Medical Assistance in Dying (MAiD): Just the Facts

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Case (Dr. Darren Lau)

BSM 81F Metastatic small cell lung cancer

Background

Dx 2023 as RUL nodule + LNs + bony metastases.
Carboplatin and etoposide x4 cycles + durvalumab maintenance

On duravalumab, subtle liver nodules were observed with dDx metastases versus durvalumab-induced.

Last progress notes – patient appeared well. No mention of preferences for end-of-life care.

UAH Presentation – Transfer from Rural Centre

- Generalized pain, weakness, nausea, vomiting, and nose bleeds.
- CT showed markedly increased size and number of liver lesions.

Initial Measurements

- VS 131/96 HR 82 RR 18 SpO2 90% 2 LPM
- AST 596 ALT 184 ALP 192 tBili 22
- Hb 107 WBC 8.4 PLT 7 (No active bleeding)
- Creatinine 110 (baseline 65)

Working diagnoses

- Liver metastases +/- darvalumab-related liver injury
- Darvalumab-induced immune-mediated thrombocytopenia
- Pneumonia vs pneumonitis

Management:

- Ceftriaxone, azithromycin, IVIg, dexamethasone, IV fluids.

Course in Hospital

Wednesday – Evening admission and transfer to an off-service unit. GoC M1.

Thursday

- Stable + comfortable. Volunteered preference for MAID. She had been told at CCI that she need only request MAID, and it would be given.
- Plan for medical therapy with repat, for MAID near home. Record of Request form given.

Friday – Fatigued, but reaffirmed desire for MAID. No progress on ROR. Physician assisted with completion as an independent witness. ROR faxed to MAID office. Labs unchanged.

Saturday – Overnight delirium. PLT did not budge after trial of PLT transfusion.

Sunday

- Overnight severe generalized pain. Improved by morning, but confused and fatigued.
- Goals of care changed to C1.
- Haloperidol and hydromorphone PRN and escalated.

Monday

- Early morning pain crisis. Patient began crying out for her mother and was agitated. PRNs ineffective.
- Patient's daughter attended the bedside. Patient passed away shortly afterwards.

Course in Hospital

Wednesday – Evening admission and transfer to an off-service unit.

Thursday

- Stable + comfortable. Patient requested MAID. She had been told at CCI that she need only request MAID and it would be given.
- Plan for medical therapy with repeat for MAID near home. Record of Request form given.

Patient's family were distressed and angry about the manner of her death and that MAID had not been provided in hospital.

Friday – Fatigued, but reaffirmed desire for MAID. No progress on ROR. Physician assisted with completion as an independent witness. ROR faxed to MAID office. Labs unchanged.

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Disclosures

- 0.2 FTE AHS salary for Medical Leadership for MAiD
- 0.5 FTE salary from Alberta Health for consulting position
- > 10 years ago did receive honorarium for speaking opportunities from Hoffman LaRoche, AstraZenaca, Pfizer

- No discussion points today relate to any pharmaceuticals, only generic names will be used.

Objectives

1. To share MAiD enrollment criterion, processes, and documentation

2. To share MAiD patient navigation processes within Alberta Health Services

3. To highlight current MAiD process challenges within an in-hospital environment within AHS

MAiD

Controversial Topic

1. Religion and Beliefs
2. Conscientious Objection
3. Own Values/Ethics vs. Our Patient’s Values

Metrics

Total Provisions - EDM Zone

2023 = 318

2024 = 402

Total Provisions in Acute Care EDM Zone

2023 = 89

2024 = 93

AHS MAiD Process: Nomenclature

1. Record of Request – ROR
2. Assessments: Independent Assessment (IA) & Provider Assessment
3. Waiver of Final Consent (WFC) – not always necessary

Duty to Refer

- If one is not a MAiD supporter or in opposition, the CPSA "Conscientious Objection" Standard of Practice states "a mbr must ensure that a patient is offered timely access to a Regulated mbr that can provide the service or a resource that will provide information about medical options.
- One can direct patient's or their families to the MAiD Coordination/Navigation Team to start the process.
- The Navigation team will direct the process, liaise with patient/family, Patient Care Manager of unit ongoing, Assessment Clinicians

Record of Request

Formal and Legal Request to Carry Out MAID Eligibility Assessment

- https://www.albertahealthservices.ca/info/page13497.aspx

Alberta Health Services

Record of Request for Medical Assistance in Dying (MAID)

Completing this form is one step in the process of contemplating and requesting medical assistance in dying.

This form must be printed and signed in front of an independent witness.

Please read this form carefully prior to completing and if you have questions or concerns about how to complete the Record of Request for Medical Assistance in Dying form, contact your doctor or nurse practitioner (NP), or contact the Alberta Health Services (AHS) Care Coordination Service at: MAID.CareTeam@ahs.ca or through Health Link at 811.

This form assists with ensuring that legal requirements are met before medical assistance in dying is provided. By providing a signed, dated and witnessed request, you are declaring that you understand clearly the request you are making and that you are making this request voluntarily and free of duress or coercion.

When you fill out this Record of Request form, this is not your final chance to decide whether you want to receive the service of medical assistance in dying. At any point in the process, you may choose to withdraw.

On completing this Record of Request form, you may choose to either send or take the form to your doctor or NP, if they are willing to help, who can submit the form to the AHS Care Coordination Service on your behalf. It will be your doctor or NP's responsibility to assist you with the next steps.

If your doctor or NP has advised you that they will not be participating in your request for medical assistance in dying, you can send the Record of Request form to the AHS Care Coordination Service:

by fax *(choose one)*
- Edmonton & North: 780-641-9123
- Calgary & Central: 403-592-4264
- South: 403-592-4265

or by mail: Provincial Medical Assistance in Dying Office
6th Floor, 10101 Southport RD SW
Calgary AB T2W 3N2

If you require further assistance, the AHS Medical Assistance in Dying Care Coordination Service may also be reached by email at MAID.CareTeam@ahs.ca or through Health Link at 811.

A. Patient Demographics

Last Name	First Name	Middle Name

Sex at Birth	Date of Birth *(dd-Mon-yyyy)*
☐ Male ☐ Female ☐ Other *(e.g. intersex)*, specify _____	
Gender Identity ☐ Male ☐ Female ☐ Other *(specify)* _____ ☐ I do not consent to provide this information	**Personal Health Number (PHN)**

2. Patient Contact Information

Home Address			
City	**Province**	**Postal Code**	**Phone**

The collection of your health and personal information on this form (including your Personal Health Number) is legally authorized by sections 20(b), 21(a) and 27(a) of the Health Information Act (Alberta) and section 33 (c) of the Freedom of Information and Protection of Privacy Act (Alberta). Your information will only be used and disclosed as necessary for responding to your request. If you have any questions about the collection of your personal information as provided on this form, please contact the Medical Assistance in Dying Care Coordination Services by emailing maid.careteam@ahs.ca, through Health Link at 811, or sending your questions in writing by prepaid mail addressed to the attention of Provincial Medical Assistance in Dying Office 6th Floor, 10101 Southport Road SW Calgary, AB T2W 3N2.

C. Patient Request	
By initialing and signing below, I confirm that:	**Patient Initial** *(or Proxy Initial if required)*
I am at least 18 years of age and I request medical assistance in dying.	
I understand that I have the right to withdraw my request at any time and in any manner.	
I am eligible for insured health services funded by a government in Canada or would be eligible except for a minimum period of residence or waiting period. For example, I have a valid Alberta personal health card or proof of other publicly-funded health insurance from another province or territory.	
I believe, and a medical practitioner or a nurse practitioner has informed me, that I have a grievous and irremediable medical condition and that all of the following apply: • I have a serious and incurable illness, disease or disability; • I am in an advanced state of irreversible decline in capability; and • my illness, disease or disability or state of decline causes me enduring physical or psychological suffering that is intolerable to me and cannot be relieved under conditions that I consider acceptable.	
My request for medical assistance in dying is voluntary and, in particular, is not made as a result of external pressure.	
I expect to die when the substance to be prescribed is administered.	
I understand that if I have been or am informed by a medical practitioner or a nurse practitioner that my natural death is not reasonably foreseeable: • then medical assistance in dying cannot be provided to me until at least 90 clear days have passed from the day on which the first assessment to determine my eligibility for medical assistance in dying began, • unless, the providing practitioner and an independent practitioner who assesses my eligibility for medical assistance in dying are both of the opinion that loss of my capacity to provide consent to receive medical assistance in dying is imminent.	
I understand that requesting medical assistance in dying will require my health information to be collected, used and disclosed to the Federal Minister of Health in accordance with legislation.	

Patient Signature *(must be signed in the presence of the independent witness listed below)*		
Name of Patient *(print)*	Signature of Patient *(or Proxy if required)*	Date *(dd-Mon-yyyy)*
Name of Independent Witness *(print)*	Signature of Independent Witness	

If you have personally completed and signed page 2, please proceed to page 4.

Otherwise, a proxy may sign for you if you are physically unable to sign the request. The proxy cannot be the same person as a witness. The proxy must meet the requirements set out in the Declaration of Proxy.

D. Declaration of Proxy

	Proxy Initial
I am at least 18 years of age.	
I am completing this request on behalf of the Patient, so that they may request access to medical assistance in dying. Name of Patient _____	
I understand the nature of the request for medical assistance in dying.	
To my knowledge I am not a beneficiary under the will of the person making the request or a recipient in any other way of a financial or other material benefit resulting from the person's death.	
I completed and signed this request for medical assistance in dying in the presence of the person making the request, on his or her behalf and under his or her express direction.	

Signature of Proxy

Name of Proxy *(print)*	Signature of Proxy	Date *(dd-Mon-yyyy)*
Mailing Address		Phone
City	Province	Postal Code

D. Declaration of Independent Witness *(see Frequently Asked Questions about Witnessing the Record of Request for Medical Assistance in Dying (alberta-healthservices.ca) for general information and guidelines for witnessing a Record of Request)*	
	Witness Initial
I am at least 18 years of age.	
I understand the nature of the request for medical assistance in dying.	
The patient signed this request in my presence, on the date indicated that follows the patient's signature; or if the patient was unable to do so, the patient's proxy signed this request on the patient's behalf in my presence and in the presence of the patient and under the patient's express direction, on the date indicated that follows the proxy's signature.	
To my knowledge I am not a beneficiary under the will of the person making the request or a recipient in any other way of a financial or other material benefit resulting from the person's death.	
I am not an owner or operator of a health care facility in which the patient is receiving treatment or of a facility in which the patient resides.	
I am not the medical practitioner or nurse practitioner involved in the assessment for or who will provide medical assistance in dying to the patient.	

Signature of Independent Witness		
Name of Independent Witness *(print)*	Signature of Witness	Date *(dd-Mon-yyyy)*
Mailing Address		Phone
City	Province	Postal Code

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Additional Information

To better understand inequality or disadvantage in relation to medical assistance in dying, Federal regulations gives AHS the authority to collect the information, but it is not mandatory.
You may indicate that you do not consent to provide this information. This will not affect your eligibility for medical assistance in dying.

What is your usual place of residence?

- ☐ Hospital *(excludes palliative care beds or unit)*
- ☐ Palliative care facility *(includes hospital-based palliative care beds, unit or hospice)*
- ☐ Residential care facility *(includes long term care facilities)*
- ☐ Private residence *(includes retirement home)*
- ☐ Correctional facility/Prison
- ☐ Shelter/Group home
- ☐ Other *(specify)* _____
- ☐ Do not know
- ☐ I do not consent to provide this information

If your usual place of residence is a private residence, what is your living arrangement?

- ☐ Living with family *(partner, children, parents)*
- ☐ Living alone
- ☐ Living with relatives
- ☐ Living with non-relatives
- ☐ Other *(specify)* _____
- ☐ Do not know
- ☐ I do not consent to provide this information

Do you identify as First Nations, Métis and/or Inuk/Inuit?

- ☐ Yes *(if yes, please specify)*
  - ☐ First Nations ☐ Métis ☐ Inuk/Inuit
- ☐ No
- ☐ Do not know
- ☐ I do not consent to provide this information

Which racial, ethnic or cultural group best describes you? *(choose all that apply)*

- ☐ Black
- ☐ Caucasian *(white)*
- ☐ East Asian *(Chinese, Korean, Japanese, Taiwanese, etc)*
- ☐ Latin American
- ☐ Middle Eastern *(Arab, Persian, Lebanese, Turkish, etc)*
- ☐ South-east Asian *(Filipino, Thai, Vietnamese, etc)*
- ☐ South Asian *(Indian, Pakistani, Bangladeshi, etc)*
- ☐ Other racial, ethnic or cultural group *(specify)* _____
- ☐ Do not know
- ☐ I do not consent to provide this information

In your opinion, do you have a disability?

- ☐ Yes *(If yes, specify disability)* _____
- ☐ No
- ☐ Do not know
- ☐ I do not consent to provide this information

Record of Request

- Is often Rate Limiting Step
- Needs completion and submission to MAiD Navigation Team to start the process
- Witness cannot be a person that may benefit from the applicant’s death
- Once completed ROR needs to be sent to AHS MAiD Coordination Team. (Not on Connect Care)

Assessment: Independent & Provider

- Determine and Adjudicate Eligibility – independently and without collaboration
- Ensure Capacity and Informed Consent
- Ensure Patient and Families Understand Process and Alternatives
- Answer questions

Alberta Health Services

Combined Assessment/Providing Practitioner Record For Medical Assistance in Dying

Once complete, **please fax all pages within 24hrs** to MAID Reporting *(if only assessing)* **OR TO** MAID Reporting **AND** Medical Examiner's Office *(if assessing and providing)*

Patient Name
Date of Birth *(yyyy-mm-dd)*
Personal Health Number (PHN)

This information is collected under the authority of sections 20, 21, 22(2)(d) and (g) of the Health Information Act, the Regulations for the Monitoring of Medical Assistance in Dying (Canada) and O.C. 142/2016 and O.C. 320/2016 for the purpose of confirming that the requirements of standards of practice and legislation applicable to medical assistance in dying are met and for the purposes set out in section 27(1)(g), 27(2)(a), (b), and (d) of the Health Information Act. If you have any questions about the collection of this information, please contact the Health Information Act Help Desk, Alberta Health, PO Box 1360 Station Main, Edmonton, AB, T5J 2N3 or by phone at 780-427-8089 or toll free in Alberta at 310-0000, then 780-427-8089, or by email at hiahelpdesk@gov.ab.ca.

Disclosure Statement: I understand that by participating in providing any part of medical assistance in dying, my professional information will be collected, used and disclosed to the provincial and federal Ministers of Health, or their delegates, for the purpose of monitoring medical assistance in dying.

****If you are ONLY assessing - complete pages 1 - 7 and fax to the MAID Reporting line at 1-403-592-4266 or 1-888-220-2729.**

****If you are assessing AND providing complete all pages 1 - 14 and fax to MAID Reporting line and Medical Examiner's Office.**

Required Information

Please note: Sections are numbered as per requirements from Health Canada and therefore not all Sections will appear in each part of this form. Further, Sections may appear out of order in order to maintain document flow.

1a. Client/Patient Identifying Information

Last Name	First Name	Middle Name	
Date of Birth *(yyyy-mm-dd)*	Gender ☐ Male ☐ Female ☐ Other	Personal Health Number *(PHN)*	Postal Code

1b. Practitioner Information: *Provide your information as the Practitioner.*

Last Name	First Name	Designation ☐ MD ☐ NP	
If you are a physician - what is your specialty ☐ Anesthesiology ☐ Cardiology ☐ Family Medicine ☐ General Internal Medicine ☐ Geriatric Medicine ☐ Nephrology ☐ Neurology ☐ Oncology ☐ Palliative Medicine ☐ Respiratory Medicine ☐ Other – specify: _____		CPSA/CARNA Registration #	
Mailing Address at Primary Place of Work	City/Town	Province AB	Postal Code
Telephone Numbers	Email Address used for work	Have you seen this patient for medical care other than MAiD? ☐ Yes ☐ No	

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1c. Receipt of the Written Request

From whom did you receive the written request for MAID that triggered the obligation to provide information?

☐ Patient Directly ☐ Another practitioner
☐ Care Coordination Service
☐ Another third party – specify: _____

Date of receipt of written request for MAID *(yyyy-mm-dd)*

Date I began my MAID assessment *(yyyy-mm-dd)*

Declaration of Practitioner Independence *(Please indicate if you meet the criteria of an independent practitioner)*

Practitioner Criteria

I am independent of the person and the referring practitioner, in that I do not know or believe that I am:

- a mentor to the other practitioner or responsible for supervising their work. ☐ Yes ☐ No
- a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request. ☐ Yes ☐ No
- connected to the other practitioner or to the person making the request in any other way that would affect their objectivity. ☐ Yes ☐ No

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PART A - ASSESSOR

Please note: Sections are numbered as per requirements from Health Canada and therefore not all Sections will appear in each part of this form. Further, Sections may appear out of order in order to maintain document flow.

B. Practitioner Assessment of Eligibility: *Please choose the appropriate response for each of the mandatory eligibility criteria.*

Date of Assessment *(yyyy-mm-dd)*

Choose Response	Mandatory Eligibility Criteria
☐ Yes ☐ No ☐ Did not assess	Was the patient eligible for health services by a funded government in Canada? Answer "Yes" if the patient would have been eligible but for an applicable minimum period of residence or waiting period.
☐ Yes ☐ No ☐ Did not assess	Was the patient at least 18 years of age?
☐ Yes ☐ No ☐ Did not assess	Was the patient capable of making decisions with respect to their health?
☐ Yes ☐ No ☐ Did not assess	Did the patient make a voluntary request for MAiD that, in particular was not made as a result of external pressure? If yes, indicate why you are of this opinion (select all that apply): ☐ Consultation with patient ☐ Knowledge of patient from prior consultations or treatment for reasons other than MAiD ☐ Consultation with other health or social service professionals ☐ Consultation with family members or friends ☐ Reviewed medical records ☐ Other *(specify)* _____
☐ Yes ☐ No ☐ Did not assess	Did the patient give informed consent to receive MAiD after having been informed of the means that were available to relieve their suffering, including palliative care?

Once complete, **please fax all pages within 24hrs** to MAID Reporting *(if only assessing)* **OR TO** MAID Reporting **AND** Medical Examiner's Office *(if assessing and providing)*

Patient Name
Date of Birth *(yyyy-mm-dd)*
Personal Health Number (PHN)

☐ Yes ☐ No ☐ Did not assess	Did the patient have a serious and incurable illness, disease or disability? If yes, indicate the illness, disease or disability *(select all that apply)* ☐ Cancer – lung and bronchus ☐ Cancer – breast ☐ Cancer – colorectal ☐ Cancer – pancreas ☐ Cancer – prostate ☐ Cancer – ovary ☐ Cancer – hematologic ☐ Cancer – other *(specify)* _____ ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other *(for stroke, select cardiovascular condition, not neurological condition, other - specify)* _____ ☐ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) ☐ Cardio-vascular condition (e.g., congestive heart failure, stroke) *(specify)* _____ ☐ Other organ failure (e.g., end-stage renal disease) ☐ Multiple co-morbidities *(specify)* _____ ☐ Other illness, disease or disability *(specify)* _____
☐ Yes ☐ No ☐ Did not assess	Was the patient in an advanced state of irreversible decline in capability?
☐ Yes ☐ No ☐ Did not assess	Did the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that was intolerable to them and could not be relieved under conditions that they considered acceptable? ***For the purposes of this MAID eligibility assessment, a mental illness is not considered to be an illness, disease or disability.*** If **yes**, indicate how the patient described their suffering *(select all that apply)*: ☐ Loss of ability to engage in activities making life meaningful ☐ Loss of dignity ☐ Isolation or loneliness ☐ Loss of ability to perform activities of daily living *(e.g. bathing, food preparation, finances)* ☐ Loss of control of bodily functions ☐ Perceived burden on family, friends or caregivers ☐ Inadequate pain control, or concern about it ☐ Inadequate control of other symptoms, or concerns about it ☐ Other *(specify)* _____ *This list is intended to support practitioners in relaying the patient's description of their suffering. It is not intended to validate or invalidate various forms of suffering in respect of eligibility for MAiD.*

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Patient Name
Date of Birth *(yyyy-mm-dd)*
Personal Health Number (PHN)

☐ Yes ☐ No ☐ Did not assess	Had the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances? If **no**, confirm that: ☐ the patient has been informed of the means available to relieve their suffering, including where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professional who provide those services or that care *Relevant subsection of the Criminal Code: 241.2(3.1g)* ☐ I have discussed with the patient the reasonable and available means to relieve their suffering and they have given serious consideration to those means. *Relevant subsection of the Criminal Code: 241.2(3.1h)*

Other Information

Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment *(do not include the mandatory written second assessment required by the Criminal Code)* ☐ Yes ☐ No	If **yes**, indicate what type of professional you consulted *(select all that apply)* ☐ Nurse ☐ Psychiatrist ☐ Oncologist ☐ Psychologist ☐ Palliative care specialist ☐ Social worker ☐ Primary care provider ☐ Speech pathologist ☐ Other health care professional *(specify)* _____
Did the patient **receive** palliative care[1]? ☐ Yes ☐ No ☐ Do not know ☐ Less than 2 weeks ☐ 2 weeks to less than 1 month ☐ 1-6 months ☐ more than 6 months ☐ Do not know If **no**, to the best of your knowledge or belief, was palliative care accessible to the Patient? ☐ Yes ☐ No ☐ Do not know	Did the patient **require** disability support services[2]? ☐ Yes ☐ No ☐ Do not know If **yes**, did the patient **receive** disability support services? ☐ Yes ☐ No ☐ Do not know If **yes**, for how long? ☐ Less than 6 months ☐ 6 months to less than 1 year ☐ 1 to less than 2 years ☐ 2 years or more ☐ Do not know If **no**, to the best of your knowledge or belief, were disability support services accessible to the patient? ☐ Yes ☐ No ☐ Do not know

[1] Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of pain and other physical symptoms, and psychosocial and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.

[2] Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.

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Patient Name
Date of Birth *(yyyy-mm-dd)*
Personal Health Number (PHN)

C. Supplementary Information *(Provide additional supplementary information. If additional consults were necessary please also complete Part E on page 8.)*

D. Approval Status

Does the person meet the mandatory eligibility criteria required to access medical assistance in dying?	If **Yes**, initial below	If **No**, initial below
Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?"	If **Yes**, initial below	If **No**, initial below

If the person DOES NOT meet the mandatory eligibility criteria required to access medical assistance in dying describe the reason(s) why in the space provided:

Assessing Practitioner Signature	Date	CPSA or CARNA Registration #

Assessment

- Will lead to decision tree
- Eligible vs. Not eligible
- If Eligible:

Track 1 – Reasonable Forseeable Natural Death (RFND) vs.

Track 2 – Not Reasonably Forseeable Natural Death (NRFND)

Waiver of Final Consent

- If there is anticipated risk of loss of capacity, assigned provider can complete a WFC
- Legal agreement to proceed at or before a mutually agreed upon date if capacity is lost during the time awaiting an agreed date of provision
- Legally bound bound between **only the provider and patient** – an alternate provider cannot provide/substitute in setting of WFC being enacted.

Provision

- At future time and place of patient: Can transfer to home, neutral location or remain in situ
- 2 people – nursing support and Providing Clinician (MD/NP)
- Confirm patient capacity if necessary
- Confirm desire to proceed
- Facilitate patient requests (as much as possible)

- **Good IV access required prior**
- **Support family and hospital staff**

Pharmaceutical Regime

- Midazolam 5-10 mg SIVP over 1-2 min
- +/- Opioid Analgesia if needed
- Lidocaine 40 mg SIVP over 1 min
- Propofol 1000-1500 mg SIVP over 3-5 min
- Rocuronium 200 mg SIVP over 2-4 min

Course of Death

- Transition is variable based upon physical state of patient
- Midazolam dosing will precipitate amnesia, sleepiness and snoring respirations
- Propofol will create deep sedation and terminate cardiorespiratory status = coma
- Rocuronium will stop future breathing
- Cardiac death will occur less than 3 min after completion of drug regime

After Death

- OCME consulted and documentation shared
- Death Certificate is completed by OCME and shared with funeral home once completed
- Remains can be transported to hospital morgue and tubes and lines removed if desired
- Funeral home contacted by family/hospital staff or MAiD team to collect remains – from morgue if in hospital
- Discharge Summary is responsibility of admitting team

Key Messages

- MAiD Navigators coordinate access to MAiD assessments and provision across all Health services and sectors.
- MAiD assessment is not a disposition and should not delay discharge
- If referring to palliative for Hospice eligibility, palliative assessors should recommend sites where forced transfer is not required if a client indicates they have or will be submitting an RoR to request a MAiD assessment.
- MAiD is not an emergency consult service (expectation – days to organize assessments - not hours)

Information “On The Line”: Resources Available

- Google – MAiD and AHS
- Look under Health Care Provider section

https://www.albertahealthservices.ca/info/page13497.aspx

- Canadian Association of MAiD Assessors and Providers (CAMAP)

Early Implementation

- Donation After Cardiac Death
- Anatomical Donations
- Comprehensive Tissue Donations (cornea and tissue)

Under Consideration

- Emancipated Minors
- Advanced Directives
- Mental Disorder as Sole Underlying Condition

- All dependent upon Canadian Politics and Legislative Processes

MAID Navigation Team

- Phone & leave message – 780-735-3781 or patients can call 811
- Fax – 780-641-9123
- Email: maid.careteam@ahs.ca

Clinician Education on MAiD

- Canadian MAiD Curriculum
https://camapcanada.ca/curriculum/

- If interested in being Assessor or Provider contact:

Me

Sunil.Sookram@ahs.ca

We will provide background information for self study
Encourage enrollment in National Curriculum
Mentorship and guidance through assessments and provision (if you choose)

Questions ?