250
2.5 to 4 hours	$ 500
4 to 10 hours	$1,000
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Mentorship Training Payment $ 132.57

3.5 Retroactive Payment

MAiDTTAP **does not** compensate for travel/training prior to effective date of policy.

4.1 Joint Standing Committee on Rural Issues (JSC)

The Joint Standing Committee on Rural Issues (JSC) is the governing body for MAiDTTAP. The JSC reports to the Medical Services Commission on the funding and administration of MAiDTTAP and will provide policy direction, evaluate exceptional circumstance requests, and resolve appeals in relation to MAiDTTAP.

4.2 Appeal Process

If the JSC has deemed a community or physician ineligible, the MCCS may submit an appeal or register exceptional circumstances, in writing, to the JSC for consideration. The JSC will attempt to respond to an appeal promptly, in consideration of MAiD timelines.

4.3 Reporting, Monitoring, and Evaluation

4.3.1 Health Authority Responsibility

The MCCS will collect and retain information on MAiDTTAP funding requests, physician visits for eligibility assessment and provision of MAiD, and mentored training sessions, and will provide this information to Rural Programs or the JSC as requested for program review or audit.

4.3.2 Ministry Responsibility

The Ministry will monitor MAiDTTAP service delivery and expenses, perform program evaluation, and forward unresolved program issues to the JSC, as needed.

POLICY TITLE

MEDICAL ASSISTANCE IN DYING – ROLE OF PHARMACY SERVICES - LMPS

POLICY MANUAL

Pharmacy Services

AUTHORIZATION	DATE APPROVED	DATE(S) REVISED
Executive Director, Lower Mainland Pharmacy Services	DRAFT 27 Oct 2016	

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POLICY TITLE

MEDICAL ASSISTANCE IN DYING – ROLE OF PHARMACY SERVICES - LMPS

POLICY MANUAL

Pharmacy Services

AUTHORIZATION	DATE APPROVED	DATE(S) REVISED
Executive Director, Lower Mainland Pharmacy Services	DRAFT 27 Oct 2016	

BACKGROUND

Interdisciplinary Policies

Interdisciplinary policies regarding medical assistance in dying have been developed in the following health organizations within the Lower Mainland Consolidation (LMC):

Health Organization	Policy Title (policy number)	Hyperlink (not yet entered)
Fraser Health		http://fhpulse/clinical_resources/clinical_policy_office/Lists/CDST%20Library/XYZ
Children's and Women's Health Centre of B.C.		XYZ
Vancouver Coastal Health		http://vch-connect/programs/client_relations/policy_consultation/maid/Pages/default.aspx

The College of Pharmacists of B.C. states that *a full pharmacist may delegate to a pharmacy technician any aspect of the preparation of drugs for the purposes of medical assistance in dying that is within a pharmacy technician's scope of practice.*
http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5195-HPA_Bylaws_MAID.pdf

PURPOSE

To outline the role of Lower Mainland Pharmacy Services in supporting the Health Authority interdisciplinary policies relating to medical assistance in dying.

To outline requirements, responsibilities, and accountability of Lower Mainland Pharmacy Services personnel for preparation, distribution and record keeping of medications for medical assistance in dying.

FOCUS

This policy focuses on processes employed by Lower Mainland Pharmacy Services when dispensing individualized medication kits for patients in facilities serviced by Lower Mainland Pharmacy Services.

POLICY TITLE

MEDICAL ASSISTANCE IN DYING – ROLE OF PHARMACY SERVICES - LMPS

POLICY MANUAL

Pharmacy Services

AUTHORIZATION	DATE APPROVED	DATE(S) REVISED
Executive Director, Lower Mainland Pharmacy Services	DRAFT 27 Oct 2016	

DEFINITIONS

Medical Assistance in Dying occurs when an authorized health professional administers or provides a drug that intentionally brings about a person's death at that person's request. Medical assistance in dying is only available to eligible patients meeting criteria set forth in federal legislation.

POLICY

Pre-printed Order

1.1 The pre-printed order form for "Medical Assistance in Dying", accompanied by a pre-printed Medication Administration Record (MAR), shall be provided directly to the prescriber, upon request, as per processes established within each Health Authority. (See Appendix A: Medical Assistance in Dying - Pre-Printed Order and Medication Administration Record")

1.1.1 In Fraser Health, the pre-printed order, along with the Medication Administration Record, is provided to the prescriber via the Medical Assistance in Dying Care Coordination Centre (MCCC)

1.1.2 At Vancouver Coastal Health, the pre-printed order, along with the Medication Administration Record, is provided to the prescriber by Pharmacy Services

1.2 The pharmacist shall review the completed pre-printed order "Medical Assistance in Dying" with the prescriber who wrote the order and initial in the appropriate section on the pre-printed order.

1.2.1 The intention is NOT that the pharmacist performs an assessment of the patient's eligibility criteria or obtains consent from the patient – these functions are only to be performed by the prescriber.

Medication Kits

1.3 Medications, along with related supplies, shall be dispensed in standardized, labelled, sealed, and tamperproof containers (kits).

1.4 Medication kits shall be requisitioned from the[s.15]
specifying the type of kit: (See Appendix D: Medication Kit Inventory List – Intravenous Regimen and Appendix E: Medication Kit Inventory List – Oral Regimen)

- IV regimen (proPOFol)
- IV regimen (phenobarbital)

POLICY TITLE

MEDICAL ASSISTANCE IN DYING – ROLE OF PHARMACY SERVICES - LMPS

POLICY MANUAL

Pharmacy Services

AUTHORIZATION	DATE APPROVED	DATE(S) REVISED
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- Oral regimen

1.5 The medication kit – oral regimen shall contain required ingredients for the oral suspension which shall be prepared by Pharmacy Services staff at the site.

1.6 Each medication kit shall be assigned a lot number by the s.15 s.15 to facilitate tracking and documentation.

Labelling

1.7 Each medication contained in the kit shall be labelled by the s.15 s.15 including: medication name, form, strength, quantity, directions for use and preparation instructions (where applicable). (See Appendix H: Medication Labels – Intravenous Regimen and Appendix I: Medication Labels – Oral Regimen)

1.7.1 The medications shall be further labelled by Pharmacy Services staff at the site with patient name and two patient identifiers (personal health number, date of birth).

1.8 Each medication kit (exterior) shall be labelled by the s.15 s.15 including: kit name, lot number and expiry date. (See Appendix J: "Medication Kit Labels – Sample")

1.8.1 Medication kits (exterior) shall be further labelled by Pharmacy Services staff at the site with facility name and Pharmacy Services phone number.

Dispensing

1.9 Medication kits shall be dispensed by the pharmacist directly to the prescriber, accompanied by a signature trail and written documentation. (See Appendix C: "Provincial Form for Medication Issues and Returns")

Return of Medications

1.10 All unused and partially used medications contained within the medication kits, shall be returned by the prescriber, directly to Pharmacy Services, as soon as possible, within 48 hours after completion of the procedure, accompanied by a signature trail and written documentation.

1.10.1 Partially administered syringes are contaminated and shall not be returned to Pharmacy Services

1.10.2 Partially administered syringes containing narcotics, controlled drugs and benzodiazepines shall be disposed in the patient care area. Disposal shall be

documented on the medication administration record and witnessed by a second health care provider.

1.11 Unopened (sealed) medication kits – IV regimen shall be returned by Pharmacy Services to the s.15 ; all other medication kits shall be dismantled at the site, after use.

Reconciliation

1.12 Working with the prescriber, the pharmacist shall reconcile all returned medications with the medications dispensed (inventory list) and the completed Medication Administration Record

1.12.1 The pharmacist shall clarify any discrepancies in medication quantities with the prescriber at the time of return.

Documentation

1.13 Narcotics, controlled drugs, and benzodiazepines shall be added and decremented from inventory, as per established procedures.

1.13.1 Intact medication kits shall be handled as a specific line item

1.14 Written documentation and signatures, both from the pharmacist and the prescriber, shall accompany all issued and returned medications. (See Appendix C: "Provincial Form – Medication Issues and Returns")

1.15 The prescriber shall provide a copy of the completed Medication Administration Record to the pharmacist, upon completion of the procedure.

1.16 The following documents shall be filed (together) in Pharmacy Services, and retained as specified in the policy entitled "Record Retention – LMPS"

- Pharmacy Task List
- Provincial Form – Medication Issues and Returns
- Pre-printed order (pharmacy copy)
- Medication Administration Record (pharmacy copy)
- Formula form for oral suspension (if dispensed)

1.17 In order to avoid inadvertent administration of the medications, Pharmacy Services shall not enter the medication orders into the pharmacy computer system.

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MEDICAL ASSISTANCE IN DYING – ROLE OF PHARMACY SERVICES - LMPS

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PROCEDURE

Pharmacist [1]

[1] The College of Pharmacists of B.C. states that *a full pharmacist may delegate to a pharmacy technician any aspect of the preparation of drugs for the purposes of medical assistance in dying that is within a pharmacy technician's scope of practice*.
http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5195-HPA_Bylaws_MAID.pdf

Pre-Printed Order

2.1 Receive the completed pre-printed order form "Medication Assistance in Dying" directly from the prescriber. (See Appendix A: "Medical Assistance in Dying - Pre-Printed Order and Medication Administration Record")

2.1.1 Initiate the Pharmacy Task List to facilitate communication among pharmacy personnel who are preparing and releasing the medication. (See Appendix B: "Medical Assistance in Dying: Pharmacy Task List")

2.2 Review the completed pre-printed order with the prescriber and initial, in the section as noted on the pre-printed order, to acknowledge discussion with the prescriber:
- I confirm the medications on this form prescribed are intended for purpose of medical assistance in dying, and patient's drug therapy has been discussed

2.3 Consult with the prescriber to ascertain the scheduled date and time for pick-up of medication kits from Pharmacy Services

2.3.1 Document the intended date and time for pick-up on the Pharmacy Task List (see Appendix B) and on the Provincial Form for Medication Issues and Returns (see Appendix C)

2.4 Place the pre-printed order (Pharmacy copy) in a segregated area, away from other medication orders, so that inadvertent medication order entry is avoided.

Medication Kit Preparation

2.5 Review the pre-printed order to determine whether the intravenous or oral regimen is ordered

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2.6 Requisition the medication kits from the[s.15] specifying the type of kit: (See Appendix D: Medication Kit Inventory List – Intravenous Regimen and Appendix E: Medication Kit Inventory List – Oral Regimen)

- Intravenous Regimen (proPOFol)
- Intravenous Regimen (phenobarbital)
- Oral regimen

2.6.1 When the IV regimen is ordered, 2 identical kits are provided

2.6.2 When the oral regimen is ordered, a medication kit – oral regimen is provided, along with a back-up kit for the IV regimen

2.6.2.1 Specify whether the back-up medication kit should contain proPOFol or phenobarbital

2.6.2.2 Note: The medication kit – oral regimen contains the required ingredients to compound the oral suspension

2.7 Upon receipt of the medication kits from the[s.15] , add to inventory as a specific line item, specifying the lot numbers

2.7.1 Document the lot numbers on the Pharmacy Task List

2.8 If the oral regimen is ordered, compound the oral medication one day prior to the scheduled procedure, if possible, as per the applicable formula:

- Appendix F: Formula: Phenobarbital, Chloral Hydrate, Morphine (in ORA-Plus® / ORA-Sweet®) Oral Suspension
- Appendix G: Formula: Phenobarbital, Chloral Hydrate, Morphine (in Distilled Water) Oral Suspension

2.8.1 The oral suspension in distilled water should be used for administration via feeding tube (e.g. percutaneous endoscopic gastrostomy (PEG) or nasogastric (NG) tube).

2.9 Place a label on each zip lock bag containing medication, that includes the following: Patient name, date of birth, personal health number
(See Appendix H: Medication Labels -Intravenous Regimen and Appendix I: Medication Labels - Oral Regimen)

2.9.1 Note: Medications contained within the kits are labelled by[s.15] [s.15] with the following information: medication name, form, strength, quantity, directions, and instructions for preparation.

2.11 Label each medication kit (exterior) with the following:

- Facility name and Pharmacy Services phone number

(See Appendix J: Medication Kit Labels - Sample)

2.11.1 Note: The exterior of the medication kits – IV regimen are labelled by the s.15 s.15 with the following information: kit name, lot number, and expiry date

Medication Kit - Release

2.12 At the time of pick-up, verify the prescriber's identification by viewing a valid and current source of picture identification, such as a Canadian driver's license or passport (if necessary)

2.13 Review procedures with the prescriber for handling unused medications:
- 2.13.1 For destruction of partially administered syringes, a second health care provider must witness destruction and both the prescriber and witness must sign on the Medication Administration Record (MAR)
- 2.13.2 All other unused and partially used medications are returned to Pharmacy Services

2.14 Determine the planned date and time for return of unused medications and document on the Pharmacy Task List
- 2.14 Unused medications must be returned to Pharmacy Services within 48 hours after completion of the procedure

2.15 Prior to releasing the kit to the prescriber, document the following on the "Provincial Form for Medication Issues and Returns" (See Appendix C): patient name, personal heath number, date, details of confirmation of photo identification
- 2.15.1 Record: printed name, signature, College ID number, date and time of dispensing the medications
- 2.15.2 Request the prescriber to document receipt of the medications on the provincial form: Printed name, signature, College ID number

2.16 Seal the kit with a plastic numbered twist-off lock
- 2.16.1 Document the twist-off lock numbers on the Provincial Form for Medication Issues and Returns, along with the kit lot numbers

2.17 Provide medication kits directly to the prescriber

2.18 Charge (issue) the medication kits to the patient care area, as a specific line item

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MEDICAL ASSISTANCE IN DYING – ROLE OF PHARMACY SERVICES - LMPS

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Return of Medications

2.19 Obtain any unused medications directly from the prescriber, as soon as possible, within 48 hours after completion of the procedure, along with a copy of the completed Medication Administration Record

2.20 Immediately upon return, working with the prescriber, reconcile returned medications with the medication kit inventory lists and the completed Medication Administration Record
2.20.1 Address any discrepancies in returned medication quantities with the prescriber

2.21 Document return of medications on the ""Provincial Form for Medication Issues and Returns" (see Appendix C) including:
- Date and time of receipt
- Kit lot numbers
- Twist-lock number (for unopened sealed medication kits)
- Medication name, form, strength and quantity received
- Printed name and signature

2.21.1 Request the prescriber to verify quantities returned, record printed name and sign the form

2.22 Verify twist-off lock number on unopened medication kits by comparing to the number documented on the Provincial Form (Appendix C), upon release of the medication kit

2.23 Where appropriate, return unopened (sealed) medication kits – IV regimen to the s.15 s.15 as per established processes, ensuring appropriate documentation for narcotics, controlled drugs, benzodiazepines and targeted substances, including kit lot number

2.24. Dismantle opened medication kits – IV regimen and ALL medication kits – oral regimen
- 2.24.1 Assess integrity of each medication (e.g. medications have been properly stored, medications are within expiry date, medications appear to be intact and labels are not soiled, discoloured or damp)
- 2.24.2 If integrity of medication is compromised or unknown, dispose medications, setting aside narcotics, controlled drugs and benzodiazepines for destruction, following processes outlined in policy "Narcotics, Controlled Drugs and Benzodiazepines – DESTRUCTION - LMPS"
- 2.24.3 If integrity of medication is not compromised, return to stock, ensuring appropriate documentation for narcotics, controlled drugs and benzodiazepines

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2.25 File the following documents (together) and retain as per policy entitled "Record Retention – LMPS":

- Pharmacy Task List
- Provincial form for Medication Issues and Returns
- Pre-printed order (pharmacy copy)
- Completed Medication Administration Record (pharmacy copy)
- Formula form for oral suspension (if dispensed)

REFERENCES

College of Pharmacists of B.C. (29 Jul 2016) Dispensing drugs for the purposes of medical assistance in dying standards, limits and conditions; Health Protection Act Bylaws; Schedule F; Part 5. Retrieved from http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5195-HPA_Bylaws_MAID.pdf

APPENDIX A

Policy: Medical Assistance in Dying – Role of Pharmacy Services

MEDICAL ASSISTANCE IN DYING
PRE-PRINTED ORDER AND MEDICATION ADMINISTRATION RECORD
(Health Authority Specific)

Health Organization	Pre-Printed Order Title	Hyperlink
Fraser Health		
Children's and Women's Health Centre of B.C.		
Vancouver Coastal Health	Medical Assistance in Dying (REGIONAL)	No hyperlink will be available at VCH. Prescribers will obtain the pre-printed order directly from Pharmacy

s.13

APPENDIX B

Policy: Medical Assistance in Dying – Role of Pharmacy Services

MEDICAL ASSISTANCE IN DYING
PHARMACY TASK LIST

PATIENT NAME: _____ **DOB:** _____ **PHN:** _____

No	PROCEDURE	DATE	INITIALS
PRE-PRINTED ORDER			
1	Receive pre-printed order directly from prescriber **Prescriber Name**: _____		
2	Review PPO with prescriber and initial appropriate section on pre-printed order		
3	Document intended date and time for pick-up of medications on Provincial Form (Appendix C)		
4	Place the Pharmacy copy of the pre-printed order in a segregated area away from other pre-printed orders in Pharmacy		
MEDICATION KIT – PREPARATION			
5	Requisition medication kits from the s.15 ____ Medication Kit – IV Regimen (propPOFol) ____ Medication Kit – IV Regimen (phenobarbital) ____ Medication Kit – Oral Regimen (also specify back-up IV kit)		
6	Upon receipt, document Medication Kit Lot Numbers on Provincial Form (Appendix C)		
7	Add medication kits to site inventory, as a line item		
8	If ordered, compound oral medication 24 hrs prior to procedure where possible		
9	Label each zip lock bag containing medication with: patient name, PHN, DOB, using addressograph or FormImprint lablels (See Appendix H and I)		
10	Label medication kit (exterior) with facility name and Pharmacy Services phone number (See Appendix J)		
MEDICATION KIT – RELEASE TO PRESCRIBER			
11	Verify prescriber's ID; specify source on Provincial Form (Appendix C) PRN		
12	Instruct prescriber regarding: use of MAR, affixing labels to syringes upon preparation, handling unused or partially used medications		
13	Determine planned date and time for return of unused medications (asap within 48 hours after the procedure); Specify on Provincial Form (Appendix C).		
14	Lock medication kit and seal with a plastic numbered twist-off lock; Specify twist-off lock numbers on Provincial Form (Appendix C)		
15	Document date and time of dispensing, along with printed names, signatures, college ID number on Provincial Form (Appendix C)		
16	Charge (issue) medication kit to patient care area as a specific line item		
RETURN OF UNUSED MEDICATIONS			
17	Receive copy of completed MAR from prescriber for pharmacy records		
18	Working with prescriber, reconcile returned medications with medication kit inventory lists and completed MAR -Document return of medications on the Provincial Form (Appendix C) -Request prescriber to verify quantity returned, print name and sign the form		
19	Upon verification of twist-off lock number, return unopened (sealed) medication kits - IV regimen to the s.15 ensuring appropriate documentation, including lot number		
20	Dismantle opened medication kits – IV regimen and ALL medication kits - oral regimen		
21	Based on assessment of integrity of medications, return medications to stock **or** set aside for destruction, following appropriate processes for narcotics, controlled drugs and benzodiazepines		

APPENDIX C

Policy: Medical Assistance in Dying – Role of Pharmacy Services

MEDICAL ASSISTANCE IN DYING
(Provincial Form for Medication Issues and Returns)

Inter-disciplinary Collaboration and Planning

Patient Name:	~~Date:~~ Date of Birth:
	Personal Health Number:

Planned Date and Time of Prescription Release (from pharmacist to prescriber)

~~Planned date (YYYY MM DD) and time (00:00 am/pm) of prescription release from Pharmacist to Prescriber.~~	Planned Release Date: Planned Release Time:

Plan for Concluding Medical Assistance in Dying Process

Procedures have been established for the return of any unused drug(s) within 48 hours to the Pharmacy for secure and timely disposal. s.13 s.13	☐ Completed

Prescription Fulfillment and Accountability

Medication Administration Record

The Prescriber has been instructed on how to complete the Medication Administration Record, **affix labels to syringes, and dispose / document disposal of partially administered syringes.** ~~**for medical assistance in dying medications.**~~	☐ Completed

Dispensing Sign Off

	Printed Name:	Signature:	College License #:
Dispensed by: (Pharmacist)			
Received by: (Prescriber)			

Details of confirmation of photo ID of Prescriber, if applicable:

Kit Lot Numbers:	Twist-off Lock Numbers:	Date:	Time:

Return of any Unused Medications to Pharmacist for Disposal

The Prescriber will notify the Pharmacist if any unused medication(s) remain. The Prescriber will return unused medications to pharmacy within 48 hours of patient's death.

Planned Return Date: _____ **Time:** _____

Medication Name(s):	Form:	Strength:	Quantity:

	Printed Name:	Signature:
Returned by: (Prescriber)		
Received by: (Pharmacy)		

Kit Lot Numbers:	Twist-off Lock Numbers:	Date:	Time:

APPENDIX D

Policy: Medical Assistance in Dying – Role of Pharmacy Services

MEDICAL ASSISTANCE IN DYING

MEDICATION KIT INVENTORY LIST - INTRAVENOUS REGIMEN

Date Prepared:	Expiry Date:	Lot Number:
Prepared by:	Checked by:	

PER KIT – INTRAVENOUS REGIMEN s.15 – place inventory list inside kit)		
Quantity	**Drug / Related Supplies (requires review by med safety and by sterile prep personnel)**	**Check (✓)**
2	**midazolam 10 mg/10 mL Inj**	
2	20 mL syringes	
2	20G Needles **(or 18G?)**	
2	medication labels (to be affixed to syringe upon preparation by prescriber)	
1	5x8 plastic bag – labelled (containing above items)	
1	**lidocaine 2% 100 mg / 5 mL Inj**	
1	3 mL syringe includes needle	
1	medication labels (to be affixed to syringe upon preparation by prescriber)	
1	5x8 plastic bag – labelled (containing above items)	
2	**proPOFol 1 g / 100 mL**	
8	60 mL syringes (**OR 30 mL syringes?)**	
8	vented dispensing pin	
8	medication labels (to be affixed to syringe upon preparation by prescriber)	
1	10x10 plastic bag – labelled (containg above items)	
50	**phenobarbital 120 mg / mL Inj** OR	
6	sodium chloride 0.9% (10 mL vial)	
2	60 mL syringes	
2	20G Needles **(or 18G?)**	
1	Ampoule breaker device	
2	Filter straw	
2	medication labels (to be affixed to syringe upon preparation by prescriber)	
1	6x10 plastic bag – labelled (containing above items)	
4	**rocuronium 50 mg / 5 mL Inj** Note: Stable for 90 days outside refrigerator)	
1	30 mL syringe	
1	20G Needle **(or 18G?)**	
1	medication label (to be affixed to syringe upon preparation by prescriber)	
1	6x10 plastic bag – labelled (containing above items)	
4	sodium chloride 0.9% (3 x 10 mL pre-filled syringes)	
1	5x8 plastic bag (containing above items)	
6	alcohol swabs	
1	5x8 plastic bag (containing above items)	

MEDICAL ASSISTANCE IN DYING
MEDICATION KIT INVENTORY LIST - ORAL REGIMEN

Date Prepared:	**Expiry Date:**	**Lot Number:**
Prepared by:	**Checked by:**	

PER KIT – ORAL REGIMEN s.15 staff – place inventory list inside kit)		
Quantity	**Drug / Related Supplies**	**Check (✓)**
2	**metoclopramide 10 mg tablet**	
1	4 x 4 plastic bag – labelled (containing above items)	
1	**ondansetron 8 mg tablet**	
1	4x4 plastic bag – labelled (containing above items)	
2	**haloperidol 5 mg/mL Inj**	
2	3 mL syringes	
2	25G - 5/8" needle (for SC administration)	
2	alcohol pads	
1	5x8 plastic bag – labelled (containing above items)	
8	**LORazepam 0.5 mg SL tablet**	
1	4x4 plastic bag – labelled (containing above items)	
Compounded Oral Suspension – 120 mL		
20 g	**phenobarbital powder**	
20 g	**chloral hydrate powder**	
3 g	**morphine sulphate powder**	
qs to 120 mL	**ORA-Plus® / ORA-Sweet® (50/50)** OR	
qs to 120 mL	**distilled water** [1]	
1	250 mL glass amber bottle – labelled	

1 Use compounded suspension in distilled water for administration via feeding tube (e.g. percutaneous endoscopic gastrostomy (PEG) or nasogastric (NG) tube).

MEDICAL ASSISTANCE IN DYING
PHENOBARBITAL, CHLORAL HYDRATE, MORPHINE (in ORA-Plus® – ORA-Sweet®) ORAL SUSPENSION

FORMULA		
Preparation: **Compounded Phenobarbital, Chloral Hydrate, Morphine (in ORA-Plus® -ORA-Sweet®) Oral Suspension**		**Package Size:** **120 mL** (Dispense in a 200 mL glass amber bottle)
Formula:		**Use(s): Medical Assistance in Dying**
phenobarbital powder	20 g	
chloral hydrate powder	20 g	**References:**
morphine sulphate powder	3 g	Physician-assisted Death, Pharmacy Protocols, Alberta Health Services
ORA-Plus®	50 mL	
ORA-Sweet®	qs to 120 mL	**Precautions:**
		Personal protective equipment: • Protective gown • Nitrile gloves • N95 mask • Eye protection Dispense in glass amber bottle (Note: Chloral hydrate powder is caustic and is incompatible with plastic containers)
Directions for Manufacture:		**Label:**
Put all powders in mortar and pestle		See Appendix K Shake well Store at room temperature May have a bitter taste Expiry: (date and time)
Triturate to form a fine powder		
Incrementally add the ORA-Plus® to the powder and mix well		
Pour mixture into graduated cylinder		
qs to 120 mL with the ORA-Sweet®		
Cap graduated cylinder tightly with paraffin paper and shake to mix well		
Pour mixture into glass amber bottle (250 mL size)		
Label bottle and put on IV Adds shaker for 10 min (if available)		**Stability:**
		72 hours at room temperature
		Prepared by:
		Date:

MEDICAL ASSISTANCE IN DYING
PHENOBARBITAL, CHLORAL HYDRATE, MORPHINE (in distilled water) ORAL SUSPENSION

Note: Use compounded suspension in distilled water for administration via feeding tube (e.g. percutaneous endoscopic gastrostomy (PEG) or nasogastric (NG) tube). Flush feeding tube with 60 to 90 mL of water after medication administration.

FORMULA		
Preparation: **Compounded Phenobarbital, Chloral Hydrate, Morphine (in Distilled Water) Oral Suspension**		**Package Size:** **120 mL** (Dispense in a 200 mL glass amber bottle)
Formula:		**Use(s): Medical Assistance in Dying**
phenobarbital powder	20 g	
chloral hydrate powder	20 g	**References:**
morphine sulphate powder	3 g	Physician-assisted Death, Pharmacy Protocols, Alberta Health Services
Distilled water	qs to 120 mL	
		Precautions:
		Personal protective equipment: • Protective gown • Nitrile gloves • N95 mask • Eye protection Dispense in glass amber bottle (Note: Chloral hydrate powder is caustic and is incompatible with plastic containers)
Directions for Manufacture:		**Label:**
Put all powders in mortar and pestle		See Appendix K
Triturate to form a fine powder		
Incrementally add distilled water to the powder and mix well		Shake well Store at room temperature Expiry: (date and time)
Pour mixture into graduated cylinder		
qs to 120 mL with distilled water		
Cap graduated cylinder tightly with paraffin paper and shake to mix well		
Pour mixture into glass amber bottle (250 mL size)		
Label bottle and put on IV Adds shaker for 10 min (if available)		**Stability:**
		72 hours at room temperature
		Prepared by:
		Date:

MEDICAL ASSISTANCE IN DYING
MEDICATION LABELS – INTRAVENOUS REGIMEN

AFFIXED BY s.15 s.15 **(to each zip lock bag containing medication)**	**AFFIXED BY SITE PHARMACY STAFF (using an addressograph or FormImprint label)**
# 1 **midazolam 10 mg / 10 mL Inj** **Quantity:** 2 **Directions:** 2.5 to 10 mg (2.5 to 10 mL) IV over 2 minutes May repeat additional dose x 1 PRN **Preparation:** 1. Draw up 10 mg (10 mL) midazolam into a 20 mL syringe 2. Repeat for additional dose	Patient Name DOB, PHN
Syringe Label: #1 midazolam 10 mg / 10 mL Inj Patient Name:_____	
#2 **lidocaine 2% 100 mg / 5 mL Inj** **Quantity:** 1 **Directions:** 40 mg (2 mL) IV over 30 seconds **Preparation:** Draw up 40 mg (2 mL) lidocaine into a 3 mL syringe	Patient Name DOB, PHN
Syringe Label: #2 lidocaine 2% 40 mg / 2 mL Inj Patient Name: _____	
#3 **proPOFol 1g / 100 mL Inj** **Quantity:** 2 **Directions:** 1 g (100 mL) IV over 5 minutes (Use 4 syringes each containing 250 mg / 25 mL) May repeat additional dose x 1 PRN **Preparation:** 1. Draw up 1 g (100 mL) proPOFol into four 60 mL syringes, each containing 250 mg (25 mL) 2. Repeat for additional dose	Patient Name DOB, PHN
Syringe Label: #3 proPOFol 250mg / 25 mL Inj Patient Name : _____	

APPENDIX H Cont'd

MEDICATION LABELS – INTRAVENOUS REGIMEN, Cont'd

AFFIXED BY s.15 s.15 **to each zip lock bag containing medication)**	**AFFIXED BY SITE PHARMACY STAFF (using an addressograph or FormImprint label)**
# 3 **phenobarbital 120 mg / mL Inj** **Quantity**: 50 **Directions** : 3 g (diluted to 50 mL sodium chloride 0.9%) IV over 5 minutes May repeat additional dose x 1 PRN **Preparation** : 1. Break ams with an ampoule breaker device 2. Draw up 3 g (25 x 1 mL amps) phenobarbital using a filter straw into a 60mL syringe 3. Draw up 25 mL sodium chloride 0.9% into same 60 mL syringe 4. Mix contents in syringe **5.** Repeat steps for additional dose	Patient Name DOB, PHN
Syringe Label: #3 phenobarbital 3 g / 50 mL Inj (diluted to 50 mL sodium chloride 0.9%) Patient Name :_____	
# 4 **rocuronium 50 mg / 5 mL Inj** **Quantity:** 4 **Directions:** 200 mg (20 mL) by rapid IV injection **Preparation:** Draw up 200 mg (20 mL) rocuronium into a 30 mL syringe (i.e. use 4 vials)	Patient Name DOB, PHN
Syringe Label: #4 rocuronium 200 mg / 20 mL Inj Patient Name :_____	

Syringe Labels
- are included in the zip lock bag containing medication and related supplies
- are to be affixed by the prescriber upon preparation

APPENDIX I

Policy: Medical Assistance in Dying – Role of Pharmacy Services

MEDICAL ASSISTANCE IN DYING
MEDICATION LABELS – ORAL REGIMEN

AFFIXED BY s.15 s.15	**AFFIXED BY SITE PHARMACY STAFF (using an addressograph or FormImprint label)**
# 1 **metoclopramide** **10 mg tablets** **Quantity:** 2 **Directions:** Take 2 tablets (20 mg) orally one hour prior to ingesting coma–inducing agent	Patient Name DOB, PHN
# 2 **ondansetron** **8 mg tablet** **Quantity:** 1 **Directions:** Take 1 tablet (8 mg) orally one hour prior to ingesting coma-inducing agent	Patient Name DOB, PHN
haloperidol **5 mg/mL Inj** **Quantity:** 2 **Directions:** 5 mg (1 mL) subcutaneously or IV PRN for emesis during procedure May repeat additional dose x 1 PRN	Patient Name DOB, PHN
LORazepam **0.5 mg sublingual tablets** **Quantity:** 8 **Directions:** Take 1 to 4 tablets (0.5 to 2 mg) sublingually 5 to 10 minutes prior to coma-inducing agent, if needed for anxiety Repeat additional dose x1 PRN	Patient Name DOB, PHN

MEDICATION LABELS – ORAL REGIMEN, Cont'd

AFFIXED BY s.15 s.15	**AFFIXED BY SITE PHARMACY STAFF**
None	Patient Name DOB, PHN Date **Compounded Phenobarbital, Chloral Hydrate, Morphine (in ORA-Plus® - ORA-Sweet®) Oral Suspension** **phenobarbital 20 g** **chloral hydrate 20 g** **morphine 3 g** **ORA-Plus® / ORA-Sweet®** **50 / 50 qs to 120 mL** **Quantity: 120 mL** **Directions:** Shake well Ingest entire contents in less than 4 minutes Follow with a small amount non-fat, non-carbonated beverage May have a bitter taste **Storage**: Store at room temperature **Expiry**: Date and time
None	Patient Name DOB, PHN Date **Compounded Phenobarbital, Chloral Hydrate, Morphine (in Distilled Water) Oral Suspension** **phenobarbital 20 g** **chloral hydrate 20 g** **morphine 3 g** **distilled water qs to 120 mL** **Quantity:** 120 mL **Directions:** Administer via feeding tube Flush feeding tube with 60 to 90 mL water after medication is administered **Storage**: Store at room temperature **Expiry**: Date and time

APPENDIX J

Policy: Medical Assistance in Dying – Role of Pharmacy Services

MEDICAL ASSISTANCE IN DYING
MEDICATION KIT LABELS
(KIT EXTERIOR)

AFFIXED BY s.15 s.15	**AFFIXED BY SITE PHARMACY STAFF**
Medication Kit – Intravenous Regimen (proPOFol) Lot Number: Expiry date: RETURN TO PHARMACY SERVICES	Facility name Phone number (Pharmacy Services)
Medication Kit – Intravenous Regimen (phenobarbital) Lot Number: Expiry date: RETURN TO PHARMACY SERVICES	Facility name Phone number (Pharmacy Services)
Medication Kit – Oral Regimen RETURN TO PHARMACY SERVICES	Facility name Phone number (Pharmacy Services) Expiry date: (date / time)

From:	Greenaway, Shelley E HLTH:EX
To:	Acker, Kelly HLTH:EX
Cc:	Archibald, Karen HLTH:EX; Wingrove, Scott HLTH:EX
Subject:	Minor Points re: Revised DRAFT Guidelines for LTC Access
Date:	March 15, 2019 12:57:00 PM
Attachments:	LTC Access Guidelines 20190314-SG.docx

Hello Kelly;

I have inserted four minor comments in the attached file for your consideration.

Thank you,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

From: Archibald, Karen HLTH:EX
Sent: March 14, 2019 1:56 PM
To: 'dee.chatha@fraserhealth.ca' ; 'Lisa.Maxfield@interiorhealth.ca' ; 'Mary.herauf@northernhealth.ca' ; 'Dawn.Connolly@northernhealth.ca' ; 'Gina.Gaspard@fnha.ca' ; 'Shelina.meghji@vch.ca' ; 'Sarah.jordan@vch.ca' ; 'Jillian.Fisher@viha.ca' ; 'Caitlin.Davies@viha.ca' ; 'Elizabeth.Pearce@fnha.ca' ; XT:Coughlin, Kevin JAG:EX ; XT:Leaney, Alison AG:IN ; 'eprice_edencare@telus.net' ; 'j-mschulz@shaw.ca' ; 'A.Berndt@gmx.net' ; 'leigh.hayes@fraserhealth.ca' ; 'Davidson, Monique [VC]' ; 'Armstrong, Barbara'
Cc: McLachlan, Debbie HLTH:EX ; Greenaway, Shelley E HLTH:EX ; Flagg, Jackson HLTH:EX ; de Aquino, Alexa HLTH:EX ; Saric, Anthony HLTH:EX ; Acker, Kelly HLTH:EX ; Wingrove, Scott HLTH:EX ; Prescott, Julia HLTH:EX
Subject: Revised DRAFT Guidelines for LTC Access

Hi all, please find attached a copy of the revised Guidelines document based on input from our last meeting.

The main changes are:

s.13

s.13 . We will discuss this further at Monday's meeting.

We are hoping to finalize the Guidelines at that meeting and get them into our approval processes.

Thanks,

Karen

Karen Archibald

Director, Strategic Initiatives | Seniors Services | Ministry of Health

Tel: 250-952-1162 | *Email*: Karen.Archibald@gov.bc.ca

From:	Greenaway, Shelley E HLTH:EX
To:	Smith, Leah M HLTH:EX
Subject:	My Suggestions
Date:	August 11, 2016 5:11:00 PM
Attachments:	DRAFT access care coordination policy Confidential V3-SG.docx

Hi Leah;

Attached are my edits/suggestions. I could have added more if I had more time, as one edit often leads to another. I didn't look at the definitions section at all, other than to make it an appendix. Once I see what you have accepted, I will likely have more suggestions based on the new draft so feel free to ask me to review it again if you have the time and patience.

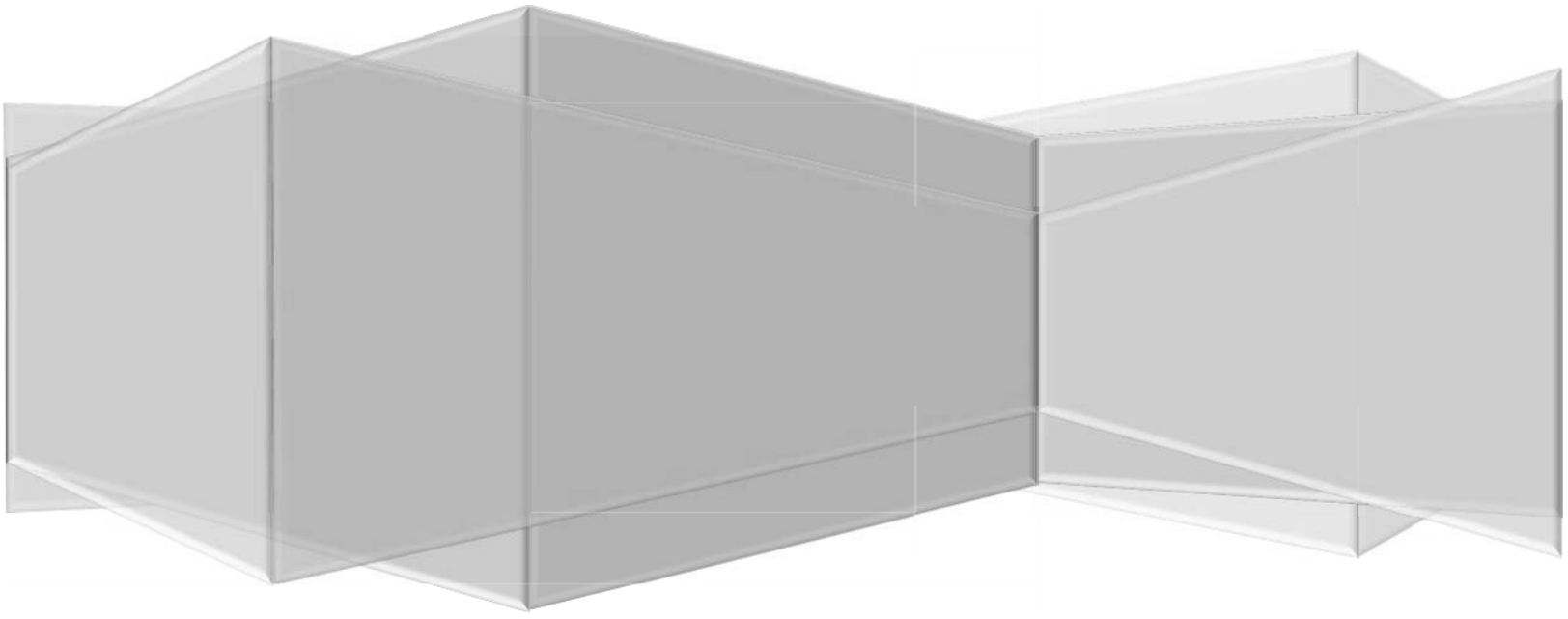
Thanks,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Health Services Policy Division
Ph: 250 952-3079

BRITISH COLUMBIA
www.gov.bc.ca

Physician Assisted Dying - Policy Considerations

Health Service Policy and Quality Assurance Division



BACKGROUND

In February 2015, the Supreme Court of Canada (SCC) issued reasons in *Carter* which effectively reversed the Court's 1993 decision in *Rodriguez*. In *Carter* the SCC found that sections 241(b) and 14 of the *Criminal Code* deprive competent adults of their right to life, liberty and security of the person under section 7 of the *Charter*. In addition, the SCC found that the prohibition of physician assisted dying (PAD) contained in the *Criminal Code* is not in accordance with the principles of fundamental justice under section 1 of the *Charter*.

The SCC concluded that a more "complex regulatory response" to the risks associated with physician assisted death were more appropriate, rather than a blanket prohibition. As such, the SCC's declaration of invalidity was suspended for one year (until February 2016), to allow provincial/territorial government to enact a "system of safeguards" that are associated with physician assisted dying.

THE COURTS RULING

The Supreme Court of Canada's (SCC) decision in *Carter* has broad policy and regulatory impacts for the Government of British Columbia and the Parliament of Canada. The SCC's decision is to suspend the declaration of invalidity for one year to allow government time to enact an appropriate response. The ruling from the SCC gives some, albeit relatively few, parameters respecting the declaration, such that section 241(b) and section 14 of the *Criminal Code* are void insofar as they prohibit physician assisted death.

In essence, the court established the following five parameters:

1. The assistance must be provided by a physician; and the person must:
2. Be an adult;
3. Be competent;
4. Clearly consent to the termination of life, and;
5. Have a grievous and irremediable medical condition, (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

INTERPRETATION

The corollary handed down by the SCC means that there is considerable uncertainty about the scope and breadth of the exemption from the *Criminal Code* prohibition. The proposed regulatory framework must bring into question all areas of uncertainty to ensure a system of safeguards are in place to protect those who are vulnerable, and to refrain from restricting access to service for individuals who qualify.

The parameters set by the SCC prohibit individuals to avail themselves of physician assisted dying so long as they are not considered to be an adult. However, laws pertaining to the age of majority are individually set by province or territory, and can ultimately create a regulatory patchwork amongst jurisdictions in Canada. There are currently Six (6) provinces (Alberta, Manitoba, Ontario, Prince Edward

Island, Quebec, and Saskatchewan) that declare a person to no longer be a minor at the age of 18. The remaining four (4) provinces and three (3) territories (British Columbia, New Brunswick, Newfoundland and Labrador, Nova Scotia, Northwest Territories, Nunavut, and Yukon) set the age of majority at 19.

Competent or competent person is not been clearly defined in British Columbia legislation; however, capable is a term used commonly in the BC legislation, and is inclusive of the *Health Care (Consent) and Care Facilities (Admission) Act,* and *Representation Agreement Act*. Every adult is presumed to be capable of making an informed decision regarding personal care, health care, and legal matters unless the contrary is demonstrated.

PHYSICIAN ASSISTED DYING IN BRITISH COLUMBIA

In the decision, the SCC provided comments regarding the level of government responsible for creating legislation for PAD. The court denied the appellants argument that assisted dying laws fall entirely within the responsibility of the province because it lies at the core of provincial jurisdiction over health care. The SCC responded suggesting both levels of government may legislate on the matter as health is a concurrent jurisdiction.

Although the ruling sheds little light on which exact elements of PAD should be regulated by Parliament or which should be regulated by the provincial legislatures, traditionally the following areas are considered to be within the constitutional purview of the provinces:

- the law of capacity and consent and mental health;
- the regulation of hospitals and health authorities;
- the regulation of health professionals, including the practice of medicine;
- the regulation of pharmacies, include the sale and dispensing of drugs within the province
- the investigation of unnatural or unexplained death, including death in the health care setting, by coroners or medical examiners;

s.13; s.14

Page 348 of 359 to/à Page 359 of 359

Withheld pursuant to/removed as

s.13

Knowledge Exchange COMMUNITY OF PRACTICE

Medical Assistance in Dying

- Steering System and Social Change

Presented by

Brian Westgate

Director, Regulatory Initiatives,
Health Sector Workforce Division

Derek Rains

Director, Acute Care Access and Policy,
Hospital, Diagnostic and Clinical Services Division

Nancy Blythe

Policy Analyst, Acute Care Access and Policy,
Hospital, Diagnostic and Clinical Services Division

Date: Wednesday, May 31st
Time: 10:30AM – 11:30AM
Location: Auditorium A/B

Presentation

From: Stainton, Genevieve HLTH:EX
To: Acker, Kelly HLTH:EX; Odell, Liam HLTH:EX
Cc: Rains, Derek HLTH:EX; Greenaway, Shelley E HLTH:EX; Gardner, Anna HLTH:EX
Subject: RCA Facility Information
Date: July 11, 2018 1:12:09 PM

Hi Liam and Kelly,

s.13

Is it possible to revise this?
Thank you,

Genevieve
Genevieve Stainton | Policy Analyst **|** Acute Care Access & Planning, Acute and Provincial Services **|**
Ministry of Health **|** Ph: 250 952 2422; Email: Genevieve.Stainton@gov.bc.ca
PO Box 9638 Stn Prov Gov, Victoria BC V8W 9P1

From: Therrien, Darlene HLTH:EX
To: Patterson, Catherine M HLTH:EX
Cc: Bergen, Sara J HLTH:EX; Schuster, Michelle M HLTH:EX; Rongve, Ian HLTH:EX
Subject: Re: ACTION REQUIRED: MAiD Policy Paper
Date: December 10, 2019 2:27:35 PM
Attachments: image001.jpg

Thanks Catherine

Just chatted with Ian and will discuss with Sara and get on it:)

Darlene

On Dec 10, 2019, at 1:59 PM, Patterson, Catherine M HLTH:EX <Catherine.Patterson@gov.bc.ca> wrote:

> Hi Ladies,
> I just had a call from Holly Moulton regarding the MAiD Policy Paper. s.13
> s.13
>
> With thanks,
> Catherine

Catherine Patterson
Manager, Divisional Operations
Provincial, Hospital and Laboratory Health Services Division
Ministry of Health
PO Box 9639 Stn Prov Govt, Victoria BC V8W 9P1

Tel: 778 698-1749
Email: Catherine.Patterson@gov.bc.ca

From: Greenaway, Shelley E HLTH:EX
To: Blythe, Nancy HLTH:EX
Cc: Gardner, Anna HLTH:EX
Subject: RE: draft letter for your review
Date: September 13, 2017 10:55:00 AM

Hello Nancy;

I have made some comments below in blue. Let me know if you want to discuss them.

s.13; s.22

Thank you for the opportunity to give input,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Hospital, Diagnostic and Clinical Services Division
Ph: 250 952-3079

From: Blythe, Nancy HLTH:EX
Sent: Tuesday, September 12, 2017 5:05 PM
To: Greenaway, Shelley E HLTH:EX
Subject: draft letter for your review

Hi Shelley, attached is draft letter we discussed. Also attached is the master agreement – only version I have – section 3.8 has been underlined by someone.

Nancy Blythe
Policy Analyst
Acute Care Programs, Acute & Provincial Services
Hospital, Diagnostic and Clinical Services Division, Ministry of Health
Tel: 250-952-1529 Fax: 250-952-2970
Main Floor, 1515 Blanshard Street, Victoria, BC
PO Box 9638 Stn Prov Govt V8W 9P1

From:	Greenaway, Shelley E HLTH:EX
To:	Acker, Kelly HLTH:EX
Subject:	RE: For your revision: Summary document for RCA Policy
Date:	April 13, 2018 5:33:09 PM
Attachments:	Summary of MoH HCC Ch. 6 RC Access Policy Changes 20180406-SG.docx

Hello Kelly;

I haven't had time to take a good look at this but I did make a few initial notes/comments that are attached. On the page where I couldn't make comments, I highlighted my questions in yellow.

Thank you,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Hospital, Diagnostic and Clinical Services Division
Ph: 250 952-3079

From: Acker, Kelly HLTH:EX
Sent: Friday, April 13, 2018 9:12 AM
To: Greenaway, Shelley E HLTH:EX
Subject: FW: For your revision: Summary document for RCA Policy

HI Shelley,

Sorry, I should have sent this to you. I sent it to Karen and Scott just a few minutes ago. I am putting together the RC Access Policy Agenda right now, but the meeting materials won't go out until Monday. Karen hasn't had a chance to review yet. If you have any issues with the attached, please try to get a hold of me today. Thanks.

Kelly

Kelly Acker

Manager, Residential Care Policy / Seniors' Services / Primary and Community Care Policy Division / Ministry of Health
250-952-3441 / kelly.acker@gov.bc.ca

From: Acker, Kelly HLTH:EX
Sent: Friday, April 13, 2018 9:02 AM
To: Archibald, Karen HLTH:EX
Cc: Wingrove, Scott HLTH:EX; Odell, Liam HLTH:EX
Subject: FW: For your revision: Summary document for RCA Policy

Hi Karen,

I know you are very busy today. I am trying to get the meeting materials out to the RC Access Policy WG for our meeting on Wednesday. I am hoping you might be able to look at my email below. You said that you wanted to make changes to the Summary Document for the key policy changes. You will note that the facility allocation criteria still contains "urgency of need".

Thanks, Kelly

Kelly Acker

Manager, Residential Care Policy / Seniors' Services / Primary and Community Care Policy Division / Ministry of Health
250-952-3441 / kelly.acker@gov.bc.ca

From: Acker, Kelly HLTH:EX
Sent: Monday, April 9, 2018 4:03 PM
To: Archibald, Karen HLTH:EX

Cc: Odell, Liam HLTH:EX
Subject: For your revision: Summary document for RCA Policy

Hello Karen,

Please find the Summary Document at the below URL, for your revision. Thank you for offering to make it more comprehensible. Kelly

Z:\Programs\HCIC\Policy & Planning\Residential Care\Access Policy RCA\Project\1_Phase_One\Summary of MoH HCC Ch. 6 RC Access Policy Changes 20180406.docx

---

Kelly Acker

Manager, Residential Care Policy / Seniors' Services / Primary and Community Care Policy Division / Ministry of Health
250-952-3441 / kelly.acker@gov.bc.ca

From: Acker, Kelly HLTH:EX
To: Greenaway, Shelley E HLTH:EX
Subject: RE: MAID Bullet
Date: March 11, 2019 4:16:31 PM

Thanks Shelley. Change inserted.

Kelly Acker, BSc Hons., MSc, JD
Manager, Residential Care Policy / Seniors' Services / Specialized Services Division / Ministry of Health
250-952-3441 / kelly.acker@gov.bc.ca

From: Greenaway, Shelley E HLTH:EX
Sent: March 11, 2019 4:06 PM
To: Acker, Kelly HLTH:EX
Subject: MAID Bullet

Hello Kelly;

Derek and Nancy would like the bullet below to replace the current MAID bullet in the Guidelines.

Thank you,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

From: Blythe, Nancy HLTH:EX
Sent: March 11, 2019 3:31 PM
To: Greenaway, Shelley E HLTH:EX <Shelley.Greenaway@gov.bc.ca>
Subject: RE: Bullet from Long Term Care Access Guidelines

Thanks Shelley – I think it should be more clearly worded – my suggestion below (have run it past Derek Rains):

s.13

Nancy Blythe
Senior Policy Analyst
Acute & Provincial Services | Provincial, Hospital and Laboratory Services Division
Ministry of Health | 250 952-1529 | Fax: 250 952-2970
Main floor, 1515 Blanshard Street, Victoria, BC | PO Box 9638 Stn Prov Govt V8W 9P1

From: Greenaway, Shelley E HLTH:EX
Sent: March 11, 2019 3:04 PM
To: Blythe, Nancy HLTH:EX <Nancy.Blythe@gov.bc.ca>
Subject: Bullet from Long Term Care Access Guidelines

Hello Nancy;

If you have any objections to the highlighted bullet below, please send your suggested edits to me

and I will forward them to Kelly. Thank you.

2.2 - Care home-specific information

Care home-specific information about care and services (differs between care homes), including:

- location, and contact information for care home;
- approximate wait time for admission for each care home;
- types of accommodation (shared occupancy, single occupancy);
- availability of other services (such as hair dressing, foot care and nail care);
- availability of spiritual/denominational/pastoral services and activities;
- frequency and type of social and recreational activities;
- if the care home is one where the assessment and provision of medical assistance in dying (MAiD) services, are or are not available on site;
- what additional services are available for a fee, and the amount of these fees;
- security at the care home; and
- accessibility of the care home.

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Provincial, Hospital and Laboratory Services Division
Ph: 250 952-3079

From: Blythe, Nancy HLTH:EX
To: Bergen, Sara J HLTH:EX; Rains, Derek HLTH:EX
Subject: RE: MAiD WG follow up
Date: September 20, 2019 9:33:38 AM

Hi Sara,
Derek could better speak to the policy –s.13
s.13; s.17; s.22

Nancy Blythe
A/Manager, Provincial Services
Provincial Services Branch | Provincial, Hospital and Laboratory Services Division
Ministry of Health | Ph: 250 952-1529 | Cell: 250-882-2471 | Fax: 250 952-2970
Main floor, 1515 Blanshard Street, Victoria, BC | PO Box 9638 Stn Prov Govt V8W 9P1

From: Bergen, Sara J HLTH:EX
Sent: September 20, 2019 8:48 AM
To: Rains, Derek HLTH:EX ; Blythe, Nancy HLTH:EX
Subject: MAiD WG follow up

Hi Derek and Nancy,
This is not urgent, you can reply back next week if you want, but I wanted to follow up about a couple of threads that came up at Working Group yesterday, in the hopes you can provide background.
1 – MAiD facility policy – where was this last left off? There were a lot of questions at the meeting yesterday,s.17
s.13; s.17

2 – It looks like now that Ed Parks.22 s.13; s.17
s.13; s.17

Also happy to drop by your office if it is easier to discuss in-person. Let me know if I can set something up.
Thanks,
Sara

Sara Bergen
Manager, Medical Assistance in Dying Oversight Unit
Hospital Services Branch | Provincial, Hospital and Laboratory Health Services Division
BC Ministry of Health I 778-698-7497
PO Box 9638 STN PROV GOVT Victoria BC V8W9P1

From: Therrien, Darlene HLTH:EX
To: Cairns, Leann HLTH:EX
Cc: Bergen, Sara J HLTH:EX; Diacu, Razvan HLTH:EX
Subject: Re: MAID: Conscience objection
Date: December 12, 2019 3:57:20 PM

Thanks - it is a start but as people keep telling me it is about the person not an organization...

Darlene

On Dec 12, 2019, at 3:55 PM, Cairns, Leann HLTH:EX <Leann.Cairns@gov.bc.ca> wrote:

> Found this:
> https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html
> **Protecting the right of providers to act according to their beliefs and values**
> Copyright
>
> https://laws-lois.justice.gc.ca/PDF/2016_3.pdf
> Preamble:
> Copyright

Leann Cairns
Manager, Acute Care Access and Policy
BC Ministry of Health |Provincial, Hospital and Laboratory Health Services Division|
PO Box 9638 Stn Prov Govt, Victoria BC V8W 9P1
Office: 250-952-2284

From:	Acker, Kelly HLTH:EX
To:	Stainton, Genevieve HLTH:EX
Cc:	Rains, Derek HLTH:EX; Greenaway, Shelley E HLTH:EX; Gardner, Anna HLTH:EX; Archibald, Karen HLTH:EX; Odell, Liam HLTH:EX; Wingrove, Scott HLTH:EX; McLachlan, Debbie HLTH:EX
Subject:	RE: RCA Facility Information
Date:	July 11, 2018 1:18:03 PM

Hello Genevieve,
By way of this email, I am bringing this proposed revision to the attention of Karen and Scott, for their comment.
Thank you Karen and Scott.
And, thanks Genevieve. We will have an answer for you as soon as possible with respect to your suggestion. We have not yet finalized the document, nor exactly how it will be used by the health authorities.
Thanks, Kelly

Kelly Acker
Manager, Residential Care Policy / Seniors' Services / Primary and Community Care Policy Division / Ministry of Health
250-952-3441 / kelly.acker@gov.bc.ca

From: Stainton, Genevieve HLTH:EX
Sent: Wednesday, July 11, 2018 1:12 PM
To: Acker, Kelly HLTH:EX; Odell, Liam HLTH:EX
Cc: Rains, Derek HLTH:EX; Greenaway, Shelley E HLTH:EX; Gardner, Anna HLTH:EX
Subject: RCA Facility Information
Hi Liam and Kelly,
I am responding on Derek's behalf regarding the Draft RCA Facility Information document, particularly the bullet point around MAiD. In your doc it mentions: s.13

s.13

Is it possible to revise this?
Thank you,

Genevieve
Genevieve Stainton | Policy Analyst | Acute Care Access & Planning, Acute and Provincial Services |
Ministry of Health | Ph: 250 952 2422; Email: Genevieve.Stainton@gov.bc.ca
PO Box 9638 Stn Prov Gov, Victoria BC V8W 9P1

From: Greenaway, Shelley E HLTH:EX
To: Gardner, Anna HLTH:EX
Cc: Rains, Derek HLTH:EX; Stainton, Genevieve HLTH:EX
Subject: RE: RCA
Date: July 11, 2018 11:37:07 AM
Attachments: DRAFT RC Facility Information - 20180629.docx

Hello Anna;
I have attached the draft so that Genevieve can see it. I assumed that the draft was based on input from Derek and/or Genevieve. Kelly's group should probably be reminded, if they have missed some input.
Thank you,

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch
Hospital, Diagnostic and Clinical Services Division
Ph: 250 952-3079

From: Stainton, Genevieve HLTH:EX
Sent: Wednesday, July 11, 2018 11:19 AM
To: Gardner, Anna HLTH:EX
Cc: Greenaway, Shelley E HLTH:EX; Rains, Derek HLTH:EX
Subject: RE: RCA
I can't see the attachment Shelley sent, s.13
s.13

Does this help?
~Genevieve

From: Gardner, Anna HLTH:EX
Sent: Wednesday, July 11, 2018 11:08 AM
To: Greenaway, Shelley E HLTH:EX; Rains, Derek HLTH:EX; Stainton, Genevieve HLTH:EX
Subject: RE: RCA
Thanks Shelley-
In the draft facility info to be provided to adults eligible considering preferred care facilities, or to their substitute decision maker, it includes
s.13

Anna

From: Greenaway, Shelley E HLTH:EX
Sent: Tuesday, July 10, 2018 4:52 PM
To: Rains, Derek HLTH:EX; Gardner, Anna HLTH:EX
Subject: RCA
FYI – attached.

Shelley Greenaway
Senior Policy Analyst
Acute & Provincial Services Branch

Hospital, Diagnostic and Clinical Services Division
Ph: 250 952-3079

From:	Chatha, Dee
To:	Archibald, Karen HLTH:EX; Maxfield, Lisa; Herauf , Mary; Connolly, Dawn; "Gina.Gaspard@fnha.ca"; Meghji, Shelina [VA]; Jordan, Sarah [VA]; "Jillian.Fisher@viha.ca"; Davies, Caitlin S.; "Elizabeth.Pearce@fnha.ca"; XT:Coughlin, Kevin JAG:EX; XT:Leaney, Alison AG:IN; "eprice_edencare@telus.net"; "j-mschulz@shaw.ca"; "A.Berndt@gmx.net"; "leigh.hayes@fraserhealth.ca"; Davidson, Monique [VC]; Armstrong, Barbara
Cc:	McLachlan, Debbie HLTH:EX; Greenaway, Shelley E HLTH:EX; Flagg, Jackson HLTH:EX; de Aquino, Alexa HLTH:EX; Saric, Anthony HLTH:EX; Acker, Kelly HLTH:EX; Wingrove, Scott HLTH:EX; Prescott, Julia HLTH:EX
Subject:	RE: Revised DRAFT Guidelines for LTC Access
Date:	March 14, 2019 4:21:28 PM

Reminder would you please remove Leigh Hayes from the distribution list and add Team Leader Access, Care & Transitions Suzanne Darling. Thank you

From: Archibald, Karen HLTH:EX [mailto:Karen.Archibald@gov.bc.ca]
Sent: Thursday, March 14, 2019 1:56 PM
To: Chatha, Dee ; Maxfield, Lisa ; Herauf , Mary ; Connolly, Dawn ; 'Gina.Gaspard@fnha.ca' ; Meghji, Shelina [VA] ; Jordan, Sarah [VA] ; 'Jillian.Fisher@viha.ca' ; Davies, Caitlin S. ; 'Elizabeth.Pearce@fnha.ca' ; XT:Coughlin, Kevin JAG:EX ; XT:Leaney, Alison AG:IN ; 'eprice_edencare@telus.net' ; s.22 'A.Berndt@gmx.net' ; 'leigh.hayes@fraserhealth.ca' ; Davidson, Monique [VC] ; Armstrong, Barbara
Cc: McLachlan, Debbie HLTH:EX ; Greenaway, Shelley E HLTH:EX ; Flagg, Jackson HLTH:EX ; de Aquino, Alexa HLTH:EX ; Saric, Anthony HLTH:EX ; Acker, Kelly HLTH:EX ; Wingrove, Scott HLTH:EX ; Prescott, Julia HLTH:EX
Subject: Revised DRAFT Guidelines for LTC Access

Hi all, please find attached a copy of the revised Guidelines document based on input from our last meeting.

The main changes are:

s.13

s.13 We will discuss this further at Monday's meeting.

We are hoping to finalize the Guidelines at that meeting and get them into our approval processes.

Thanks,

Karen

_____

Karen Archibald

Director, Strategic Initiatives | Seniors Services | Ministry of Health

Tel: 250-952-1162 | *Email*: Karen.Archibald@gov.bc.ca

Page 18 of 44 to/à Page 26 of 44

Withheld pursuant to/removed as

s.13

PROVINCE OF BRITISH COLUMBIA

Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (Medical Assistance in Dying)

Policy Analysis & Options for British Columbia

Health Services Policy Division
Ministry of Health

Updated July 2016

To provide an overview of amendments to the Criminal Code of Canada (Bill C-14) and seek direction on British Columbia's policy approach to medical assistance in dying. Updated July 2016; originally provided April 2016.

Contents

s.13

Background

In February 2015, the Supreme Court of Canada (SCC) ruled in *Carter v. Canada* that the blanket prohibition against assistance in dying set out in the *Criminal Code of Canada* is unconstitutional. The SCC declared that competent adults may obtain assistance to die from a physician when they clearly consent to the termination of life, and have a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the person. The SCC indicated that the risks associated with lifting the prohibition could be mitigated through a carefully designed and managed system of safeguards.

The Criminal Code Amendment

On April 14, 2016, the Government of Canada introduced Bill C -14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. The Bill re-enacts the general prohibition on assisted suicide, but creates exemptions from criminal liability to allow for medical assistance in dying in accordance with prescribed rules, including eligibility criteria and procedural safeguards. Exceptions from criminal liability are included for: medical practitioners (physicians) and nurse practitioners (NP) to assess persons for eligibility and provide medical assistance in dying; pharmacists to dispense drugs; persons who aid a physician or NP (e.g., a registered nurse, social worker or licensed practical nurse); and, other persons (such as a family member or friend) who aid the patient to self-administer at their explicit request. Bill C-14 received Royal Assent on June 17, 2016.

Allowable forms of medical assistance in dying

The legislation allows for both practitioner-administered (voluntary euthanasia) and self-administered (assisted-suicide) forms of medical assistance in dying and does not include limits on the location or institution where this service may be provided.

Eligibility

The eligibility criteria set out in the *Criminal Code* limits access to medical assistance in dying to capable individuals 18 years of age or older, with a grievous and irremediable medical condition, who have made a voluntary request free of external pressure, and have provided informed consent to receive medical assistance in dying after having been informed of the means available to relieve their suffering, including palliative care. To ensure that Canada does not become an international destination for those seeking medical assistance in dying, only individuals eligible for publicly funded health services in Canada may access this service.

According to the federal legislation, for a medical condition to be considered "grievous and irremediable" all of the following criteria must be met:

a. they have a serious and incurable illness, disease or disability;
b. they are in an advanced state of irreversible decline in capability;
c. that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,
d. their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Safeguards

The legislation provides safeguards intended to balance personal autonomy with the risks to vulnerable individuals. These safeguards are similar to those found in legislation from jurisdictions where medical assistance in dying is legal and require that:

- The patient must submit a written request which is signed and dated by the patient and two independent witnesses, after the patient was informed by a physician or NP that the person has a grievous and irremediable medical condition;
- Two independent medical assessors (physician or NP) must assess the patient's eligibility and confirm in writing that the patient meets all of the eligibility criteria;
- 10 days must pass from the day on which the written request was made and the day on which medical assistance in dying is provided. This period must be observed unless both assessors agree that death or a loss of capacity appears imminent;
- The patient must be informed of their ability to rescind their request for medical assistance in dying at any time;
- Immediately before providing medical assistance in dying, the medical practitioner or nurse practitioner must give the patient the opportunity to withdraw consent and ensure that the patient gives express consent to receive medical assistance in dying; and,
- If the person has difficulty communicating, take all the necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

Policy Impacts and Analysis

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Urgent Proposal to Medical Services Commission and Tariff Committee — Medical Assistance in Dying

Future Fee Items and Billing for Medical Assistance In Dying (MAID)

Introduction

We are all family physicians (FPs) or specialists who are already providing services related to medical assistance in dying (MAID). Collectively, we have provided over 75 MAID assessments and have participated in a total of 23 MAID Events. Most of us serve on community, health authority or provincial working groups dedicated to studying and developing policies for the provision of MAID in the province of British Columbia. We have dedicated many hours to this very detailed and painstaking work.

Medical assistance in dying is a new service. Its nature makes it uniquely challenging for physicians, and this will not change even when the service is well established. However, the gravity and complexity of MAID are not reflected in current interim remuneration rates for the service. At the moment, physicians will earn much less consulting for or providing assistance in dying than they will if they spend the same amount of time in their offices seeing regular patients. This is not appropriate. If eligible British Columbians in all regions of the province are to have fair, timely access to this new right, a fee structure must be created that respects the intense professional, emotional and time pressure involved in providing MAID.

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