MEDICAL ASSISTANCE IN DYING

INFORMATION FOR HEALTH AND SOCIAL SERVICES PROFESSIONALS

This resource is informed by Health Canada's
'Advice to the Profession: Medical Assistance in Dying (MAID)'.

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Medical Assistance in Dying in the NWT

1. What is medical assistance in dying?

- Medical assistance in dying is one of a number of choices that can be considered in end-of-life care. It is a process where a medical practitioner or nurse practitioner ('practitioner') helps a patient who wants to voluntarily and intentionally end their life by:
    - Administering a medication to the patient that will cause their death peacefully; or

      Prescribing a medication that will cause their death peacefully that the patient will self-administer in the presence of a practitioner.

2. Who is eligible for medical assistance in dying?

- To receive medical assistance in dying, a patient must meet all of the following criteria:
    - Have a serious and incurable illness, disease, or disability;
    - Be in an advanced state of decline that cannot be reversed;
    - Have suffering that is constant and unbearable, and cannot be relieved in any way that they find acceptable;
    - Be at least 18 years old and capable of making decisions with respect to their health;

- Be eligible for publicly-funded health services in Canada;
- Voluntarily request medical assistance in dying, without pressure or influence from anyone else; and
- Give informed consent throughout the process.

3. Are those suffering from mental illness eligible for medical assistance in dying?

- Mental illness is excluded as a 'serious and incurable illness, disease, or disability' for the purposes of medical assistance in dying, and therefore, those whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying.
- Mental illness as a comorbidity, however, does not exclude a person from accessing medical assistance in dying.

4. What is the Central Coordinating Service and what does it do?

- The Central Coordinating Service serves as a main point of contact for individuals, families, and health and social services professionals who have inquiries related to medical assistance in dying.
- The Central Coordinating Service assists NWT residents and health and social services professionals with understanding the medical assistance in dying process and the paperwork involved.
- The Territorial Specialist for MAID, a registered nurse, manages the Central Coordinating Service, and can answer questions, provide resources, and facilitate access to practitioners who are willing to assess, and if applicable, provide medical assistance in dying.
- The Territorial Specialist for MAID works within a case management framework, helping patients access supports and services, coordinating assessments, and monitoring and evaluating care received.
- Anyone, including a patient's health and social services provider, can call the Central Coordinating Service on the patient's behalf.
- Non-MAID practitioners and nurses (registered nurses, registered psychiatric nurses, and licensed practical nurses) are required to provide contact information for the Central Coordinating Service to patients who ask for information on medical assistance in dying.

NWT Central Coordinating Service
Toll-free at 1-833-492-0131
Monday - Friday: 9:00am - 5:00pm
Email: maid_careteam@gov.nt.ca
Website: www.gov.nt.ca/maid

5. What is guiding how medical assistance in dying is provided in the NWT?

- The *Medical Assistance in Dying Guidelines for the Northwest Territories ('Guidelines')* guide the provision of medical assistance in dying in the NWT. The *Guidelines* adhere to the same eligibility criteria and safeguards as those set out in the *Criminal Code*.

General Information for Health and Social Services Professionals

6. Who can provide information on medical assistance in dying, and how can this be done without "counselling" on medical assistance in dying?

- Medical practitioners, nurse practitioners, nurses, social workers, psychologists, psychiatrists, and other regulated health and social services professionals can provide information on medical assistance in dying.
- Information provided must be factual and should be limited to how medical assistance in dying may be an option for patients who meet the eligibility criteria and how the process for medical assistance in dying works in the NWT.
- Abetting or counselling suicide is an offence under the *Criminal Code*. Health and social services professionals must not discuss medical assistance in dying with a patient with the aim of inducing, persuading, or convincing the patient to request medical assistance in dying.

7. Am I being required to provide this service?

- No. Nothing compels a health or social services professional to provide or assist in providing medical assistance in dying.
- Practitioners and nurses are only required to provide the Central Coordinating Service's contact information to patients who request information on medical assistance in dying.
- The Territorial Specialist for MAID manages the Central Coordinating Service and can help the patient with understanding the medical assistance in dying process and paperwork required. The Territorial Specialist for MAID can also facilitate access to practitioners who are willing to assess the patient, and if applicable, provide medical assistance in dying.
- Practitioners, nurses, and other health and social services professionals may also provide patients with the "Medical Assistance in Dying - Information for the Public" document (found at www.gov.nt.ca/maid), but are not obligated to do so, nor are they required to discuss or review the information in the document with the patient.
- Practitioners and nurses choosing not to participate must take reasonable steps to ensure the quality and continuity of care for patients is not compromised according to their duty to care and non-abandonment obligations.

8. I have received a request for medical assistance in dying, but I'm not comfortable being involved. What do I do?

- Any health or social services professional can direct a patient to contact the Central Coordinating Service or refer or transfer their patient to a willing practitioner at any time in the medical assistance in dying process.

9. I am interested in participating in medical assistance in dying. What should I do?

- You should inform your supervisor of your willingness to participate. If you are a physician or nurse practitioner, please reach out to the medical assistance in dying Clinical Lead or the NWT Central Coordinating Service.
- You should ensure you are familiar with the *Medical Assistance in Dying Guidelines for the Northwest Territories* (*Guidelines*). The *Guidelines* set out the rules for how medical assistance in dying can be requested and provided in the NWT, including the responsibilities and obligations of patients and health and social services professionals. The rules included in the G*uidelines* reflect those established in the *Criminal Code.*
- You could also become a member of the Canadian Association of MAID Assessors and Providers (CAMAP), complete the Canadian MAID Curriculum and any other relevant training, and become familiar with their resources (see www.camapcanada.ca for more information).

10. Are practitioners being trained on how to provide this service?

- Practitioners should pursue the necessary training to develop and maintain the professional competencies required to provide medical assistance in dying. While there are no specific training requirements for medical assistance in dying in the NWT, practitioners are expected to seek the appropriate experience and develop the necessary skills before assessing for and providing medical assistance in dying.
- The Canadian Association of MAID Assessors and Providers has developed a Canadian MAID curriculum, a nationally accredited and comprehensive educational program to support the practice of medical assistance in dying in Canada. Visit https://camapcanada.ca/curriculum/ for the most up-to-date information.
- The Canadian Medical Association has developed a training package that is available to medical practitioners.
- The Canadian Nurses Association has developed education resources for nurse practitioners and additional resources for nurses to support their practice.
- For more information about capacity assessment, refer to the "Capacity and Informed Consent" resources listed at the end of this document.
- For more information about trauma-informed care, refer to the "Trauma-Informed Care" resources listed at the end of this document.

- For more information about cultural safety and humility, refer to the "Cultural Safety and Humility" resources listed at the end of this document.
- To be granted medical assistance in dying privileges, physicians need to indicate on their Privileging Application Form that they are requesting this privilege, indicating that they believe they have the skills and experience necessary to safely and competently provide this service. Nurse practitioners must also request medical assistance in dying privileges if they wish to offer the service.

11. How can a patient request medical assistance in dying? What is the medical assistance in dying process?

- If a patient would like to proceed with making a formal written request, a practitioner (or other health or social services professional) can help the patient to complete Form 1 – Formal Written Request.
- In order to make a formal written request, the patient must not sign and date the request until **after** they are informed by a practitioner that they have a grievous and irremediable medical condition.
- After making a formal written request, the patient is assessed by at least two practitioners (an 'Assessing Practitioner' and a 'Consulting Practitioner'). Both practitioners must agree that the patient meets the eligibility criteria in order for the patient to be able to receive medical assistance in dying.
- The patient's natural death does not need to be reasonably foreseeable in order to be eligible for medical assistance in dying. However, additional safeguards must then be met, including:
    - Both practitioners must provide information on means to relieve suffering in accordance with the *Guidelines*;
    - The Assessing Practitioner or Consulting Practitioner must have expertise in the condition that is causing the patient suffering, or if neither has that expertise, one must consult with another practitioner who has that expertise; and
    - There must be a minimum of 90 clear days (i.e., 90 full days) between the day on which the assessment by the Assessing Practitioner begins and the day on which medical assistance in dying is provided. However, if both practitioners agree that the patient's loss of ability to consent will occur in less than 90 days, they may grant a shorter period.
- At the time medical assistance in dying is provided, the patient must be competent and able to provide consent unless valid advance consent has been provided in accordance with the *Guidelines*. Patients whose natural death is reasonably foreseeable may provide Advance Consent if they:
    - Are at risk of losing capacity to provide final consent before the date on which they wish to receive medical assistance in dying;

- Have the capacity to provide advance consent; and
- Have been deemed eligible for medical assistance in dying by both the Assessing Practitioner and the Consulting Practitioner.

- The patient is free to change their mind at any time, including at the time medical assistance in dying is to be provided.
- See the *Medical Assistance in Dying Guidelines for the Northwest Territories* for more details.

12. Is medical assistance in dying listed as an option under Goals of Care?

- No, medical assistance in dying is not currently included as an option under Goals of Care; however, a patient's Goals of Care Designation can be adjusted to reflect their unique wishes for care.
- Members of a patient's health care team may initiate and undertake Goals of Care conversation and document this discussion in the health record.
- Practitioners should ensure patients' Advance Care Planning and Goals of Care Designation is kept up to date and matches their current wishes throughout their medical assistance in dying journey.

13. Have drug protocols been developed for medical assistance in dying?

- Yes, the *Medical Assistance in Dying Medication Protocols for the Northwest Territories* ('*Medication Protocols*') is the NWT standard for all medical assistance in dying medications. The *Medication Protocols* have been shared with medical assistance in dying practitioners and pharmacists in the NWT.
- The *Medication Protocols* are also available on the Department of Health and Social Services' Professionals webpage (www.hss.gov.nt.ca/professionals/en/services/medical-assistance-dying-maid).

14. I am a nurse. What is my role?

- Registered nurses, licensed practical nurses, and registered psychiatric nurses can aid practitioners in providing medical assistance in dying to a patient, as long as it is within their regular scope of practice. If you have questions about what is within your scope, please contact:

College and Association of Nurses of the Northwest Territories and Nunavut
Phone: 1(867) 873-2745
www.cannn.ca

15. Where can I go if I have more questions?

- If you have any questions about medical assistance in dying, please refer to the *Guidelines* or contact the Central Coordinating Service. You can also reach out to your Area Medical Director or the medical assistance in dying Clinical Lead.

Information for Practitioners

16. When is it appropriate to initiate discussion about medical assistance in dying as an option?

- As in all situations of clinical care, practitioners have a responsibility to explore patients' values and discuss their goals for care. Practitioners should always provide information about treatment options and services that are appropriate to the patient's condition, in light of these values and goals of care. If a practitioner has determined that medical assistance in dying is consistent with a patient's values and goals of care and has good reason to believe that the patient might be eligible to receive medical assistance in dying, the practitioner must inform the patient about medical assistance in dying.
- The practitioner must also indicate an openness to discussing the topic and be attentive to the patient's wishes about further dialogue. The timing of initiating a conversation about medical assistance in dying should be determined by the practitioner, using their professional judgment, and should be undertaken with care, skill, and sensitivity.
- If a practitioner is aware that medical assistance in dying is not consistent with a patient's values and goals of care, they should not initiate a discussion about medical assistance in dying.
- In either case, the practitioner should document that the conversation has or has not taken in place and their rationale for the decision.
- For more information, refer to the "Initiating a Discussion about MAID" resources listed at the end of this document.

17. Is it necessary to assess capacity to consent to medical assistance in dying?

- Yes. A patient must have the decision-making capacity to give a free and informed consent to receive medical assistance in dying, and this must be established before medical assistance in dying is provided. A substitute decision-maker does NOT have the authority to provide consent for medical assistance in dying on behalf of the patient.
- In addition to being familiar with any legal and regulatory requirements for capacity, practitioners should familiarize themselves with rigorous and established capacity assessment methods and tools.

- Capacity to consent to an intervention is context, task, and time-specific. For individuals with fluctuating capacity, efforts should be made to assess capacity when they are at their best level of cognitive function. Reasonable efforts should be made to ensure that the assessment is adapted to the patient's needs. For example, practitioners should be alert to sensory, language, and speech deficits as well as slowed processing related to situations such as high doses of pain medications or ongoing substance use disorder and should make reasonable efforts to ameliorate them in the context of medical assistance in dying discussions. In some cases, it may be necessary for practitioners to undertake continual assessments of a patient's decision-making capacity in order to have enough information to make a judgment. Care must also be taken to ensure that the approach to the assessment is culturally appropriate.
- As with all clinical care, the assessment of capacity in different cases can range from relatively straightforward to very challenging. Practitioners should be alert to situations in which capacity assessment requires additional knowledge and experience in this area and, in such cases, should seek assistance through consultation with colleagues.
- The presence or a history of illness that may adversely affect capacity or a previous finding of incapacity to consent to a treatment or intervention including incapacity to receive medical assistance in dying, does not automatically mean a patient is <u>currently</u> incapable of consenting to medical assistance in dying. Similarly, a past history of suicidality does not mean that a patient is necessarily incapable of consenting to medical assistance in dying. Capacity needs to be assessed in the context of the current request.
- Practitioners must document the reasoning and evidence upon which their assessment of capacity was based supporting their finding of capacity or incapacity.
- For more information, refer to the "Capacity and Informed Consent" resources listed at the end of this document.

18. What is irremediability?

- The legal term 'irremediable' is part of the medical assistance in dying eligibility criterion 'grievous and irremediable medical condition.' This criterion is defined in the *Criminal Code* by way of three components: a serious and incurable illness, disease or disability; an advanced state of irreversible decline in capability; and enduring and intolerable suffering that cannot be relieved by means acceptable to the patient.
- Because the expression 'grievous and irremediable medical condition' is already defined in this way in the *Criminal Code*, practitioners must establish whether this criterion is fulfilled by ensuring all three components are met.

19. How do I assess incurability?

- 'Incurable' means there are no reasonable treatments remaining, where reasonable is determined through a process of the practitioner and patient together exploring the recognized, available, and potentially effective treatments in light of the patient's overall state of health, beliefs, values, and goals of care.
- At the time of the medical assistance in dying eligibility assessment, practitioners should explore treatment attempts made up to that point including their duration and intensity, outcomes of those treatments, and severity and duration of illness, disease, or disability.

20. Is there a specific number of treatment trials a patient has to have had before they can be considered to have an incurable condition?

- No. It is not possible to give a specific number of treatments a patient must have tried that will apply to all medical conditions leading to a medical assistance in dying request. Each condition has its own treatment approach including standard or recognized treatments for that condition. To understand the range of treatment options available, practitioners can refer to recognized clinical practice guidelines for the specific condition underlying a patient's medical assistance in dying request, or where guidelines do not exist, to the scientific literature and clinicians experienced in treating the condition.
- The incurability of the illness, disease, or disability does not require that a patient has attempted every potential option for intervention irrespective of the potential harms, nor that a patient must attempt interventions that exist somewhere in the world but are inaccessible to them.
- At the same time, a capable patient cannot refuse all or most interventions and automatically render themselves incurable for the purposes of accessing medical assistance in dying.
- A practitioner cannot form an opinion about medical assistance in dying eligibility in the absence of evidence required to form that opinion, i.e., that there are no reasonable treatments remaining where reasonable is determined through a process of the practitioner and patient together exploring the recognized, available, and potentially effective treatments in light of the patient's overall state of health, beliefs, values, and goals of care.

21. How do I assess an advanced state of irreversible decline in capability?

- 'Capability' refers to a patient's functioning (physical, social, occupational, or other important areas), not the symptoms of their condition. 'Function' should be understood as the ability to undertake those activities that are meaningful to the patient. 'Advanced state of decline' means the reduction in function is severe.

- For example, a patient may have incurable symptoms of a disorder, but this does not mean that they are in a state of decline or, if they are in a state of decline, that it is advanced and irreversible. The opposite is also true, as someone can be in an advanced state of irreversible decline in capability but still have potential for symptom improvement.
- 'Irreversible' means there are no reasonable interventions remaining, where reasonable is determined through a process of the practitioner and patient together exploring the recognized, available, and potentially effective interventions in light of the patient's overall state of health, beliefs, values, and goals of care.
- At the time of the medical assistance in dying eligibility assessment, practitioners should explore attempts at interventions made up to that point, outcomes of those interventions, and severity and duration of illness, disease, or disability. How many interventions, how many kinds of interventions, and over what period of time will vary according to the patient's baseline function as well as functional goals.
- The irreversibility of decline does not require that a patient has attempted every potential intervention irrespective of the potential harms, nor that a patient must attempt interventions that exist somewhere in the world but are inaccessible to them.
- At the same time, a capable patient cannot refuse all or most interventions and automatically render themselves in an advanced state of irreversible decline for the purposes of accessing medical assistance in dying.
- As discussed in the previous question, a practitioner cannot form an opinion about medical assistance in dying eligibility in absence of the evidence required to form that opinion, i.e., that there are no reasonable interventions remaining where reasonable is determined through a process of the practitioner and patient together exploring the recognized, available, and potentially effective interventions in light of the patient's overall state of health, beliefs, values, and goals of care.

22. What does it mean to make a voluntary request?

- As in all clinical care, practitioners must be satisfied that the patient's decision to request medical assistance in dying has been made freely, without undue influence (contemporaneous or past) from family members, health and social services providers, or others.
- Undue influence occurs when a person is not able to act in their own interests because of the interference by others.
- This undue influence may occur as a result of current or past pressure. For example, past abusive relationships may have been sufficiently severe that the patient is not able to do what is good for them, but rather evaluates decisions according to what the abuser thinks or thought was good for them. However, having experienced trauma does not mean that that one cannot make a voluntary request.

- The practitioner must assess whether the voluntariness of a patient's request has been compromised (for example, by incentives or threats). Practitioners should speak with the patient alone as part of the assessment process. If that is not possible because the patient requires supports (whether physical supports or for communication), the person providing support should not be someone who might be a source of undue influence. The practitioner should ask questions that will help to identify undue influence, such as interpersonal dependencies or past abuse that may leave the patient vulnerable. The practitioner should take steps to eliminate threats to voluntariness, and this may require continual assessments.
- A patient's request may not be voluntary at one time, but voluntary at a later time and vice versa. The Assessing and Consulting Practitioners must be satisfied the request is voluntary when it is made and the Providing Practitioner must be satisfied it is voluntary when medical assistance in dying is provided.

23. How do I interpret "reasonably foreseeable natural death"?

- According to the only Canadian court to provide an opinion on the interpretation of 'natural death has become reasonably foreseeable' (*2017 ONSC 3759, par. 79-80. AB c. Canada*):
    - [79]… natural death need not be imminent and that what is reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.
    - [80]… in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.
- For more information, refer to the "Reasonably Foreseeable Natural Death" resources listed at the end of this document.

24. How do I assess whether a patient's request for medical assistance in dying is a form of suicidal ideation?

- It is important to remember that suicidality (thoughts or wishes to be dead, plans, notes) can arise at any time during the life span, including at the end of life. Completed suicide is not exclusive to people with mental disorders, but as a group, persons with mental disorders are at higher risk of completed suicide as are certain other demographic groups such as Indigenous persons and military veterans. It is also important to remember that not all individuals with mental disorders experience suicidality, including those for whom suicidality is a potential symptom of the condition (a person can have such a condition without having that symptom).
- At an individual level, anyone with suicidal ideation may require active suicide prevention efforts whether or not they belong to a high-risk group. Similarly, a

medical assistance in dying request by a patient who belongs to a high-risk group should not be assumed to be evidence of suicidality.

- There is debate about whether to consider a request for medical assistance in dying as a form suicidal ideation. However, without needing to resolve that debate, clinical management in other situations of life-ending decision-making can point practitioners towards appropriate management of medical assistance in dying requests by patients with mental disorders.
- For example, if a patient states that they wish to discontinue a life-maintaining treatment (for example, renal dialysis), the treating practitioners will undertake several complementary and contemporaneous actions. They will assess the patient's capacity to consent to or refuse dialysis. They might request a psychiatric consultation – including on an urgent basis – if they have reason to believe there is a psychiatric disorder influencing the patient's decision-making capacity. If the patient suddenly stopped attending dialysis without notice, particularly if it is impulsive or seemingly inconsistent with a patient's prior stated wishes, the practitioner might ask the patient to come to hospital or be brought by family, or if the patient is refusing to come, request that the police bring the patient to hospital against their will due to dangerousness to self due to mental state or mental disorder as defined under territorial laws. Finally, and in parallel, practitioners will try to explore the problems making dialysis difficult to endure and propose solutions that might address these problems. This latter step will be undertaken whether the patient is capable or incapable, voluntary or involuntary. These different actions will be guided by knowledge of the patient's past behaviour, whether or not there is an untreated or unstable psychiatric disorder, and whether the patient had made references or allusions to wanting to end their life, made plans to end their life, or undertaken actions to further those plans such as researching means and self-harming behaviours.
- A similar approach can be taken towards a patient who makes a medical assistance in dying request. Whether or not to request an urgent psychiatric consultation and engage in suicide prevention efforts (voluntarily or involuntarily) will depend on the extent to which the patient's mental disorder is untreated or unstable as well as their associated risk behaviours as mentioned above.
- Practitioners should always be alert to the possibility of acute suicidality and should mobilize individual suicide prevention efforts where appropriate. These will often include referral to mental health resources for assessment and follow-up. Medical assistance in dying eligibility assessments must not be undertaken in circumstances of acute suicidality.
- For more information, refer to the "Managing Suicidality" resources listed at the end of this document.

25. If a person with a mental disorder makes a medical assistance in dying request, could this be grounds for an application for involuntary hospitalization based on dangerousness to self?

- By itself, a request for medical assistance in dying by a patient with a mental disorder should not be interpreted as dangerousness to self. The requirement of proximate harm to self permitting involuntary hospitalization under the NWT *Mental Health Act* is not met by the simple fact of making a medical assistance in dying request.
- Persons who are involuntarily hospitalized or subject to Assisted Community Treatment Certificates under the NWT *Mental Health Act* are not automatically excluded from making medical assistance in dying requests. Practitioners should be up to date about the relevant health authority policies, standards, and standard operating procedures in respect of how to handle medical assistance in dying requests in these contexts.

26. What if a patient refuses to allow the Assessing and Consulting Practitioners to obtain collateral history and/or access to the patient's health records?

- Obtaining 'collateral history' (discussions with persons who know and interact with the patient such as those within the patient's social circle and past or current treating clinicians) and reviewing past health records is often an essential part of clinical assessments. Practitioners must obtain collateral information and review health records as necessary to complete a thorough medical assistance in dying eligibility assessment. Practitioners must have the patient's consent to seek collateral information and to obtain past health records, including documentation of past medical assistance in dying assessments.
- Where a patient refuses to consent to the practitioners communicating with other clinicians, family members or other significant contacts, and/or for access to health records, the reasons for refusal should be explored. There may be good reasons that led to the refusal. For example, there may be a history of serious conflict or abuse in the relationship such that the patient may fear that seeking collateral information may reactivate conflict or abuse. In such cases, the practitioner can work with the patient to seek alternative sources of needed information. Alternatively, the patient may misunderstand the rights of a person who gives collateral information. For example, they may believe that a person giving collateral history can veto the medical assistance in dying request (which they cannot). In such cases, the practitioner should clarify the purpose of seeking collateral information and how such information will be used.
- If, however, a patient refuses consent to access collateral information and/or records without sufficient reason and the practitioner believes in good faith that the information is needed to form the opinion about eligibility, the practitioner must explain to the patient that the assessment cannot be completed because of this refusal and therefore, they cannot be found eligible for medical assistance in dying.

27. One of the Track 2 (where natural death is not reasonably foreseeable) safeguards is that before a practitioner provides medical assistance in dying they have to ensure the patient has been informed of the means available to relieve suffering. What does this involve?

- The *Criminal Code* provides a list of examples of means that could relieve a patient's suffering. These include counselling services, mental health and disability support services, community services, and palliative care. Community services must be taken to include housing and income support.
- This list is not exhaustive, and practitioners may be aware of other means available in their areas or professional networks that could relieve suffering. The means available that must be discussed with the patient are those that are reasonable and recognized.
- The *Criminal Code* also requires that the patient be offered consultations with relevant professionals who provide those services or that care. Providing Practitioners have the responsibility to ensure this requirement is fulfilled but may work in a multidisciplinary network or team in which colleagues assist with this process. Practitioners should themselves strive to become knowledgeable about existing resources and competent in system navigation.

28. One of the Track 2 safeguards is that a patient has to have given 'serious consideration' to the means available to relieve suffering. What does this mean? Is this different from the patient having capacity?

- Capacity to provide informed consent to receive medical assistance in dying is a separate legislative requirement from the requirement for a patient to have given serious consideration to the means available to relieve suffering.
- Serious consideration requires the *exercise* of decision-making capacity, not only *possessing* decision-making capacity. In other words, a patient must actually understand and appreciate the different elements of the decision, not merely have the ability to understand and appreciate. 'Serious' means that the consideration must be careful and non-impulsive. Serious consideration includes a genuine openness to the means available to relieve suffering.

29. Do Assessing and Consulting Practitioners have to be medical specialists for certain types of medical assistance in dying requests?

- No. The *Criminal Code* requires that Practitioners who do not have expertise in the condition causing the patient's suffering consult with a physician or nurse practitioner with such expertise. In other words, if neither the Assessing Practitioner nor the Consulting Practitioner has this expertise themselves, they must ensure they consult with someone who does. Depending on the case, they may require this

expertise in matters of diagnosis, treatment options, and capacity assessment, among others.

- The choice of the person with expertise (or people, if multiple types of expertise are required) should be directly related to the knowledge and experience that is required by the case. Although the person with expertise is not legally required to be a medical specialist, the clinical opinions being sought will often require specialty-level knowledge and experience.
- It is essential that everyone involved understand that the person with expertise is not being asked to assess the patient's eligibility for medical assistance in dying.

30. What does it mean to 'consult with' a physician or nurse practitioner with expertise?

- If neither the Assessing Practitioner nor the Consulting Practitioner who are involved in assessing a patient's request have expertise in the condition causing the patient's suffering, they must consult with a physician or nurse practitioner who has this expertise.
- In this context, to 'consult with' means to seek out the expertise in areas where the Practitioners do not have the necessary degree of knowledge and experience. Input of different types may be needed such as elaboration on therapeutic options, diagnostic clarification, or evaluation of the adequacy of past treatments.
- Depending on the clinical question being asked, it may require one or more meetings with the patient or it may require one or more case discussions with the Assessing Practitioner, Consulting Practitioner and/or Providing Practitioner.

31. What are social determinants of health and what is structural vulnerability?

- The social determinants of health are the non-medical factors that influence health outcomes. These include income, education, employment, housing status, race, ethnicity, and access to health services, among several others.
- Differences in these non-health related factors influence health outcomes due to social, political, and economic structures. For example, a higher income may be associated with better health outcomes, but an individual's efforts to increase their income (through further education) may be constrained by systemic barriers (like tuition fees, lack of accessible childcare, or poor public transit) that are difficult to overcome.
- A person is 'structurally vulnerable' with respect to health, when systemic barriers work against the person achieving better health outcomes. In addition, there may be negative conclusions or stereotypes drawn about people in situations of structural vulnerability. For example, one may characterize an individual as making poor choices (not pursuing education) rather than focusing on the social forces that led to those choices.

- For more information, refer to the "Structural Vulnerability" resources listed at the end of this document.

32. What are practitioners' responsibilities with respect to structural vulnerabilities in the context of medical assistance in dying requests?

- Because systemic barriers and biases are part of the fabric of our society, they cannot be undone by a single practitioner in the course of an individual medical assistance in dying assessment.
- Practitioners should strive to achieve structural competency: the ability for health professionals to recognize and respond with self-reflexive humility and community engagement to the ways negative health outcomes and lifestyle practices are shaped by larger socio-economic, cultural, political, and economic forces.
- As in all clinical practice, practitioners should strive to be aware of structural vulnerability and how associated systemic barriers and biases against medical assistance in dying patients may have affected their interactions in the healthcare system and their ability to access appropriate resources. For example, certain groups such as people living with disabilities, and racialized and Indigenous persons have been subject to long-standing discrimination in and by the health system. In their assessments of individuals requesting medical assistance in dying, practitioners must work to keep systemic biases out of their assessment.
- There may be situations in which a practitioner finds themselves in the following dilemma: a patient fulfills the eligibility criteria for medical assistance in dying but the means that could relieve suffering are not available due to systemic barriers. On the one hand, providing medical assistance in dying might lead the practitioner to believe they are complicit with societal failures. On the other, not providing medical assistance in dying to a patient who wishes to access it and fulfills the eligibility criteria might lead the practitioner to believe they are forcing the patient to live in a state of intolerable suffering. As in all clinical practice, practitioners must navigate these tensions by focusing on informing patients about all available options and doing whatever is in their power to remove barriers and biases encountered by individual patients. Of course, a practitioner is never compelled to provide medical assistance in dying in the face of such a dilemma.
- For more information, refer to the "Structural Vulnerability" resources listed at the end of this document.

33. What if a patient must wait to gain access to a treatment or intervention that is aimed at relieving their suffering?

- If a patient can gain access in a reasonable timeframe to an established and effective intervention aimed at alleviating the suffering related to the request for medical assistance in dying, the practitioner should advise the patient that they cannot form

the opinion that the patient is eligible for medical assistance in dying until that treatment or intervention is received.

- 'Reasonable' is determined through a process of the practitioner and patient together exploring how much time the patient can wait in light of their overall state of health, beliefs, values, and goals of care.

34. What if an eligible patient wishes to proceed with medical assistance in dying without informing family and/or friends?

- Practitioners must not disclose that a patient has requested or received medical assistance in dying to a patient's family or friends without the express consent to do so from the patient.
- That said, a patient's family and friends can be harmed if they are not aware that their loved one has requested or received medical assistance in dying. Practitioners should explain the potential harms of non-disclosure to the patient but must respect a capable patient's privacy and confidentiality.
- NWT death certificates do not include cause or manner of death. NWT Death Registration Statements include cause and condition(s) of death but are only released in very rare circumstances following an application to the NWT Registrar General of Vital Statistics.

35. What if I receive threats from patients or family members?

- In some cases, practitioners have received threats from patients or family members that they will file complaints to regulatory authorities or hospital complaint officers, initiate lawsuits, or even act violently towards them or colleagues.
- If a patient makes threats, they should receive a clear statement from the practitioner that medical assistance in dying eligibility assessments cannot proceed in circumstances of aggression and fear.
- With respect to threats from family members, practitioners should remain non-defensive but should seek advice from institutions, insurers, and trusted colleagues.

Information for Pharmacists

36. I work in a retail pharmacy. What if I am provided with a prescription to dispense medical assistance in dying medications?

- This should not occur. The *Guidelines* limit the dispensing of medical assistance in dying medications to pharmacies located in a hospital.

- If provided with a prescription to dispense medical assistance in dying medications from a retail pharmacy, you must notify the prescribing practitioner of the error as well as the Medical Assistance in Dying Review Committee as soon as possible.

MAID Review Committee
Department of Health and Social Services
Government of the Northwest Territories
Phone: 1(867) 767-9062 ext. 49190
Secure Fax: 1(867) 873-2315

37. What if a pharmacist is not willing to dispense the medications?

- Every practitioner and pharmacist has the right to conscientiously object from participating in medical assistance in dying. If a pharmacist objects, another pharmacist who is willing to dispense the medications should be asked to participate.

38. I'm a pharmacy technician. Can I dispense medical assistance in dying medications?

- No, only pharmacists are permitted to dispense medical assistance in dying medications.

Additional Resources

- Government of the Northwest Territories' Medical Assistance in Dying webpage: www.gov.nt.ca/maid
- Medical Assistance in Dying – Information for the Public: www.hss.gov.nt.ca/en/node/2031/
- Medical Assistance in Dying Guidelines for the Northwest Territories: www.hss.gov.nt.ca/sites/hss/files/resources/maid-interim-guidelines.pdf
- Medical Assistance in Dying forms: www.hss.gov.nt.ca/professionals/en/services/medical-assistance-dying-maid
- Medical Assistance in Dying Medication Protocols for the Northwest Territories: www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/maid-interim-medication-protocols.pdf
- Government of Canada resources: www.canada.ca/en/health-canada/services/medical-assistance-dying.html
- Canadian Association of MAID Assessors and Providers (CAMAP): www.camapcanada.ca
- Canadian MAID Curriculum: https://camapcanada.ca/curriculum/

Additional Resources by Topic

Initiating a Discussion about Medical Assistance in Dying

- Canadian Association of MAID Assessors and Providers (CAMAP) – Bringing Up Medical Assistance in Dying as a clinical care option: https://camapcanada.ca/wp-content/uploads/2022/02/Bringing-up-MAiD.pdf

  It should be noted that in light of the NWT's unique cultural context, practitioners shall only initiate a discussion about medical assistance in dying with a patient if the practitioner has determined that medical assistance in dying is consistent with the patient's values and goals of care and has good reason to believe that the patient might be eligible to receive medical assistance in dying. This is in line with Health Canada guidance, (see Question 16 above), and differs from what is presented in the CAMAP document.

- Canadian Medical Protective Association (CMPA) - Patient-centred communication: www.cmpa-acpm.ca/en/education-events/good-practices/physician-patient/patient-centred-communication

Capacity and Informed Consent

- CMPA - Informed Consent: www.cmpa-acpm.ca/en/education-events/good-practices/physician-patient/informed-consent?panel=checklist-documentation
- CAMAP - Assessment for Capacity to give Informed Consent for MAID: https://camapcanada.ca/wp-content/uploads/2022/02/Capacity-assessment.pdf

Reasonably Foreseeable Natural Death

- CAMAP – The Interpretation and Role of "Reasonably Foreseeable" in MAID Practice: https://camapcanada.ca/wp-content/uploads/2022/03/The-Interpretation-and-Role-of-22Reasonably-Foreseeable22-in-MAiD-Practice-Feb-2022.pdf
- CAMAP – The Clinical Interpretation of "Reasonably Foreseeable": https://camapcanada.ca/wp-content/uploads/2022/02/Clinical-Interpretation-of-Reasonably-Foreseeable.pdf

Cultural Safety and Humility

- National Collaborating Centre for Indigenous Health: Cultural Safety Collection: www.nccih.ca/1673/Cultural_Safety_Collection.nccih?Collectionid=3
- Cultural Safety in the NWT Health and Social Services System: www.hss.gov.nt.ca/en/services/cultural-safety

Managing Suicidality

- Centre for Addiction and Mental Health: Managing Suicidality: www.camh.ca/en/professionals/treating-conditions-and-disorders/suicide-risk/suicide---managing-suicidality
- UpToDate: Suicidal ideation and behaviour in adults: www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults#H14
- Sadek, Joseph (2019): A Clinician's Guide to Suicide Risk Assessment and Management: https://novascotia.cmha.ca/wp-content/uploads/2019/01/AClinician'sGuidetoSuicideRiskAsse.pdf

Trauma-Informed Care

- BC Mental Health & Substance Use Services: Trauma-informed Practice: www.bcmhsus.ca/health-professionals/clinical-professional-resources/trauma-informed-practice
- Trauma-informed care and suicide: www.suicideinfo.ca/wp-content/uploads/2017/11/Trauma-Fact-Sheet.pdf

Structural Vulnerability

- Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care - PubMed (nih.gov): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233668/