ALERT— Review of BC Forms for Medical Assistance in Dying

Introduction
Each province and territory is responsible for establishing procedures and providing any necessary forms related to implementation of medical assistance in dying in its jurisdiction. Regulatory bodies for physicians seem to be taking the lead on this matter. We noticed that in Alberta, the forms are available to the public and appear to be more closely aligned to the legislation than in BC (although they also use the term proxy for someone signing on behalf of a patient, which we believe is misleading).

Background
Nidus came across the BC standard forms produced for medical assistance in dying (MAiD) on the websites for Vancouver Coastal Health and Fraser Health in a section for medical/clinical staff. When we reviewed the BC MAiD forms, we found discrepancies between the forms and the federal legislation.

Nidus does not have a position on MAiD. Our objective is to try and provide the public with access to accurate and current information to enable them to exercise their rights. We published a fact sheet on MAiD for this purpose.

We sent our fact sheet to the College of Physicians and Surgeons of BC in advance. We then noticed that the health authorities appear to be tweaking the forms in different ways and labelling them with different dates. We alerted the College and they responded quickly to acknowledge the problem of different versions. The College is focused on materials for physicians, which is their mandate. They have passed on our feedback to a provincial working group, which is coordinating materials for the public. We appreciate their assistance in this.

Nidus believes collaboration needs to be the norm today – in order to keep up with change and best practices and get feedback from various perspectives.

There are a number of forms related to the medical procedures for MAiD in BC. We are not providing links to the forms as the various changes by the health authorities makes it extremely confusing.

Likely the health authorities are noticing some basic errors such as our #6 on the Assessor/Prescriber form. This commentary concerns two forms we first found on the Vancouver Coastal Health website in a file dated June 29, 2016:

- Patient Request Form
- Assessor/Prescriber Form

How to read the comments
The comments below are intended for discussion and are not legal advice. The comments are numbered and with footnotes for that section to correspond to the numbers on the scanned forms – attached. Make sure you are looking at the correct form when reading the comments.

We have highlighted our suggestions in yellow. Section references are to Criminal Code of Canada – www.canlii.org > French/English > Canada (Federal) > Statutes and Regulations > select C under Consolidated Statutes of Canada > Criminal Code.

RECORD OF PATIENT REQUEST FORM

General comments

One of the challenges with the Patient Request Form is that it is for the use of the health care system and is also a consent form that a patient has to sign in front of two witnesses.

The current form (used by VCH) doesn't provide clear information/direction for the patient. For example, does the patient fax this form to 1-888-865-2941? Does the patient give it to their family physician/physician most responsible to put in the patient's chart? Who contacts the second assessor?

Specific comments

#1

~~When the initial request is made~~ When page 1 and 2 of this form are completed[1], fax to 1-888-865-2941, retain original in the patient's chart, and contact ~~the most responsible physician~~[2] to proceed with the patient's request. Contact 1-844-550-5556 for questions. *(wording from VCH form)*

[1]*Form can't be completed until the drug is administered. Recommendation: revise the instructions and make a separate page 3 for the patient to sign and reconfirm their request.*
[2]*We would all like a responsible physician – likely it means* 'the physician most responsible'….

#2

We have re-organized and re-written most of this section as it seems convoluted. We have added some points that we think may be missing. The legislative references are to help keep track of the requirements – they may not be necessary on the form.

Should the checklist reference informed consent per the BC Health Care Consent and Care Facility Act? Some appear to be included, but not others.

Need to provide direction: *If patient is unable to sign, whose initials are used in the checklist?*

By initialing and signing below[1], I, patient's name, confirm that:

- I am eligible for health services funded by a government in Canada[2] (section 241.2(1)(a))
- I am at least 18 years of age (section 241.2(1)(b)) ~~and I request and voluntarily consent to the termination of my life.~~
- I have been informed by a medical practitioner or nurse practitioner that I have a grievous and irremediable medical condition(section 241.2(1)(c)) + (section 241.3(b)(ii)) [3]
    - I have a serious and incurable illness, disease or disability; (section 241.2(2)(a))
    - I am in an advanced state of irreversible decline in capability (section 241.2(2)(b))
    - As a result of my illness, disease, disability or state of decline, I am enduring physical or psychological suffering that is intolerable to me and that cannot be relieved under conditions that I consider acceptable (section 241.2(2)(c))
    - My natural death is reasonably foreseeable (section 241.2(2)(d))
- I give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve my suffering, including palliative care (section 241.2(1)(e))

- I am ~~make this request~~ voluntarily, ~~and~~ without pressure from others, making a request for medical assistance in dying (section 241.2(1)(d))
- I ~~understand that I have the right to change my mind~~ have been informed that I may withdraw my request at any time and in any manner (section 241.2(3)(d))
- The information provided has been communicated to me in a manner that I can understand (section 241.2(3)(i))

[1]To be consistent with the confirmation of independent witnesses on page 2.
[2]This is one of the requirements listed in the legislation. Not sure if patient or practitioner should confirm this.
[3]The legislation says that the patient request is made AFTER the patient has been informed they fit the criteria. It does not require the patient to state "I believe my medical condition is grievous and irremediable…" as currently shown on the Patient Request Form (first checkbox). Would you need to record the name of the medical practitioner or nurse practitioner who informed the patient of this?

#3
Patient signature for initial request (to be signed in the presence of two witnesses, see page 2)[1]

[1] Add wording in brackets to be clear they must not sign before or at a different time than the witnesses.

#4
If patient is physically unable to sign, ~~a proxy~~[1] another person[2] may sign and date this request on the patient's behalf ~~and express direction~~[3] per section 241.2(4) of the Criminal Code.

ADD the following: [4]
I am name_____. I am signing on behalf of and under express direction of patient's_____name____ (the "patient"), who is requesting medical assistance in dying, and I confirm that:
- I am at least 18 years old;
- I am signing in the presence of the patient named above and witnesses named on page 2;
- I understand the nature of the request for medical assistance in dying;
- I am not a witness to this form; and
- I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.

[1]Delete the word 'proxy' as it is confusing, misleading, and unnecessary. This term does not appear in the legislation and we expect deliberately. The popular understanding of proxy (and some definitions) is someone who can act on a person's behalf according to the circumstances – a substitute – most often in the case of mental incapability and/or the person's physical absence. In the case of MAiD – it would better to be clear that it is about someone signing if the patient cannot physically sign.
[2] Add information highlighted in yellow, and in this case, including the legislative reference.
[3] Delete 'and express direction' here, it fits better as a confirmation by the person.
[4] Add the following, it can go on page 2 if necessary – better to be clear and accurate than try to fit in the space.

#5

~~Declaration~~ Confirmation by independent witnesses[1]

By initialing and signing below, ~~I declare~~ I confirm that:

- I am at least 18 years of age and understand the nature of the request for medical assistance in dying (section 241.2(5))[2]
- ~~The patient is personally known to me or has provided proof of identity.~~[3]
- The patient (or ~~the proxy in the presence and at the express discretion of the patient~~[4] person signing on their behalf) signed and dated this request in my presence.
- I ~~am not~~ do not know or believe that I am[5] a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death (section 241.2(5)(a))
- I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides (section 241.2(5)(b))
- I am not directly involved in providing health care services to the patient (section 241.2(5)(c))
- I do not directly provide personal care to the patient (section 241.2(5)(d))

[1] The terms 'declare' and 'declaration' do not appear in the legislation. Because the term declaration in a legal context has to be 'sworn,' this is not a useful term to use here, particularly since we understand that some physicians are telling patients to get the form witnessed by a notary public. It causes confusion. The terms 'confirm' and 'confirmation' are more appropriate.
[2] To be consistent with the formatting used for the other confirmations.
[3] See below for Witness to indicate relationship to the adult. Clearly there is an advantage for the witnesses to have a relationship to the adult since many of the health care providers are unlikely to have long term relationships (except perhaps for the family physician) with the adult. The witnesses can strengthen the patient's consistent and determined request. Simply witnessing on the basis of proof of identity is weak and possibly even suspect.
[4] The word "proxy" is not used in the legislation. The law doesn't say witnesses have to attest to this statement.
[5] This is the wording used in section 241.2(5)(a) and the Assessor/Prescriber form.

#6

Why are statements for the witnesses numbered when those for others are not? Need to be consistent within the form and among various forms.

#7

Witness signatures

ADD a new field for each witness 'Relationship of Witness to Adult _____'

Although this is not in the legislation, it can be a positive addition. It is not part of the Representation Agreement Act, but became part of Nidus' practice from the beginning. We encouraged representatives, alternates and monitors to indicate their relationship to the adult. We find that people often want to express their relationship and connection, for example 'a friend of 40 years' to indicate the history and commitment to the individual. As we discuss in the fact sheet, there can be advantages to having witnesses who know you and your consistent wish for MAiD.

#8

Confirmation of request immediately prior to administration[1]

DELETE: ~~I am aware that a near relative/next of kin will be advised that I have requested and received medical assistance in dying~~.

~~Name: _____ Relationship to patient: _____~~

~~Phone: _____ Address: _____~~[2]

Patient signature for confirmation of request

ADD the following:

I, patient's name, confirm that: [3]

- I give express consent to receive medical assistance in dying and confirm the information initialed on page 1 (section 241.2(3)(h)).
- I was given an opportunity to withdraw my request immediately prior to receiving medical assistance in dying.

I am choosing to[4] (look at point 5 on page 1)

- take prescribed medication(s) that I may self-administer.
- have a physician administer medications to me.
- I understand if the regimen is not effective within a reasonable period of time, as determined by my physician, my physician will administer intravenous medication to fulfil my request.

[1] As suggested, make this page 3 of the form.
[2] Delete this reference; it is not mentioned in Bill C-14. It appears to be a policy requirement instituted by the College and left from a previous version of this form used June 6 to June 17?
[3] Use same approach as when patient signed initial – checkboxes for initials.
[4] Use initials to be consistent.

#9

If patient is physically unable to sign, ~~a proxy~~ another person may sign and date this request on the patient's behalf ~~and express direction~~ per section 241.2(4) of the Criminal Code.[1]

ADD:

I am name_____. I am signing on behalf of and under express direction of patient's name_____ (the "patient"), who is requesting medical assistance in dying, and I confirm that:

- I am at least 18 years old;
- I am signing in the presence of the patient named above;
- I understand the nature of the request for medical assistance in dying;
- I am not a witness to this form (page 2); and
- I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.

[1] Similar wording and same format as for person who signed on behalf of patient previously. Clarify whose initials go in the checkboxes if patient cannot sign.

ASSESSOR/PRESCRIBER FORM
Specific comments

#1
ADD: By initialing and signing, I, physician's name, confirm that:

#2
Don't health care providers always confirm date-of-birth and provincial health number?

#3
ADD: Other practitioner's name and I are not each other's mentor or supervisor. We do not know or believe that we are a beneficiary under the patient's will, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death. And, we are not connected to each other or the patient in any other way that would affect our objectivity.
[Section 241.2(3)(f) – satisfied that independent; Section 241.2(6) – criteria]

#4
Why are the determinations of the doctor numbered? Need to be consisten.

#5
~~His or her right to rescind the~~[1] That they may withdraw their request at any time and in any manner
[Section 241.2(3)(d)]

[1]*rescind is a new term for the forms and is not in the legislation. Why not use the terminology in the law? Why no initials for this section - inconsistent?*

 # 6
Cannot refer for assessment of incapability if person is requesting MAiD solely due to a psychiatric condition. They are not eligible for MAiD.

#7
ADD: Other practitioner's name has provided a written opinion confirming that the patient is eligible for medical assistance in dying
[Section 241.2(3)(e)]

 # 8
Delete extra "or"

#9
I have planned ~~contingency planning~~ for potential issues

#10
If the intended date is less than 10 days[1] from the initial request, please check the relevant box:[2]

- Death is imminent, or
- The patient's loss of capacity to provide informed consent is imminent

[Section 241.2(3)(g)]

*[1] The legislation says 10 **clear** days? Not sure what this means. For example, would it include the day the request was submitted?*
[2]We found that there are only two rationales acceptable under the legislation. We also read that the first physician determines the shorter time period.

#11
I have informed the pharmacist that the substance is for medical assistance in dying, before the pharmacist dispensed the substance
[Section 241.2(8)]

NEED clarification – College Guidelines and some wording on the forms are not based on requirements of the legislation – particularly for self-administration. Presumably there are practical issues to address.

What is the procedure for returning leftover medication if self-administered at home?
Do you have to take the medication within a specific time frame? Do the medications expire?

#12
Immediately prior to administering the prescription, the patient was given an opportunity to withdraw ~~his or her~~ their request and gave express ~~informed and voluntary~~ consent to receive medical assistance in dying

To be consistent with the wording in section 241.2(3)(h)

#13
Documenting experience – do you need to get patient's consent? Where does this go? Any privacy issues?

Vancouver Coastal Health Authority

Medical Assistance in Dying
Record of Patient Request

PATIENT LABEL

(1) **When the initial request is made, fax to 1-888-865-2941, retain original in the patient's chart, and contact the most responsible physician to proceed with the patient's request. Contact 1-844-550-5556 for questions.**

A. Patient information					
Last name	**First name**	**Middle name**	**Date of birth**	**Gender** ☐M ☐F ☐Other	**PHN**
Medical diagnosis relevant to request for assisted death					
Location (site, unit) **of request**					

(2) **I,** _____ **, am at least 18 years of age and I request and voluntarily consent to the termination of my life.** -eligible for health services funded....

Initials	I believe that my medical condition is grievous and irremediable, my suffering is intolerable, there are no treatments that I consider acceptable, I am in an advanced state of irreversible decline, and my death is reasonably foreseeable.
Initials	I have been fully informed of my diagnosis and prognosis and of options for treatments towards cure or control of my condition/disease, that may be applicable to my circumstances.
Initials	Treatments for symptom control, including the potential benefits of palliative care or other treatment, have been described to me in a manner that I understand.
Initials	I understand that I will be assessed for eligibility by one or more colleagues of my physician and, if eligible, a pharmacist and other staff will be contacted to aid my physician in addressing my request.
Initials	I understand that my physician will confirm with me whether my request is to take prescribed medication(s) that I may self-administer (assisted suicide) or that a physician will administer medications to me (voluntary euthanasia). I understand that if I choose self-administration and the regimen is not effective within a reasonable period of time, as determined by my physician, my physician will administer intravenous medication to fulfil my request.
Initials	I have had an opportunity to ask questions and to request additional information, and have received answers to any questions and responses to any requests.
Initials	I understand that I have the right to change my mind at any time. withdraw
Initials	I expect to die when the medication to be prescribed is administered.
Initials	I make this request voluntarily and without pressure from others.

(3) **Patient signature for initial request**

Print name: _____ **Signature:** _____ **Date:** _____

(4) **If patient is physically unable to sign, a proxy may sign on the patient's behalf and express direction.** (Cannot be the same person as the witness. Must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.)

Print name: _____ **Signature:** _____ **Date:** _____

Relationship: _____ **Phone:** _____

Address: _____

Vancouver CoastalHealth Vancouver Coastal Health Authority

Medical Assistance in Dying
Record of Patient Request

PATIENT LABEL

Declaration of independent witnesses

By initialing and signing below, I declare that I am at least 18 years of age and understand the nature of the request for medical assistance in dying. (5)

Witness 1	Witness 2	
Initials	Initials	1. The patient is personally known to me or has provided proof of identity. ?
Initials	Initials	2. The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence.
Initials	Initials	3. I am not a beneficiary under the will of the patient or a recipient in any other way of a financial or material benefit resulting from the patient's death.
Initials	Initials	4. I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides.
Initials	Initials	5. I am not directly involved in providing health care services to the patient.
Initials	Initials	6. I do not directly provide personal care to the patient.

(6) Why use numbers?

Witness signatures

(7) Add relationship

Witness 1				
Print name	Signature	Date		
Phone #	Address	City	Province	Postal code

Witness 2				
Print name	Signature	Date		
Phone #	Address	City	Province	Postal code

Confirmation of request immediately prior to administration (8)

I am aware that a near relative/next of kin will be advised that I have requested and received medical assistance in dying.

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

Patient signature for confirmation of request

Print name: _____ Signature: _____ Date: _____

If patient is physically unable to sign, a proxy may sign on the patient's behalf and express direction. (9)
(Must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial benefit resulting from the death of the patient, and must sign in the presence of the patient.)

Print name: _____ Signature: _____ Date: _____

Relationship: _____

Phone: _____ Address: _____

Assessor Form

Vancouver CoastalHealth Vancouver Coastal Health Authority

Medical Assistance in Dying Assessment Record (Assessor/Prescriber)

PATIENT LABEL

When page 1 and 2 of this form are completed, fax to 1-888-865-2941, retain original in the patient's chart, and contact the other providers involved to proceed with addressing the patient's request. Contact 1-844-550-5556 for questions.

A. Patient information

Last name	First name	Middle name	Date of birth	Gender	PHN
				☐ M ☐ F ☐ Other	

Medical diagnosis relevant to request for assisted death

B. Practitioner conducting assessment

Last name	First name	Middle name	CPSID #	Phone number

Mailing address	City	Postal code

Initials I have been contacted by the patient or another colleague and agree to be an assessor. I am prepared to be the prescriber concerning this patient's request for medical assistance in dying.

Confirmation of eligibility and informed consent

Each assessing physician is to make these determinations independently, document in the health record, and summarize their findings by initialing the boxes below*.

Patient diagnosis: _____

Patient prognosis: _____

This assessment was conducted: ☐ In person ☐ By telemedicine Date: _____

(1) **I confirm that:**

Initials	(2) The patient is personally known to me or has provided proof of identity. → patient label has DOB PHN
Initials	I do not know or believe that I am a beneficiary under the will of the patient requesting medical assistance in dying or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death, other than the standard compensation for their services relating to the request.
Initials	The patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person on their behalf and under their express direction.
Initials	The patient's request for medical assistance in dying was singed and dated after the patient was informed by a practitioner that they have a grievous and irremediable medical condition.
Initials	I have satisfied that the request was signed and dated by the patient, or by another person on their behalf and under their express direction, before two independent witnesses who then also signed and dated the request.

(3) Confirm independent of other witness.

Assessor Form

Vancouver CoastalHealth Vancouver Coastal Health Authority

Medical Assistance in Dying
Assessment Record (Assessor/Prescriber)

PATIENT LABEL

I have determined that the patient meets all of the criteria to be eligible for medical assistance in dying: (4) why numbered?

Initials	1. The person is eligible for health services funded by a government in Canada
Initials	2. The person is at least 18 years of age
Initials	3. The person is capable of making this health care decision
Initials	4. The person has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the person enduring physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the person considers acceptable. The person is in an advanced state of irreversible decline and the person's death is reasonably foreseeable.
Initials	5. The person has made a voluntary request for medical assistance in dying that was not made as a result of external pressure
Initials	6. After having been informed of the means that are available to relieve their suffering, including palliative care, the person has given informed consent to receive medical assistance in dying

I have also determined that the patient has been fully informed of:

- His or her medical diagnosis and prognosis
- The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
- His or her right to rescind the request at any time
- The potential risks associated with taking the medication to be prescribed
- The probable outcome/result of taking the medication to be prescribed
- The recommendation to seek advice on life insurance implications

(5) Why different format? No initials

Consideration of capability to provide informed consent** (Indicate one of the following):

Initials	I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying.
Initials	The request for medical assistance in dying is arising solely from a psychiatric condition and/or I otherwise have reason to be concerned about capability and I have referred the patient to Dr. _____ for a determination of capability to provide informed consent. On receipt of the requested opinion, I determine that the patient: ☐ Is capable of providing informed consent ☐ Is **not** capable of providing informed consent

(6) This Makes person NOT eligible for MAiD

Conclusion regarding eligibility

I determine that the patient: ☐ **Does meet the criteria for medical assistance in dying**
☐ **Does not*** meet the criteria for medical assistance in dying**

(7) Name other assessor

Physician signature: _____ **College ID:** _____ **Date:** _____ **Time:** _____

* Comments for any matter in any section are clarified in the medical record.
** Capable means that person is able to understand the relevant information and the consequences of their choices – under HCC+CFA Act?
***If the patient is determined to not meet the criteria, the physician assessor is to advise attending physician and patient of determination and of his or her option to seek another opinion.

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Assessor Form is same p. 1+2. Prescriber Form has p. 3

Medical Assistance in Dying Assessment Record (Assessor/Prescriber) Page 3 of 3 PATIENT LABEL

Planning

Initials	I have received and reviewed the assessment by at least one other colleague indicating the patient is eligible for medical assistance in dying.
Initials	*I have discussed with the patient the options of routes and the patient has requested:* ☐ Self-administration (assisted suicide) or or ☐ Intravenous medication administered by a physician (voluntary euthanasia)
Initials	*Contingency planning for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)*
Initials	*A location and timeline for provision* *Planned location:* _____ *Planned date:* _____ *Days from initial request:* _____ *If the intended date is is less than 10 days from the initial request, please indicate rationale:* _____ 2 conditions only
Initials	*I have reviewed with the pharmacist the request, assessments, and a plan to provide and administer medical assistance in dying, as well as to return any unused medications to the pharmacist within 48 hours after confirmation of death:* ↳ how works if self-administer at home?
Initials	*I have indicated on the prescription or order that the medication is for medical assistance in dying*

Administration

Date: _____ Location: ☐ Home ☐ Facility (site and unit): _____

☐ Office (address): _____

Initials	Immediately prior to administering the prescription, the patient was given an opportunity to withdraw his or her request and gave express informed and voluntary consent
Initials	The medication was administered via the method chosen by patient: ☐ Physician administered (IV) ☐ Self-administration (oral) ☐ Physician administered on determination that ____ hours after ineffective self-administration Comment: _____
Initials	Medication administered: _____ Interval between administration and confirmation of death: _____ Event comments Please indicate who was present, whether there were aspects that went well, any suggestions for improvement that could improve the experience for other patients and colleagues.