

**BC Coroners Service Death Review Panel:
A Review of Medically Assisted Deaths
for the period of
January 1 – December 31, 2016**

**REPORT TO THE CHIEF CORONER OF BRITISH
COLUMBIA**

October 3, 2017

PREFACE

On February 22, 2017, the British Columbia Coroners Service (BCCS) held a death review panel on medical assistance in dying. The review panel was convened for the purpose of providing advice to the Chief Coroner:

- to better understand the medical, legal, social welfare, and other matters with respect to medical assistance in dying; and,
- to make recommendations that may impact public health and safety with respect to legislative and regulatory compliance, patient access, quality assurance, and continuous quality improvement in the provision of medical assistance in dying.

I am sincerely grateful to the following members of this panel for sharing their expertise, bringing the support of their respective organizations and participating in a collaborative discussion. The participants' contributions have generated actionable recommendations that I am confident will contribute to quality assurance of medically assisted deaths in British Columbia (B.C.). BCCS staff, Lori Moen and Carla Springinotic provided panel support, compiled the background research for panel discussions and prepared this report.

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Kirsten Thomson - Northern Health Authority

David Unger - Providence Health Care

Holli Ward - Ministry of Justice

Barb Willson - College of Registered Nurses of British Columbia

On behalf of the panel, I submit this report and recommendations to the Chief Coroner of B.C. for consideration.

Michael Egilson

Chair, Death Review Panel

EXECUTIVE SUMMARY

Following the decision of the Supreme Court of Canada in *Carter vs. Canada* (February, 2015), the federal government passed Bill C-14 on June 17, 2016. Bill C-14 amended the Criminal Code and related Acts to allow eligible adults to access medical assistance in dying.

In keeping with the provincial responsibility for the delivery and administration of medical assistance in dying and in the absence of federal regulations, on July 19, 2016, by Order in Council, the *Coroners Act* was amended requiring that all deaths believed to have resulted from medical assistance in dying be reported to the BC Coroners Service (BCCS).

To better understand medically assisted deaths and identify quality assurance processes, a death review panel appointed under the *Coroners Act* was held on February 22, 2017. The review panel was comprised of professionals with expertise in health care delivery, health administration, public health, regulatory colleges, ethics, justice, Aboriginal health, monitoring and quality assurance.

This report will inform on details of medical assistance in dying in B.C., outline the safeguards and quality assurance processes in place, and, identify further opportunities to enhance the quality assurance processes.

In 2016, 194 medically assisted deaths occurred in B.C. The circumstances of the people who died were reviewed in aggregate. Current research and statistics were assessed and key themes identified.

The review found:

- Issues with documentation (40% of case files were missing forms).
- The documentation transfer process is complex.
- There is regional variation in provision of medical assistance in dying.
- Quality assurance processes can be enhanced by establishing clear documentation, reporting standards and a case review framework.

In relation to the deaths reviewed, the panel identified three key areas to improve quality assurance of medically assisted deaths:

- Improve documentation completeness and streamline documentation transfer processes;
- Establish clear guidelines for quality assurance and monitoring; and
- Develop information sharing protocols and identify key reporting requirements.

These findings are the basis for the following recommendations put forward to the Chief Coroner by the panel.

Recommendation 1: Improved documentation and completeness

1a) By November 2017, with respect to medical assistance in dying, the Ministry of Health, in partnership with relevant stakeholders, will:

- Provide clarity regarding expectations for documenting diagnosis on assessment forms.
- Develop standardized terms for documenting prognosis on assessment forms.
- Streamline and improve document transfer.

Recommendation 2: Establish a Framework for Quality Assurance and Monitoring

2a) By December 2017, the BC Coroners Service, in partnership with relevant stakeholders, will:

- Establish clear guidelines for notification to regulatory bodies and law enforcement.
- Clarify and communicate quality assurance roles.

2b) By November 2017, the Ministry of Health, in collaboration with the College of Pharmacists of BC, College of Physicians and Surgeons of BC and the College of Registered Nurses of BC, will establish provincial requirements and procedures to ensure return of all unused medications.

2c) By November 2017, the College of Pharmacists of BC, in collaboration with the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC, will ensure that standards include requirements for complying with established provincial processes for returning unused medications.

2d) By January 2018, the College of Pharmacists of BC, the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC will develop and communicate joint messaging for their respective registrants related to the requirements and standards for return of unused medications.

Recommendation 3: Develop Information Sharing Processes and Reporting Requirements

3a) By February 2018, the BC Coroners Service in partnership with relevant stakeholders will:

- Develop Information Sharing Agreements with relevant partners;
- Develop requirements for statistical tracking and accountability measures;
- Establish timelines and content for provincial public reporting; and,
- Establish a process to improve reconciliation of documentation.

3b) By December 2017, the Ministry of Health, in partnership with relevant stakeholders, will establish a centralized process to track all patient requests for medically assisted death and the disposition of those requests.

3c) By November 2017, the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC will develop practice standards requiring notification to the health authority for all patient requests for medical assistance in dying.

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PATIENT'S JOURNEY

The decision to access medical assistance in dying is complex. It is just one of many options a person may consider when thinking about end-of-life care or relief from intolerable suffering.

In B.C., an individual interested in medical assistance in dying generally begins their journey by accessing information through a health care provider or through information posted on the B.C. government's [Medical Assistance in Dying](#) website. Not all health care providers are willing or qualified to provide medical assistance in dying. If that is the case, a patient's health care provider may refer them to a **qualified health care provider**¹, direct them to the health authority's medical assistance in dying care coordination centre, or the patient may be provided with information about how to access the medically assisted death [Patient Request Record](#).

Each health authority has health care providers who as part of their role will provide information about medically assisted death and help coordinate further assessments.

If the person wishes to proceed they will complete and sign a Patient Request Record in the presence of two independent witnesses.

A physician or nurse practitioner will act as an **assessor**. The assessor will review the case, meet with the patient, and determine if the patient meets the eligibility criteria for medical assistance in dying. If the assessor determines necessary, an expert opinion may be sought concerning the patient's capability to consent.

If the patient meets the criteria for medically assisted death and wishes to proceed further, a second independent assessment is done by another qualified assessor. The second assessor also reviews the case, meets with the patient and determines eligibility, including capacity. If the two assessors agree that the eligibility criteria are met, the medically assisted death procedure can then be planned. One of the assessors will be responsible for providing medical assistance in dying; this assessor is known as the **prescriber**.

The prescriber and the patient will discuss the best timing for the death, based on the patient's condition and wishes. The prescriber then completes the required forms to access specialized medication.

On the planned day of death, the patient and the prescriber gather at the location where medical assistance in dying will be provided. Family and friends, clergy and other members of the health care team may be present to provide personal support.

The patient must be given the opportunity to withdraw their request immediately prior to the procedure. If the patient wishes to proceed, they sign the Confirmation of Patient Request section of the Patient Request Record, by proxy if necessary, indicating their final consent.

Medication is then administered, and shortly thereafter death occurs.

¹ Bolded terms are defined in the glossary.

PART 1: INTRODUCTION

On June 17, 2016, the federal government passed Bill C-14 which amended the *Criminal Code of Canada* and related acts to allow eligible adults to access medical assistance in dying.

These amendments allow for the provision of medical assistance in dying if an individual:

- Is eligible for health services funded by a government in Canada;
- Is at least 18 years old and capable of making health care decisions;
- Has a **grievous and irremediable medical condition**;
- Makes a voluntary request for medical assistance in dying which is not the result of external pressure; and
- Gives informed consent to receive medical assistance in dying after being informed of the means available to relieve their suffering, including palliative care.
(*Criminal Code, s. 241.2 (1)*)

The amendment to the *Criminal Code of Canada* also requires the federal Minister of Health to make regulations for the monitoring of medical assistance in dying. At the time Bill C-14 was passed these regulations had not yet been developed. In the absence of federal regulations and in keeping with the province's responsibility for the delivery and administration of medical assistance in dying, on July 19, 2016 by Order in Council, the *Coroners Act* was amended requiring that all deaths believed to have resulted from medical assistance in dying be reported to the BCCS. The BCCS is a unique investigative agency; it is impartial, independent and fact finding, with extensive powers of investigation under the *Coroners Act*.

With respect to medically assisted deaths in B.C., the mandate of the BCCS is to ensure compliance with federal and provincial laws and regulations. In support of this mandate, the BCCS maintains a database for aggregate reporting of deaths to identify any trends and patterns and participates in multidisciplinary panels to review aggregate information and recommend changes to guidelines or regulations.

Oversight of medical assistance in dying is essential to ensure public trust in the system, ensure safeguards and protocols are being followed, and to support improvements and adaptations to the system as necessary.

The BCCS recognizes that the decision to pursue medical assistance in dying is a complex process undertaken by an individual in consultation with their health care providers. Given the regulatory standards, guidelines and training for health care providers that are in place and the forthcoming development of federal regulations, the BCCS has adopted a process-based investigation to review medically assisted deaths.

A process-based review entails ensuring that the required documents have been provided, are complete and that on the face of the documentation, all eligibility criteria, statutory safeguards and regulatory requirements have been met.

To better understand medically assisted deaths and identify opportunities for improved quality assurance, a death review panel appointed under the *Coroners Act* was held in February 2017.

This current review comprises all BCCS medically assisted deaths in B.C. for the period of January 1, 2016, to December 31, 2016. The circumstances of 194 medically assisted deaths were reviewed in **aggregate**.

For the purpose of this review the following terms are defined as:

Prescriber: a physician or nurse practitioner who assesses a patient for eligibility and capability, ensures a second independent assessment has been completed and, when all safeguards and criteria are met, prescribes or administers medications for a medically assisted death.

Assessor: a physician or nurse practitioner who assesses a patient for eligibility for medically assisted death.

DEATH REVIEW PANEL

A death review panel is mandated² to review and analyze the facts and circumstances of deaths to provide the Chief Coroner with advice on medical, legal, social welfare and other matters concerning public health and safety. The BCCS is responsible for undertaking a review of the facts and circumstances of medically assisted deaths in British Columbia to ensure that the requirements set out in the *Criminal Code*, other acts, and B.C. provincial regulatory requirements are met. A death review panel may review one or more cases before, during or after a coroner's investigation, or inquest.

Panel members were appointed by the Chief Coroner of BC under section 49 of the *Coroners Act* and included professionals with expertise in health care delivery, health administration, public health, regulatory colleges, ethics, justice, Aboriginal health, monitoring and quality assurance.

Regardless of their employment or other affiliations, individual panel members were asked to exercise their mandate under the *Coroners Act* and express their personal knowledge and professional expertise. The findings and recommendations contained in this report need not reflect, or be consistent with, the policies or official position of any other organization.

In the course of reviewing medical assistance in dying deaths that occurred in 2016, the panel reviewed:

- BCCS investigative findings;
- Information provided by panel members;
- Environmental, social and medical factors associated with the deaths;
- Possible trends or themes;
- The current state of related public policy and strategies; and,
- Existing challenges.

The panel collectively identified actions for improving qualitative review and quality assurance processes with respect to medically assisted deaths.

LIMITATIONS AND CONFIDENTIALITY

The number of persons who died as a result of medically assisted death presents challenges in accurately analyzing and reporting information while protecting privacy and data accuracy. Provisions

² Under the *Coroners Act*

under the *Coroners Act* and *Freedom of Information and Protection of Privacy Act* allow for the BCCS to disclose information to meet its legislative mandate and support the findings and recommendations generated by the review process. For the purposes of this report, information is presented in aggregate. Details that could identify the people have been omitted to respect the privacy of the person who died and their families. The BCCS is sensitive to the privacy of individuals and families that it serves and proceeds with caution when reporting case review findings.

PART 2: MEDICALLY ASSISTED DEATH IN CANADA - LEGISLATION AND REGULATIONS

The federal *Criminal Code of Canada* is the main statutory source of criminal law and procedure in Canada. It defines the type of conduct that constitutes a criminal offence and establishes the sentence that may be imposed when an individual is convicted of an offence. It also sets out the procedures that are to be followed throughout the criminal law process.

In keeping with the with the direction of the Supreme Court of Canada in *Carter v. Canada* (February, 2015), the federal government passed Bill C-14 on June 17, 2016, which amended the *Criminal Code of Canada* and related Acts to allow eligible adults to access medical assistance in dying.

The Supreme Court of Canada held that the *Criminal Code* provisions a) preventing a person from giving consent to their own death and b) prohibiting a person from assisting another person to end their own life presented those who are grievously and irremediably ill with the choice to either end their own life prematurely or be condemned to a life of severe and intolerable suffering. The Supreme Court of Canada found this represents a violation of the right to life, liberty and security of the person under s. 7 of the Charter.

The Supreme Court of Canada agreed with the finding of the lower court that vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally.

The Supreme Court of Canada concluded that “the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards³.”

Bill C-14 laid out safeguards in s. 241.2 (3) to (8) of the *Criminal Code*. The delivery of health care is a provincial and territorial responsibility. Additional regulations and professional guidelines and standards have been enacted in B.C. to supplement the *Criminal Code* safeguards.

In B.C., medically assisted death is delivered through regional health authorities and primary health care providers in the community. The provincial *Health Professions Act* requires that the health professionals engaged in providing medical assistance in dying must do so in compliance with the standards, limits and guidelines established by their respective regulatory colleges.

In B.C., the three regulatory Colleges that provide oversight to registrants participating in medically assisted deaths are the College of Physicians and Surgeons, the College of Registered Nurses and the College of Pharmacists. Each college sets practice standards and has established processes to respond to questions and complaints. These standards are accessible on the following links.

³ Source: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>

- [College of Physicians and Surgeons of BC Medical Assistance in Dying](#)
- [College of Registered Nurses of BC Medical Assistance in Dying](#)
- [College of Pharmacists of British Columbia Medical Assistance in Dying](#)

The BCCS is responsible for investigating all unnatural, sudden and unexpected or unexplained deaths in B.C. On July 19, 2016, by Order in Council the *Coroners Act* was amended requiring that all deaths believed to have resulted from medical assistance in dying be reported to the BCCS. The *Coroners Act* sets out the legislative requirements for investigation and reporting.

PART 3: BC IMPLEMENTATION PROCESS

The BC Ministry of Health has led the planning and implementation of medically assisted death in partnership with regulatory colleges, health authorities, health care providers and other relevant ministries and agencies. The implementation process has included the development of standardized training for health care professionals, and the development of provincial forms and information materials to support practitioners and inform the public about how to access information about medical assistance in dying and other palliative care services.

The Province made regulatory changes to the *Health Professions Act*, giving the standards set out by the College of the Physicians and Surgeons of British Columbia, the College of Registered Nurses of British Columbia, and the College of Pharmacists of British Columbia the weight of law.

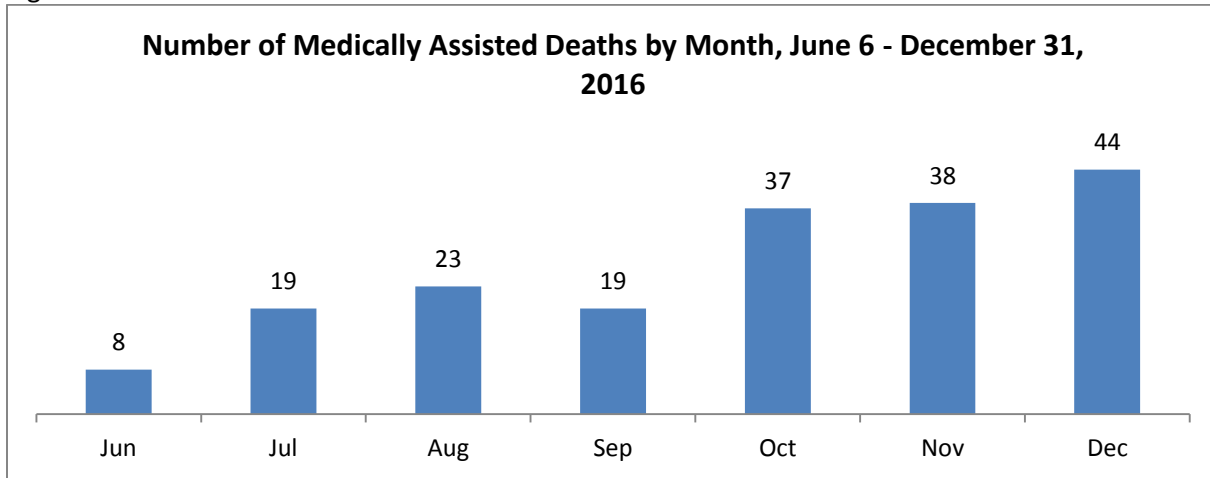
Each health authority in B.C. has implemented a care coordination service for medical assistance in dying, to ensure reasonable and safe access. Care coordination service provides an additional point of contact for patients, their families, and health care providers which require assistance in navigating access to medical assistance in dying. The service also serves to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing assessors and prescribers.

In addition to regional and provincial implementation activities, Health Canada is putting in place federal regulations that will create a national monitoring system for medical assistance in dying.

PART 4: BC CORONERS SERVICE CASE REVIEW FINDINGS

In 2016, 194 medically assisted deaths were reported to the BCCS. Of these, 189 medically assisted deaths occurred between June 6, 2016 and December 31, 2016; an average of 27 medically assisted deaths per month for this seven-month period (see Figure 1). Five medically assisted deaths occurred prior to June 6, 2016. These five individuals received a court-ordered personal constitutional exemption for medically assisted death.

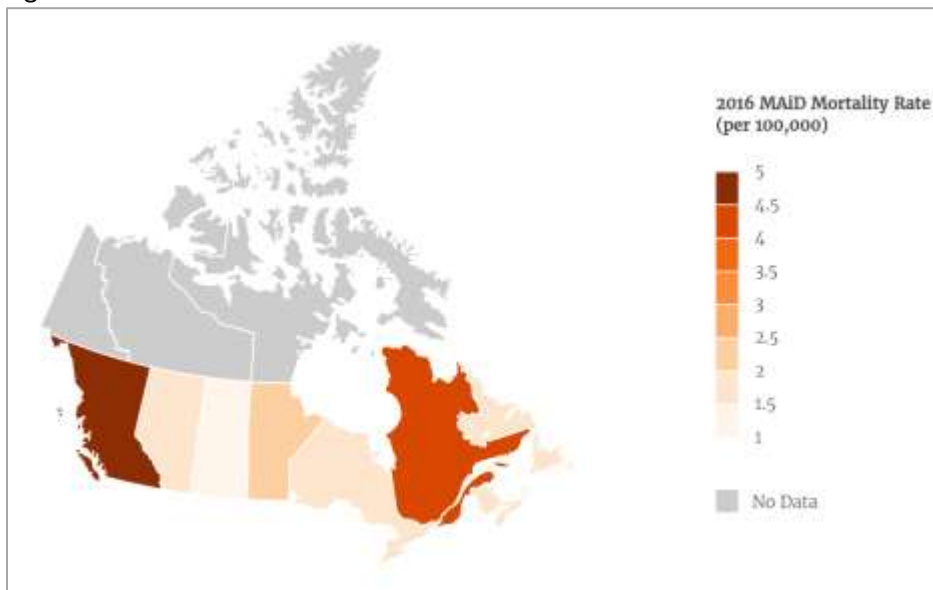
Figure 1



Source: BC Coroners Service

This review found that British Columbia has the highest rate of medically assisted death in comparison to other provinces and territories. In B.C., the provincial rate of medically assisted death was 5.1 deaths per 100,000 population compared to the Canadian rate* of 2.8 per 100,000 population (see Figure 2).

Figure 2



Source: Health Canada, 2017.

* Note: Atlantic provinces (NS, Nfld, NB, and PEI) were combined when calculating rates.

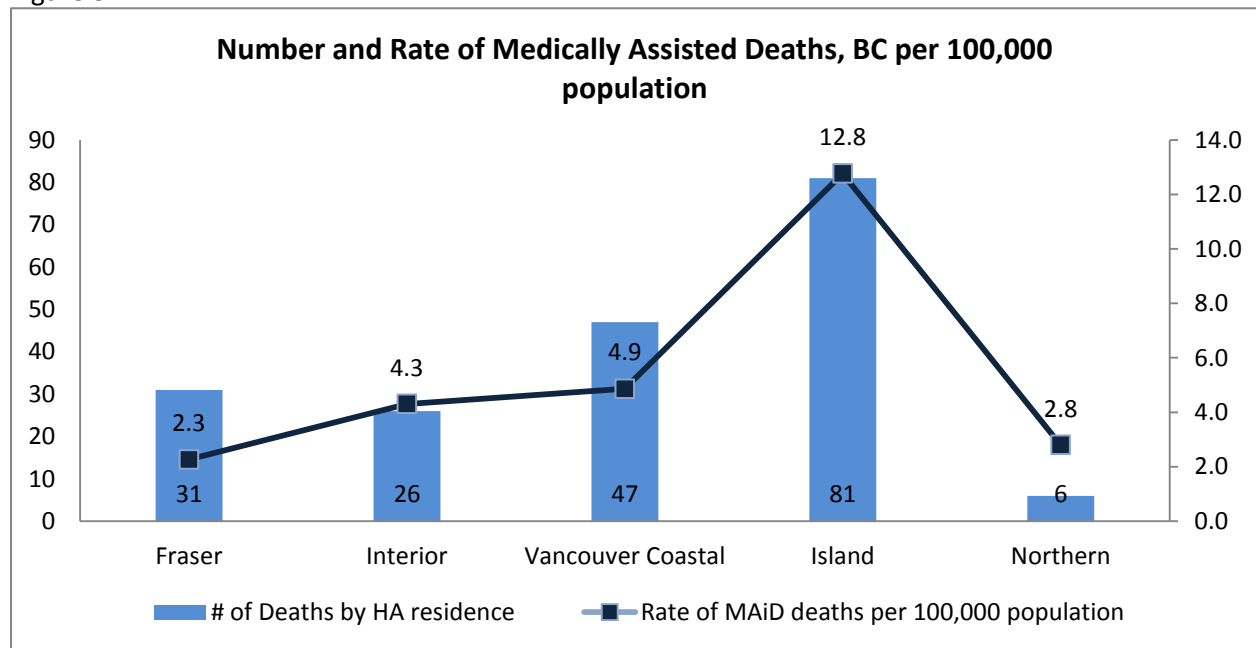
* Data was not available for the territories.

Three individuals travelled to B.C. from another province to receive medical assistance in dying. These three deaths occurred soon after medically assisted death was permissible.

This review also found regional variations for medically assisted death between health authorities and health service delivery areas (HSDA). Island Health Authority had the highest number of medically assisted deaths, followed by Vancouver Coast Health (VCH), then Fraser and the Interior. Northern Health Authority had the fewest number of medically assisted deaths (see Figure 2).

In this review, the Island Health Authority (12.8) also had the highest rate of medically assisted deaths per 100,000 population (see Figure 3).

Figure 3



Source: BC Coroner Service

For this review, South Vancouver Island (16.1), North Vancouver Island (14.2) and Kootenay Boundary (9.4) HSDAs had higher rates of medically assisted deaths than other HSDAs. Fraser East (1.8), Northern Interior (1.9), North East (1.9) then Fraser South (2.0) HSDAs had the lowest rates of medically assisted death (see Figure 4).

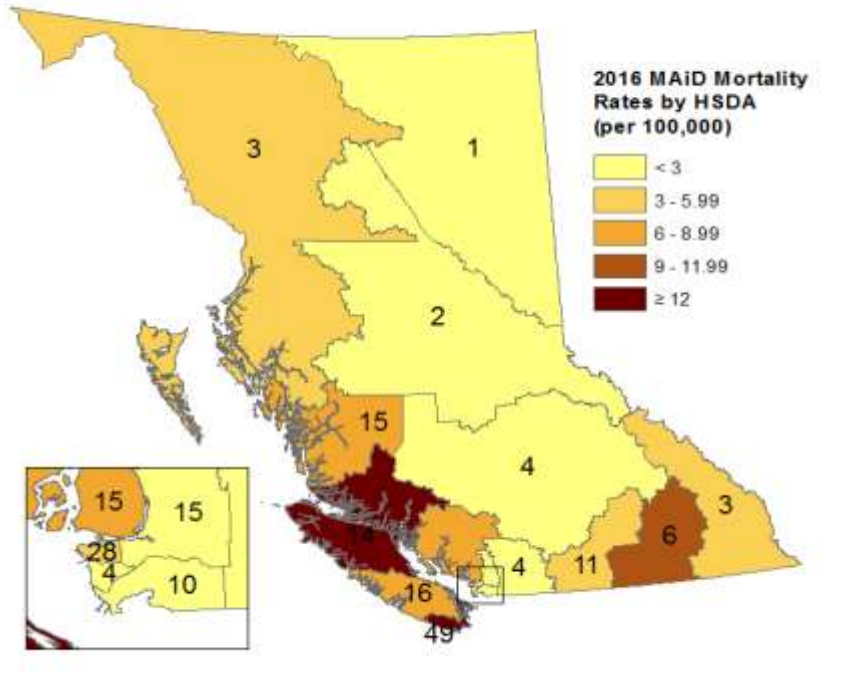
The panel is unable to account for the variation in the numbers as the documentation does not speak to the differences in the regional rates. Regional variation may indicate differences in access to medically assisted deaths or differences in demographic profiles within regions. For example, people may choose to live in certain communities because of specific profiles (e.g. personal interests, services available, population demographics).

The population (age, general health) within specific regions may differ. These factors may result in differences in disease prevalence that make an individual eligible for medical assistance in dying.

Cancer, for example, is a disease of increasing age. Individuals with incurable cancers access medical assistance in dying more often than individuals with other diagnoses (see Figure 8). Areas with younger populations would therefore be expected to have lower rates of cancer, whereas areas with older

population would be expected to have higher rates of cancer. It may be more likely that medical assistance in dying will be more often provided in areas with older populations due to the higher prevalence of cancer in that population.

Figure 4



A) THE DECEDENT

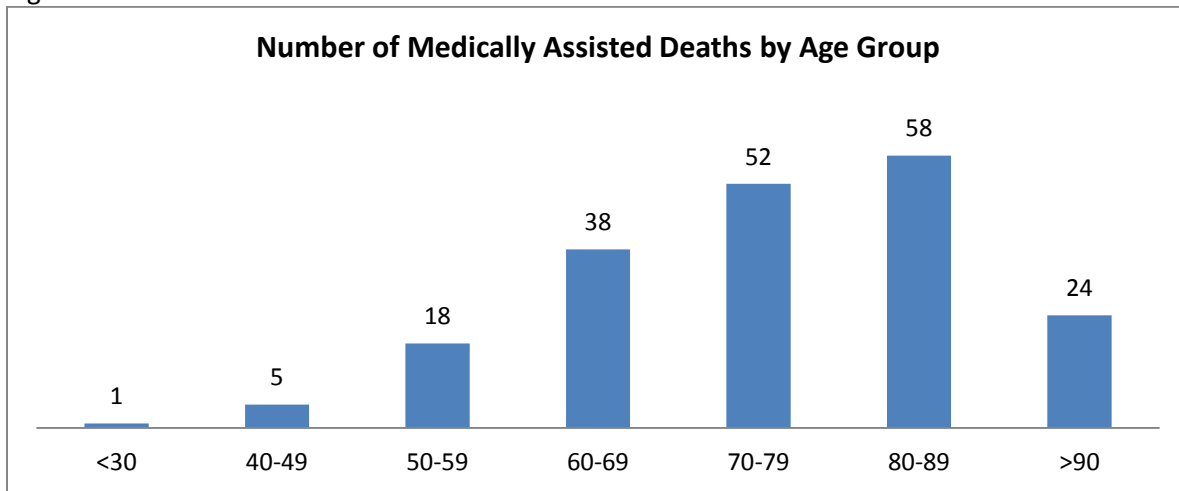
Sex

The review found that males and females were almost equally represented. Just over 52% of medically assisted deaths were females and 48% were males.

Age

In this review, the average age for medically assisted deaths was 74 years (see Figure 5). The highest number of medically assisted deaths (n=58) was for decedents aged 80-89 years of age

Figure 5



Source: BC Coroners Service

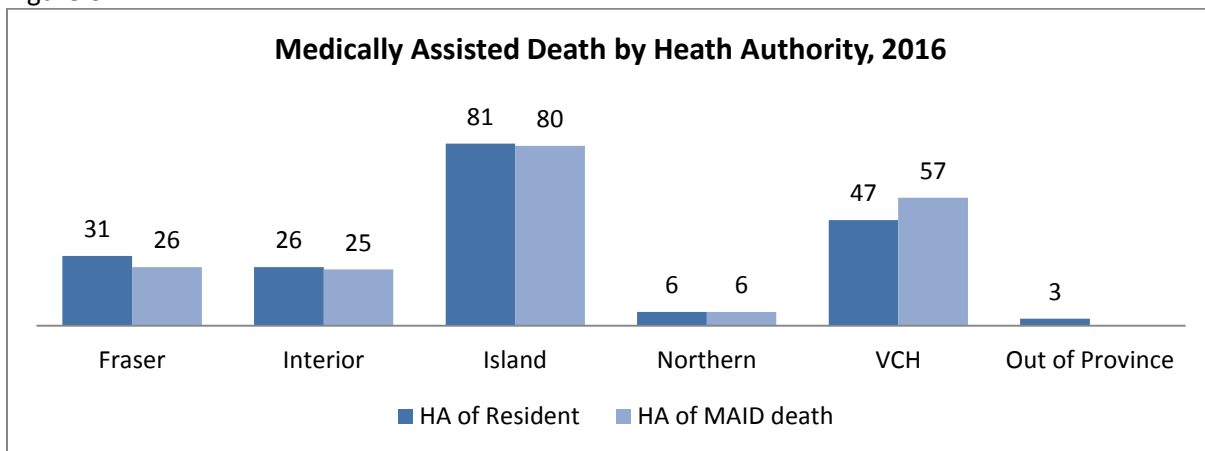
Patient Request

Almost all (98%) Patient Request Forms (original request and consent at time of medically assisted death provision) were signed by the patient. There were four persons who had a proxy sign the consent on their behalf.

Health Authority of Residence and Health Authority of Death

Most decedents accessed medically assisted death within their health authority of residence. There were 10 persons (5%) who traveled to British Columbia from another province, or to a different health authority to receive medically assisted death (see Figure 6).

Figure 6

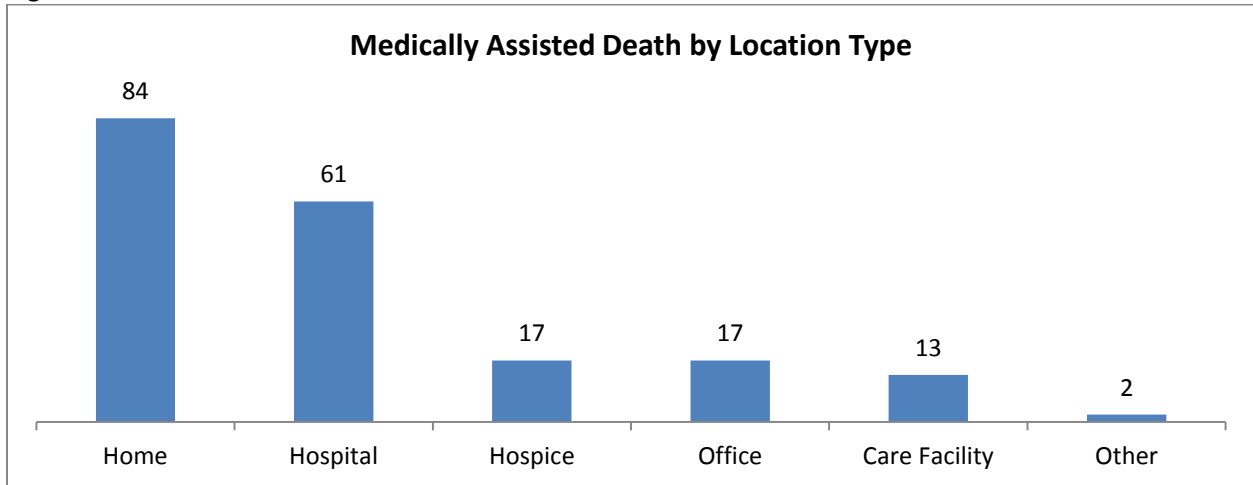


Source: BC Coroners Service

Location of Medically Assisted Death

In this review, half of decedents (50%) died at their residence (home or long-term care facility), compared to 40% of decedents who died in a hospital or hospice setting. Fewer than 10% of patients received medically assisted death at a physician's office or other setting (e.g., friend's home) (see Figure 7).

Figure 7



Source: BC Coroners Service

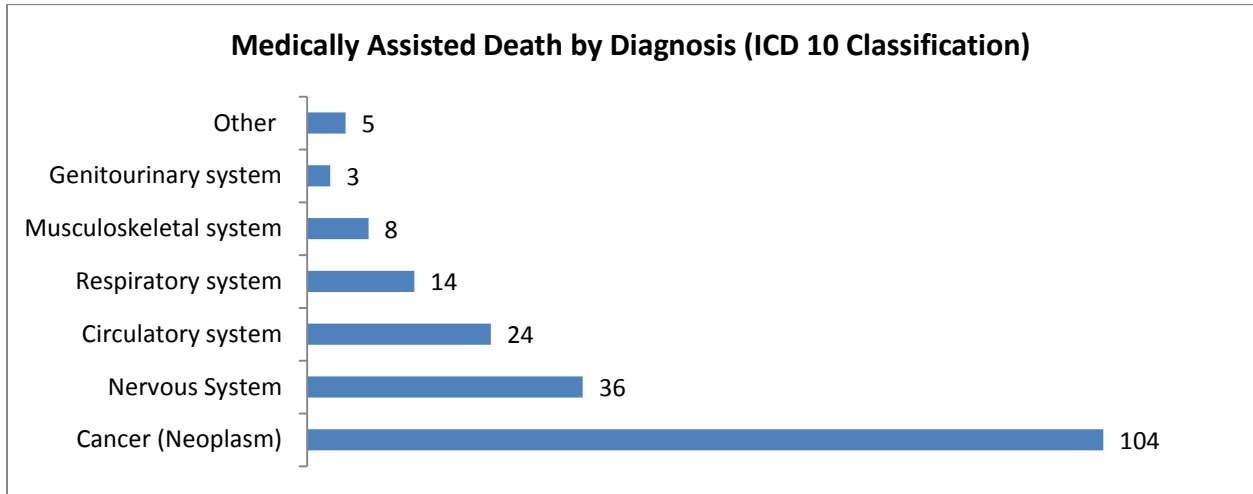
Reasons for Medically Assisted Death

The diagnoses for each medically assisted death was reviewed and matched to the best corresponding **International Classification of Disease -10 (ICD10)** code in order to group the reasons for medically assisted death by disease classification (see Figure 8).

- Cancers (neoplasms) accounted for half (53%) of medically assisted deaths (n=104);
- Nervous system disorders accounted for 18% of medically assisted deaths (n=36);
- Circulatory system disorders accounted for 12% of medically assisted deaths (n=24); and,
- Respiratory system disorders accounted for 7% of medically assisted deaths (n=14).

Musculoskeletal system disorders (n=8), digestive system disorders (n=2), genitourinary system disorders (n=3), and endocrine, nutritional and metabolic disease (1) were also indicated as reasons for medically assisted deaths. There were two medically assisted deaths that could not be classified using ICD10 coding based on the diagnostic information provided.

Figure 8



Source: BC Coroners Service

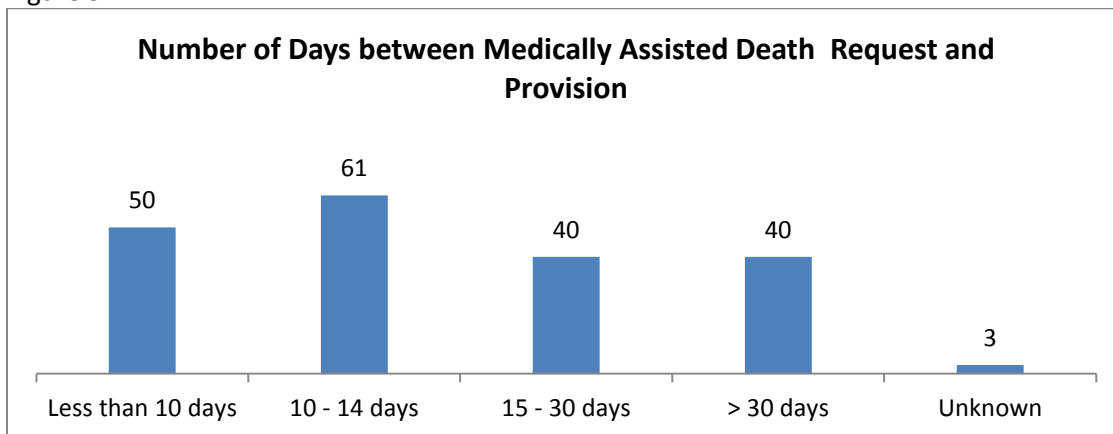
Interval between Request and Provision

“ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided” (Criminal Code, s. 241.2(3)(g))

The safeguard for contemplation set out in the *Criminal Code* as noted above, is subject to an exemption, or shortened interval, if the assessor and prescriber agree that the patient’s death, or the loss of their capacity to provide informed consent, is imminent.

More than 73% of medically assisted death requests had 10 or more days between the request and provision of medically assisted death. There were 50 cases (26%) where a 10-day reflection period was shortened due to the patient’s deteriorating condition or risk of losing capacity. There were three cases where the time interval was unknown at the time of this review (see Figure 9).

Figure 9



Source: BC Coroners Service

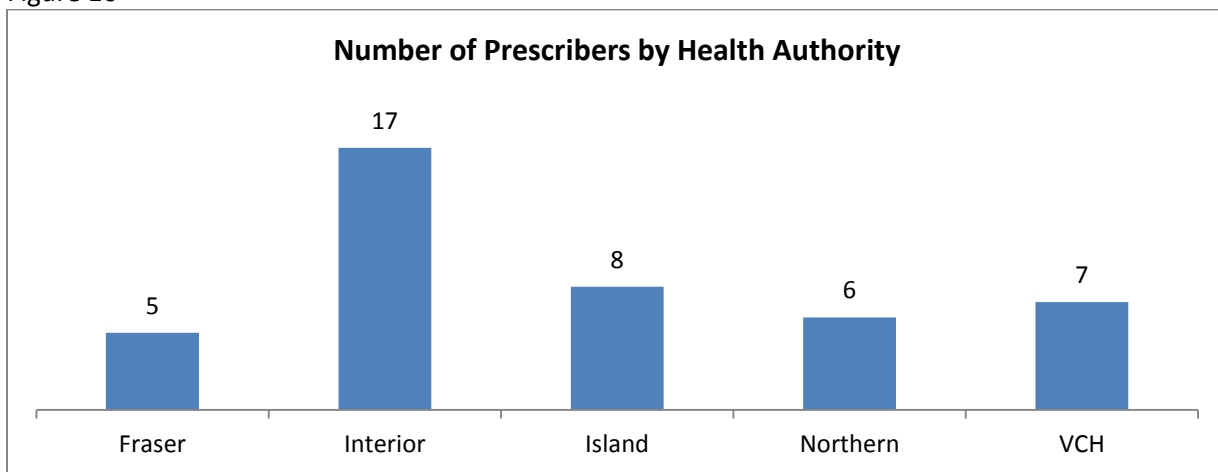
Eligibility Assessments

All medically assisted deaths require the completion of two independent medical assessments confirming eligibility. More than 83% of medically assisted death assessments were conducted in person. In 12% of medically assisted deaths, one of the assessments was conducted via telemedicine. In 5% of cases, this information was not available. An independent witness was present at all telemedicine assessments, as required.

Prescribers

In 2016, medical assistance in dying was provided by 40 prescribers in five regional health authorities. As well, five of these prescribers provided medically assisted death in more than one health authority.

Figure 10



Source: BC Coroners Service

Some medically assisted death forms indicated that an additional nurse practitioner, registered nurse or physician was present at the medically assisted death to offer support and care. As well, there were 117 cases (62%) that noted that family and/or friends were present at the death. For a small number of medically assisted deaths a minister or clergy member was present.

Assessors

There were 138 unique assessors for medically assisted deaths. There were 24 assessors who have acted as an assessor for more than one decedent, providing between two to seven assessments. Almost all assessors were physicians (98%). Nurse practitioners comprised 2% of assessors.

B) DOCUMENTATION

In B.C., the Ministry of Health has developed standardized forms for medical assistance in dying. These forms are designed to ensure that both federal and provincial law, regulations and the practice standards and guidelines of the provincial regulatory colleges are met. The following documents are to be submitted to the BCCS for all medically assisted deaths:

- Patient Request Record
- Assessment Record (Assessor)

- Assessment Record (Prescriber)
- Consultant’s Assessment of Patient’s Informed Consent Decision Capability (if assessment was requested)
- Prescription
- Medical Certificate of Death
- BC Coroners Service Report of Medical Assistance in Dying Death

In the documentation review, the BCCS reviewed each case file to determine whether:

- All required forms were submitted;
- All submitted forms were completed; and,
- Eligibility criteria and safeguards for medically assisted death were met.

In addition, the BCCS reviewed each case file for confirmation of prognosis and diagnosis, for reporting timeliness, prescriber and assessor independence with regards to assessments, and return of unused medications. The following sections provide documentation findings.

Documentation Data Definitions

Diagnosis *“they have a grievous and irremediable medical condition” (Criminal Code, s. 241.2 (1)(c))*

Medically assisted death forms require that prescribers and assessors document the patient’s diagnosis. The diagnosis assists in the determination of whether the patient meets the eligibility criteria for medically assisted death. Patients accessing medically assisted death may have multiple complex, chronic conditions. This may well demonstrate the fragility of these individuals.

In this review, forms listed multiple diagnoses or conditions that supported criteria for a medically assisted death. However, the primary condition leading to the decision for medically assisted death was unclear for some decedents. Frailty was indicated on five case files. Panel discussion identified that frailty will be an increasingly common diagnosis and reporting this as a reason for medical assistance in dying may increase as a result. The discussion further identified that forms should be amended to include additional space to allow for further details to be provided, such as the frailty score, a brief description or consult note.

It was frequently difficult for the BCCS to identify the primary condition leading to the decision for medically assisted death as multiple conditions were noted on forms.

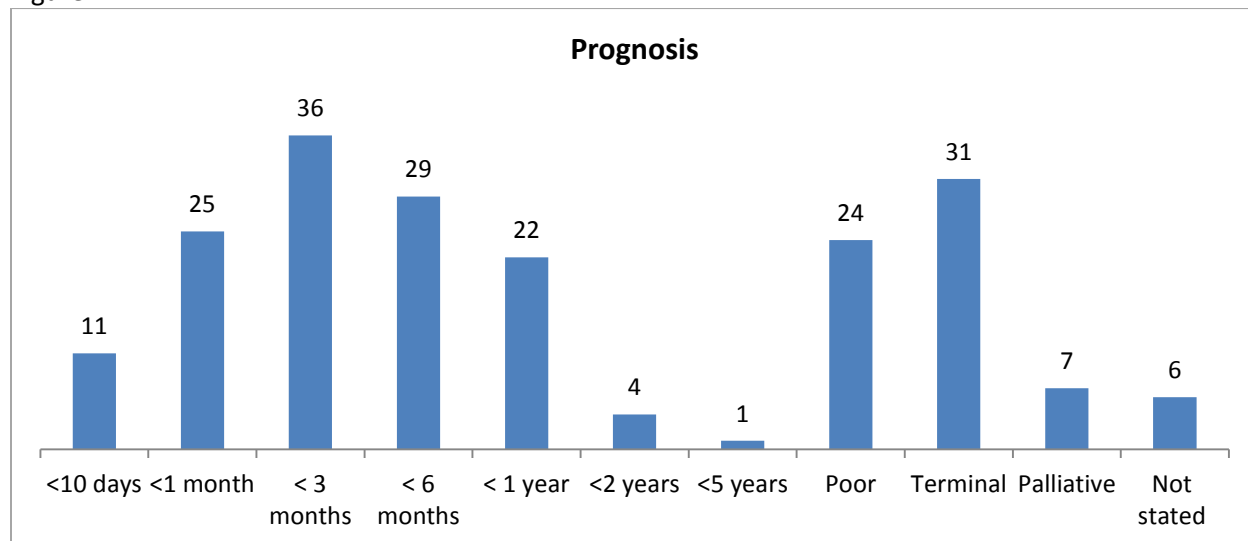
Prognosis *“their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.” (Criminal Code, s.241.2 (2)(d))*

The B.C. medically assisted death forms require that prescribers and assessors document the patient’s prognosis. The prognosis timeline assists in the determination of whether the patient meets the eligibility criteria that a natural death is reasonably foreseeable.

This review found that patient prognosis was documented as an estimated time until death in almost two-thirds (64%) of assessments. Descriptive text was used to indicate prognosis (e.g. poor, terminal, or

palliative) in almost one-third (32%) of the assessments. Fewer than 3% of files (n=5) had a prognosis of more than 2 years until death (see Figure 11).

Figure 11



Source: BC Coroners Service

It was difficult for the BCCS to determine the timeframe of prognosis when descriptive terminology (e.g. palliative, end stage, poor) was used. The panel found that the assessment forms would benefit from standardized terms and definitions for prognosis or the provision of check boxes to define prognosis timeframes (e.g., 0-1 month, 1 month to 6 months, 6 months to 1 year, greater than 1 year etc.). As well, discussion identified that education for health care providers should include how to document patient prognosis.

The panel identified that further clarity is required with respect to the interpretation of reasonably foreseeable.

Timeliness of Reporting

The *BC Coroners Act* requires that all deaths be reported immediately. Reporting is currently accomplished by transmitting the medically assisted death documentation to the BCCS via facsimile.

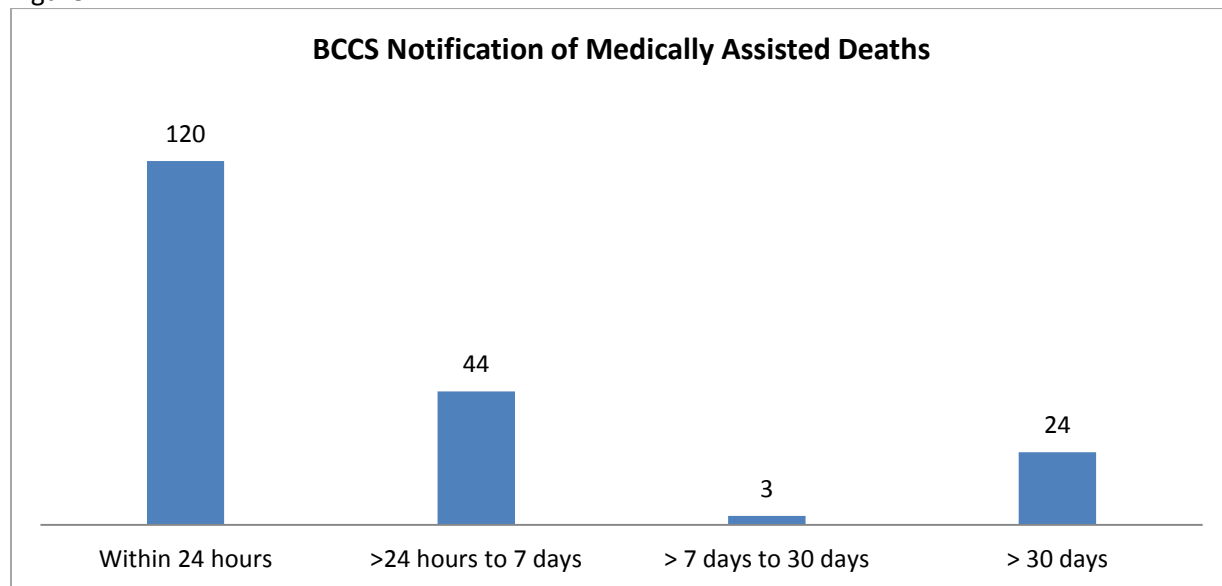
The *Vital Statistics Act* requires that a medical certificate must be prepared within 48 hours after a death and that the medical practitioner, nurse practitioner or coroner must a) complete and sign a medical certificate in the form required by the registrar general stating in it the cause of death according to the international classification, and (b) make the certificate available to the funeral director.

Almost two-thirds (61%) of medically assisted deaths were reported to the BCCS within 24 hours; a total of 84% of medically assisted deaths were reported within seven days. In approximately 12% of case files, the death was reported more than 30 days after death. These notifications were received through Vital Statistics death registration records and/or health authorities.

Panel discussion suggested that the settings where medically assisted death is provided may result in notification delays or documentation transfer issues. For example, in a home setting there is no mechanism to immediately transmit a copy of the Medical Certificate of Death (MCO) to the BCCS. The

MCOD may be left at the residence for collection by funeral home staff. Over half of deaths occur in residences, which may explain why many case files were missing MCOF forms.

Figure 12



Source: BC Coroners Service

Safeguards and Monitoring

Assessor-Prescriber Independence “ensure that another independent medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria” (Criminal Code, s. 241.2(3) (e))

This review found that, for the most part, there were unique pairings of prescribers and assessors on medically assisted death forms (there was not the same prescriber and assessor and/or a reciprocal relationship confirming medically assisted death eligibility).

In 2016, there were 152 unique pairings for prescribers and assessors on medically assisted death forms. There were five pairings where the prescriber and assessor completed three or more assessments together. This occurred in a total of 31 deaths (16%). Prescribers and assessors with a higher number of pairings may be related to the number of available assessors and prescribers within a health area.

Return of Unused Medication “all unused medications and forms must be signed and returned to the pharmacy within 48 hours of Medical Assistance in Dying provision”

This review identified that one-third (33%) of case files were missing *Prescription* information, which includes the medication administration record and medication return forms. From a quality assurance perspective this means that the BCCS could not determine if unused medications were returned to a pharmacy. A significant part of the BCCS mandate with respect to medically assisted death is ensuring public safety. A lack of information about medication return is concerning.

The three regulatory colleges that provide oversight to registrants participating in medically assisted deaths have standards in place to ensure the return of unused medications.

- The College of Pharmacists standard is that *“the full pharmacist must contact the prescribing medical practitioner or nurse practitioner within 48 hours of the scheduled date and time of drug administration to confirm that the medical administration record documents what drugs were consumed and to ensure appropriate return of any unused medications for disposal”*.
- The College of Physicians and Surgeons and College of Registered Nurses each have a standard that the physician or nurse practitioner *“is responsible for returning to the pharmacy any unused substances as soon as reasonably practicable, and ideally within 48 hours of confirmation of the patient’s death”*.

The panel discussion indicated that the dispensing of and return of medications and documentation of the same is complex. The complete medication process may require up to three visits by the prescriber to the pharmacy. The first visit is to provide the preprinted order to the pharmacy, the second visit to collect the medications, and the third visit to return the medications and sign the forms. There are different processes in place for hospital sites than community settings, and different processes in each health authority.

There was consensus from the panel that the transfer of prescription forms needs to be streamlined. This includes addressing the difficulty in providing original forms to pharmacy and clarifying that all prescription forms must be sent to the BCCS. Prescribers and pharmacists must be informed that the BCCS needs confirmation that unused medications are returned.

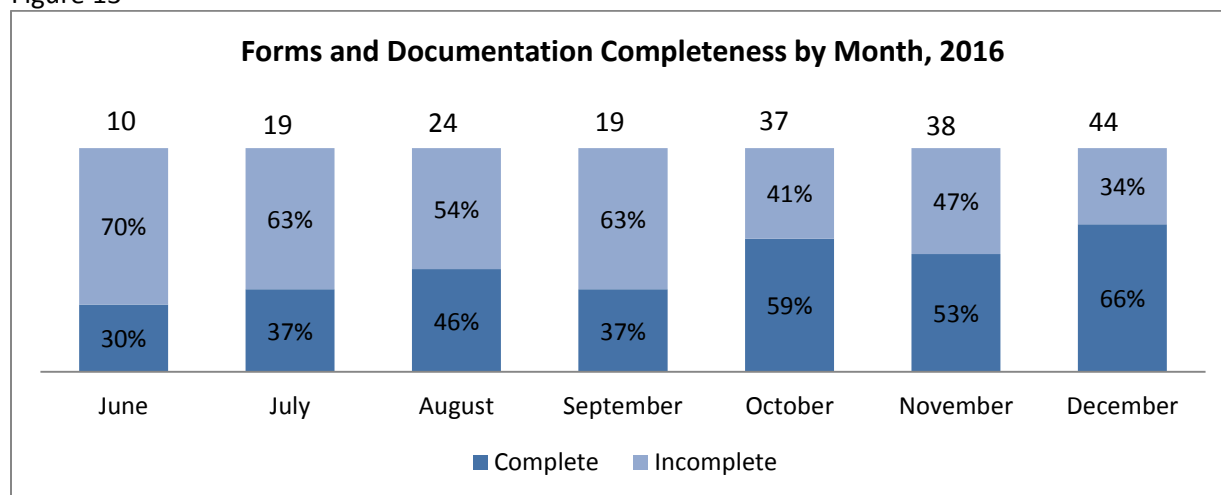
Missing or Incomplete Forms

In this review, case files were assessed for completeness of required forms. The documentation review focused on identifying the overall number of case files with missing or incomplete forms, and ability for BCCS to interpret information provided as it related to medical assistance in dying criteria. This documentation review excluded deaths occurring prior to June 6, 2016, as these deaths were approved by court order and prior to provincial form development.

Completeness

Overall, the documentation review found that there were discrepancies in documentation completeness and form return. During the period of June to December 2016, medically assisted death files were considered complete for approximately half (52%) of the case files. Figure 13 shows the percent of medically assisted death files with complete or incomplete information by month based on the total number of cases per month. Completeness has varied by month from a low of 30% in June to up to 66% in December. For these seven months, the most commonly missing or incomplete forms were the prescription and the Medical Certificate of Death.

Figure 13



Source: BC Coroners Service

To determine if documentation completeness was improving over time, documentation completeness was reassessed for deaths occurring in November and December of 2016. For the period of November to December 2016, 60% of medically assisted death case files were considered complete (see Table 1). This is an 8% improvement compared to the June to December time period.

The completeness of medically assisted death forms received by BCCS varied by health authority. Prescribers in Vancouver Coastal, Island and Interior health authorities had higher proportions of incomplete records (see Table 1).

Table 1: Documentation Completeness – November and December 2016

	Fraser	Interior	Island	Northern	VCH	Total
Complete	8	6	21	3	11	49
Incomplete	2	6	14	0	11	33
Total Assisted Deaths	10	12	35	3	22	82

Similar to earlier findings, the most commonly missing forms for deaths reported in November and December were the completed Medical Certificate of Death (75%) and prescription forms (46%). As well, 9% of records were missing assessor forms.

Documentation completeness did not appear to be associated to the type of place where medically assisted deaths occurred. Similar rates for missing forms were noted for deaths occurring in private residences and health care centres or offices (see Table 2).

Table 2: Location of Death and Incomplete Forms

Premise Type	Nov-Dec	June-Dec
Residence	17	41
Hospital/Hospice/Medical Office	15	47
Total	32	88

The panel noted different collection timeframes and document pathways may have a role in compliance. For example, prescription forms must be completed within 48 hours of the death, whereas

BCCS requires immediate notification of the death. As noted earlier, the Medical Certificate of Death is often left at the patient's residence for funeral home staff.

Incomplete documentation is a quality assurance issue; it raises compliance concerns and results in multiple agencies requesting missing forms to confirm information.

C) QUALITY ASSURANCE PROCESSES

Clearly defined quality assurance processes are required so that the BCCS and the public remain confident that the provision of medically assisted death in B.C. is undertaken in compliance with law, regulations, practice standards and guidelines.

This review identified two broad themes for quality assurance processes.

First, there needs to be clearly defined processes for identifying compliance concerns and reporting processes to the appropriate agencies (for example, the BCCS, regulatory colleges, health authorities and law enforcement). This includes identifying what constitutes a concern or flag and ensuring that all health care providers, agencies, and the public are aware of the safeguards and how the safeguards are being monitored.

The panel also identified that further work needs to be done to investigate and confirm reasons for regional variation in terms of quality assurance. For example, differences in rates may be related to access, and/or the number of available assessors and prescribers, or it may be a reflection of demographics and community profiles.

D) INFORMATION SHARING AND REPORTING

To support a robust quality assurance process, there is a need for information sharing between the BCCS, health authorities, assessors and prescribers, ministry partners and regulatory colleges. This includes the sharing of case information so that any identified concerns can be reviewed and addressed.

For example, the panel identified the need for centralized health authority collection of completed patient requests. The group suggested that all complete Patient Request Forms be sent to Care Coordination at the appropriate health authority. This would allow health authorities to monitor the total number of patient requests for medically assisted deaths and the disposition of those requests. Although the regulatory colleges currently have practice standards that require the provision of medical records once death occurs, an additional standard would be required to support the transfer of Patient Request Forms, whether a medically assisted death occurs or not, to the appropriate health authority.

In addition, all parties need access to aggregate data and reporting about medical assistance in dying for quality assurance, monitoring and analyzing trends. This would assist the Ministry of Health and health authorities to identify issues related to patient access and availability of end-of-life supports and services, plan for and address capacity issues, and identify health care provider training needs.

Provincial and regional reporting is needed to ensure that the public is informed about medical assistance in dying and maintains confidence that the legal requirements and safeguards are being met.

The panel recognized that there is a need to identify key reporting requirements to support provincial reporting. Information Sharing Protocols which outline the legislative authorities to collect, use and disclose information will be required.

PART 5: RECOMMENDATIONS

This death review panel has developed a set of recommendations based on the medically assisted death case findings. The recommendations arising from the death review panel were developed in a manner that was:

- Collaborative;
- Attributable to the deaths being reviewed;
- Focused on identifying opportunities for improving public safety and quality assurance;
- Targeted to specific parties;
- Realistically and reasonably implementable; and,
- Measurable.

The panel identified three key areas to strengthen quality assurance processes for medical assistance in dying:

- Improve documentation completeness and streamline documentation transfer processes;
- Establish clear guidelines for quality assurance and monitoring; and,
- Develop information sharing protocols and identify key reporting requirements.

A) Documentation Completeness, Data Quality and Streamlined Information Transfer

Programs and services benefit from the use of standardized forms. Ease of documentation, collection of key information, and use of consistent terminology and definitions results in improved data quality and completeness. Streamlined data collection and document transfer processes assist health care providers in their day-to-day work, improve quality of care, and support program managers and decision makers in surveillance and monitoring activities.

This review found that only half (52%) of all case files were complete. Files that were incomplete were primarily missing the Medical Certificate of Death and the prescription forms.

The review also found that for some decedents it was difficult to determine the prognosis or the primary diagnosis based on descriptive terms used and the multiple comorbidities listed.

The review found that documentation transfer was complicated by multiple transfer processes and reporting requirements, ability to submit forms from some death locations, and differences in reporting timelines. These challenges result in multiple calls requesting missing information or confirmation of information.

Recommendation 1: Improved documentation and completeness

1a) By November 2017, with respect to medical assistance in dying, the Ministry of Health, in partnership with relevant stakeholders, will:

- Provide clarity regarding expectations for documenting diagnosis on assessment forms;
- Develop standardized terms for documenting prognosis on assessment forms; and,
- Streamline and improve document transfer.

B) Quality Assurance and Monitoring

Oversight for medical assistance in dying is essential to ensure public trust in the system, ensure safeguards and protocols are being followed, and to support improvements and adaptations to the system as necessary. Given the regulatory standards, guidelines and training for health care providers that are in place, the BCCS has adopted a process-based investigation to review medically assisted deaths.

A process-based review entails ensuring that the required documents have been provided and are complete and, on the face of the documentation, all eligibility criteria, statutory safeguards and regulatory requirements have all been met.

The BCCS in performing its oversight role has identified a possible procedural gap with respect to the return of medications or documentation of the return of medications. Additional work will be required by the professional colleges to establish clarity around medication return processes.

Recommendation 2: Establish a Framework for Quality Assurance and Monitoring

2a) By December 2017, the BC Coroners Service, in partnership with relevant stakeholders, will:

- Establish clear guidelines for notification to regulatory bodies and law enforcement;
- Clarify and communicate quality assurance roles.

2b) By November 2017, the Ministry of Health, in collaboration with the College of Pharmacists of BC, College of Physicians and Surgeons of BC and the College of Registered Nurses of BC, will establish provincial requirements and procedures to ensure return of all unused medications.

2c) By November 2017, the College of Pharmacists of BC, in collaboration with the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC, will ensure that standards include requirements for complying with established provincial processes for returning unused medications.

2d) By January 2018, the College of Pharmacists of BC, the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC will develop and communicate joint messaging for their respective registrants related to the requirements and standards for return of unused medications.

C) Data Access and Information Sharing

Programs, agencies and services must work collaboratively and effectively share information to deliver services, ensure patient safeguards are maintained, and support comparable public reporting. This includes establishing reporting requirements, identifying core data sets, and monitoring adherence to the accountability safeguards for medically assisted deaths.

Recommendation 3: Develop Information Sharing Processes and Reporting Requirements

3a) By February 2018, the BC Coroners Service, in partnership with relevant stakeholders, will:

- Develop Information Sharing Agreements with relevant partners;
- Develop requirements for statistical tracking and accountability measures;

- Establish timelines and content for provincial public reporting; and,
- Establish a process to improve reconciliation of documentation.

3b) By December 2017, the Ministry of Health, in partnership with relevant stakeholders, will establish a centralized process to track all patient requests for medically assisted death and the disposition of those requests.

3c) By November 2017, the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC will develop practice standards requiring notification to the health authority for all patient requests for medical assistance in dying.

PART 6: GLOSSARY AND REFERENCES

GLOSSARY

Aggregate: presentation of individual findings as a collective sum.

Assessor: a physician or nurse practitioner who assesses a patient for eligibility for medically assisted death.

Eligibility for medical assistance in dying:

S. 241.2 (1) a person may receive medical assistance in dying only if they meet all of the following criteria:

- a) they are eligible – or, but for any application minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada;
- b) they are at least 18 years old and capable of making decisions with respect to their health;
- c) they have a grievous and irremediable medical condition;
- d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and,
- e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Grievous and irremediable medical condition:

S. 242.2 (2) a person has a grievous and irremediable medical condition only if they meet all of the following criteria:

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

International Classification of Disease-10 (ICD10): “ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions”

<http://www.who.int/classifications/icd/en/>

<http://apps.who.int/classifications/icd10/browse/2016/en>

MAiD: medical assistance in dying.

Prescriber: a physician or nurse practitioner who assesses a patient for eligibility and capability, ensures a second independent assessment has been completed and, when all safeguards and criteria are met, prescribes or administers medications for a medically assisted death.

Qualified health care provider: a health care provider acting within scope of practice.

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