Goals of Care Designation Orders and Personal Directives During Response To Apparent Attempted Suicide

Guidance for Emergency Medical Services and other healthcare providers providing initial time sensitive emergency responses

Sometimes health care providers encounter an individual who appears to be attempting suicide and who has a declared wish not to be resuscitated. That declared wish might be a written one, including through a Personal Directive or a Goal of Care Designation (GCD) order. This scenario has prompted the question:

Does a Personal Directive or GCD Order give direction about whether or not to provide potentially life-preserving interventions in cases of attempted suicide?

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Background Considerations

Suicide, the act of intentionally taking one's own life, is a challenging event to encounter with associated legal, ethical, emotional, and spiritual impacts, and sometimes associated stigma. Generally, suicide is presumed to be an act of illness and/or an act arising from impaired decisional capacity. Those first on scene will typically have limited insight into the state of mind of a person who is trying to die by suicide. Was their decision-making impaired by a mental illness, acute emotional reaction, or substance ingested immediately prior to initiating a suicide attempt? It should be acknowledged that some persons make a considered decision to end their own life, absent any impairing mental illness, but this is estimated to be a small minority of deaths by suicide. Healthcare providers will not know if the person had decisional-impairment in the moments just prior to the suicide attempt, and may have otherwise wished to be saved. The possibility also exists that some nefarious action was perpetrated by a third party, resulting in the subject person's near/imminent demise, of which healthcare providers and first responders arriving on the scene would not be aware.

As healthcare providers, we have a **duty to respect patient autonomy** – the patient's inherent right of self-determination over their own body and life. When a patient is conscious and has capacity, we demonstrate our respect for their autonomy by seeking their informed consent before providing any interventions. When a patient is unconscious or does not have capacity, we try to find other ways to respect their autonomy by ensuring that decisions about healthcare interventions are made based on the wishes, values, and beliefs of the patient. One of the ways patients can communicate their wishes in advance of lost capacity is through advance care planning tools such as a personal directive and a GCD Order.

At the same time, healthcare providers also have a **duty of care** – we are obliged to try to maximize the well-being of our patients and minimize harms. So, as healthcare providers arriving at the scene of an apparent attempted suicide, we may experience an ethical tension between our duty of care (which tells us to intervene to attempt to preserve life) and our duty to respect patient autonomy (which may be to hold off providing care if that is what the patient wishes).

In **time-sensitive situations of uncertainty** about patient wishes regarding medical interventions, emergency medical service, and other healthcare providers appropriately defer to attempting to preserve life first and then asking questions later about the appropriateness of having done so. This is justified due to the time-sensitive nature of response efforts and the unalterable consequences of not intervening to preserve life.

This means that when responding to an apparent suicide attempt, healthcare providers may need to provide emergent interventions (such as resuscitative measures), even when there is some suggestion that the patient might not have wanted such interventions.

It is with the tension between our duty of care and our duty to respect patient autonomy in mind that this guidance document has been developed, and some of the nuances are explored through questions and answers below. **It is important to note that the guidance and Q&A scenarios below are for illustrative and discussion purposes only; they do not replace clinical judgment and are not to be considered to be directive nor legal advice since advice and appropriate action may vary depending on each unique fact scenario.**

Personal Directives

The *Personal Directives Act* has a preamble, which states:

"WHEREAS Albertans should be able to provide advance personal instructions regarding their own personal matters while recognizing that such instructions may only be made voluntarily and cannot include instructions relating to aided suicide, euthanasia or other instructions prohibited by law;"

This means healthcare providers should not take direction from instructions in a personal directive that would result in the healthcare provider withholding clinically indicated interventions when a patient has attempted suicide.

In addition to this preamble in the Personal Directives Act, some of the considerations below with regards to GCD Orders (such as whether or not the patient had capacity at the time they attempted suicide) also support the premise that health care providers should not withhold clinically indicated care based upon directions in a personal directive in the event of an attempted suicide.

For information on how personal directives guide clinical actions in other circumstances see:

a) The Personal Directives Act
or Office of the Public Guardian website https://www.alberta.ca/personal-directive.aspx
b) AHS Advance Care Planning (ACP) and Goals of Care Designation Procedure or AHS Health Law resources (which can be accessed on insite: Teams→Legal and Privacy → Health Law → Resources and FAQs → Consent/Guardianship and Substitute Decision Making, see Legal and Privacy)

Goals of Care Designations

The GCD architecture was created for care decisions around natural illness progression, whether from known (e.g. chronic and anticipated causes) or from unknown and suddenly life-threatening circumstances (e.g. trauma). As a result, there are some particular challenges that need to be addressed when considering the applicability of a GCD in the context of suicidality.

A GCD order communicates the general aim or focus of care, including the preferred location of that care, and which types of interventions a person would accept if clinically indicated. The GCD is meant to assure the patient's voice in medical decision-making, by aligning the patient's values, beliefs and care wishes with expert clinical advice regarding appropriate medical care. The GCD order should be the result of a deliberate conversation between a patient and their physician or nurse practitioner. A GCD order and the conversation leading up to its determination cannot hope to contemplate every possible clinical situation. Some peoples' wishes will not be rigid and may change depending on the circumstance. For both these reasons, healthcare providers can consider a person's GCD to be a strong informing guide but not an absolute directive that is blind to context. The GCD procedure describes the need for a clinician to always validate the person's GCD with them in light of the current clinical circumstances and to seek informed consent for treatments/procedures.

If the patient cannot engage in a validation conversation, in an emergency a clinician bears the dual responsibility of trying to interpret and honour the expressed wish of the patient, while also applying it to the clinical circumstance. Clinicians are asked to exercise clinical judgement. Section 1.3 of the AHS ACP and GCD Policy indicates that the GCD is "prescriptive but is also subject to clinical judgement of the current most responsible health practitioner" treating the patient. There must be rationale to countermand a patient's GCD if life-preserving measures are invoked against the expressed wish not to use them, or if life-preserving measures are avoided despite an expressed wish for their use.

In situations of uncertainty about patient wishes regarding medical interventions, healthcare providers appropriately defer to preserving life first and later ask questions about the appropriateness of having done so. This is justified due to the time-sensitive nature of response efforts, incomplete information about the patients' capacity and wishes, as well the unalterable consequences of not intervening to preserve life.

When responding to an apparent suicide attempt, you may need to provide interventions on scene (such as resuscitative measures) that are not usually indicated by the patient's GCD.

Questions and Answers with Case Examples

1. Can you give me a "typical" example of what this looks like in practice?

CASE EXAMPLE – attempted suicide with no information on scene

A woman in her 60's with a progressive degenerative neurological condition was living in long-term care. She went on a day pass and did not return to her facility. The police were called and she was found to have checked into a hotel room and taken an overdose of pills. EMS were called to the scene and because her GCS was 5, her airway was unprotected and she was hypoxic. She was intubated and transferred to the emergency room and admitted to the intensive care unit.

When her family arrived in the intensive care unit, they described that their mother had a C1 GCD and that her eldest daughter was her agent on her personal directive (not enacted). The personal directive, and the daughter and her family all stated that her wish would be for withdrawal of "life support" as she had repeatedly explained to them that she did not want to be intubated in any circumstance (having experienced ICU twice in the past). They also explained that their mother was a pragmatic woman with no history of depression who believed that people have the right to take their own lives, as long as no one else is harmed, and that she had been talking for some months about ending her own life on her own terms. With this new information, the intensivists consulted ethics, psychiatry and social work. Her personal directive was enacted and the team made a decision with her personal directive agent to withdraw ventilator support and to extubate. She died shortly after this.

Summary

In this scenario, the first responders had very little information available on scene and appropriately provided the therapies and interventions available that were aimed at stabilizing the patient and transferring the patient to hospital. Once more information was available, and with the patient stabilized, there was time for all involved to review the legal, ethical and medical context and make a decision that honoured the patient's previously stated wishes and allowed withdrawal of the medical interventions that were preventing her death.

2. What should I do if I encounter a patient who appears to have acute opioid toxicity and who has a C1 GCD?

Key Considerations

A paramedic, first responder, or other healthcare provider providing an emergency response might encounter a person with loss of consciousness in the context of possible opioid toxicity (e.g. reduced respiratory rate, hypoxia, pinpoint pupils). The provider may need to decide whether or not to provide non-invasive airway assistance, such as mask bagging, or chemical reversal with a drug such as naloxone or even to intubate.

Responders on scene may have uncertainty as to whether:

- This is an overdose (either intentional or accidental), or
- An effect or side-effect of opioids used appropriately, or
- Expected, natural death occurring in person who has also been receiving opioids

The apparent clinical context informs the healthcare provider's clinical judgement. For instance, if the person with the C1 GCD (or C2 GCD) is known to have a terminal illness, appears to be near their expected end-of-life and has a reduced level of consciousness from prescribed opioids that appear to have been taken appropriately, it is likely that the healthcare provider would determine naloxone and airway support would not be provided. Rather, supportive care as the person proceeds through phases of normal and expected dying would be provided. However, if the context appears to be one of intentional or accidental overdose, or respiratory depression secondary to toxicity with prescribed opioids then it would be appropriate to respond with ventilator support and reversal agents.

It is acknowledged how hard this is and that healthcare providers try to *"make the best call in the moment"*, while they seek input from others in the healthcare team and the Most Responsible Healthcare Provider. Paramedics and first responders can always seek the opinion and advice of EMS Online Medical Consultation (OLMC).

CASE EXAMPLE – expected natural death

A 68-year-old woman with end stage renal failure and ischemic heart disease has made a decision to stop dialysis, and is being cared for with expected death at home within some days to short weeks. She has a C1 GCD. She has been increasingly delirious with uremia and is bed bound. Her daughter is caring for her and finds her one morning suddenly struggling to breathe, in a panic she calls 911 and then while waiting for them to arrive she administers the doses of subcutaneous fentanyl and midazolam that had been prescribed for "dyspnea, delirium or terminal distress". On arrival, the paramedic finds the woman actively dying, unarousable with apneic periods of 20 seconds and shallow respiratory effort and a weak irregular pulse. The daughter is crying and asking, "Have I done the right thing? Is she suffering? Have I killed my mother?"

The paramedics explain that she is dying and reassure her that her mother is comfortable, unaware of her breathing or any suffering. They remain on scene and the patient dies after about 15 minutes.

Summary

This is an example of, "Expected, natural death occurring in person who has also been receiving opioids", and of paramedics supporting a patient and family with appropriate care through the dying process, without providing interventions that attempt to preserve life.

3. Are there times when a response to an apparent attempted suicide might not include cardiopulmonary resuscitation (CPR) and intubation?

Key Considerations

While preserving life is the default position for a healthcare provider encountering a person who may be attempting suicide, there is room, albeit limited room, to exercise clinical judgement regarding which interventions to employ. If the passage of time since the suicide was initiated, or the proximity to natural death prior to the suicide attempt mean that the person's physiology cannot respond to resuscitative interventions, then clinical judgement may be a helpful guide in the following way: It may be appropriate for the first responder to weigh the degree of intrusiveness of various possible interventions against the likely clinical benefit in determining whether or not they should be offered. Paramedics and first responders can always seek the opinion and advice of EMS Online Medical Consultation (OLMC).

CASE EXAMPLE – attempted suicide, naloxone and ventilator support administered but CPR not clinically indicated

A 53-year-old cachectic patient with advanced cancer is living at home, with a C1 GCD. His wife calls 911 when she finds him unconscious and barely breathing, having taken all the opioid pills in his bottle. She thinks he may have been trying to kill himself, and tells the paramedics that he learned yesterday from his oncologist that he likely only had days to weeks left to live. The paramedics' impression is that he is close to the expected end-of-life from his underlying terminal cancer and has taken an intentional overdose of opioids. They administer naloxone and provide non-invasive ventilator support, but he rapidly becomes apneic and pulseless with asystole on the cardiac monitor. They determine that chest compressions, intubation or provision of electric shocks, considering their intrusiveness and risk of physical harm are not appropriate and are unlikely to preserve his life (he is physiologically very cachectic and frail). They call the EMS Online Medical Consultation who agrees with their assessment and CPR is not initiated. The Office of the Chief Medical Examiner is contacted and police are dispatched for on-scene review.

Summary

This example illustrates clinical judgement being applied to the appropriateness of using interventions and respects the principle of "Beneficence" by only providing treatments likely to help and not harm.

4. What should I do when a person on scene who is not the patient is trying to give me verbal direction to limit or withhold care?

Key Considerations

- Healthcare providers cannot take direction from anyone who is not the legal alternate decision-maker.
- There are very strong arguments that alternate decision-makers do not have legal authority to direct withholding care such that the result would be the completion of a patient's suicide.
- *In the event of a time-critical medical emergency, the health practitioner may need to initiate resuscitation, even if contrary to the alternate decision-maker's position (potentially involving law enforcement for scene management).*

In the situation of an apparent suicide, a healthcare provider cannot take direction from bystanders that limits appropriate clinical intervention.

People who are not a patient's legal alternate decision-maker ("ADM") do not have authority to direct the patient's care. (Examples of an ADM include an agent under a personal directive that has already been brought into effect in accordance with the *Personal Directives Act* or a guardian appointed under the *Adult Guardianship and Trusteeship Act*.) Generally, ADMs have a legal obligation to make decisions about the patient's care in a way that respects the patient's previously expressed wishes and values, and are in the patient's best interests. ADMs can provide valuable information to care providers about the patient's wishes and values.

There are very strong arguments that an ADM does not have legal authority to direct withholding care such that the result would be the completion of a patient's suicide. (Section 23(b) *Adult Guardianship and Trusteeship Regulation (AGTR);* section 35 *Adult Guardianship and Trusteeship Act (AGTA)*; preamble & section 14 *Personal Directives Act (PD Act)*; section 241 *Criminal Code.)*

In addition, in some cases, it is unclear whether the patient has attempted suicide or whether the circumstances are accidental. Further, sometimes there is no time to explore dispute in cases where the ADM is requesting a different course of action from that which the healthcare provider thinks is clinically indicated. Moreover, there may not be time to verify whether someone is a legal ADM. Section 7.6 of AHS' Advance Care Planning and Goals of Care Designation procedure provides that: *"in the event of a time-critical medical emergency, when the patient lacks capacity and there is not time to complete the steps of the dispute resolution process, the most responsible health practitioner may need to initiate specific interventions necessary to address the emergency need, even if contrary to the alternate decision-maker's position"*. The foregoing applies when there is a disagreement about the patient's best interests, the application of the patient's prior expressed wishes/values/beliefs, or when the patient's wishes/values/beliefs are unknown. AHS' Consent to Treatment Policy reflects the legal exception to obtaining consent to treatment in emergency situations to preserve life or alleviate serious pain; this exception may be relevant, for example, in situations where the ADM's authority to provide direction is unclear, when the incapable patient does not have an ADM, or when the patient's previous direction is unclear. Working through this process takes time and is facilitated after stabilization of the critical medical emergency has occurred.

The compassion you provide to the ADM while you are also responding to the medical emergency is so important. For example, you may reassure the ADM and other people on scene that there is a process for them to clarify future treatment decisions once immediate emergency care has been provided. Consider debriefing as a care team and/or with the ADM/family later.

CASE EXAMPLE – family object to intervention during attempted suicide

A man in his 80's who has been recently bereaved is living in a rural assisted living facility with frailty. A nurse has come into his room to deliver some medications. The nurse notices there is an empty bottle of meds on the floor, the bottle states it had acetaminophen and codeine in it and was filled yesterday with the patient's son's name on the prescription.

A note is found reading, "My son is innocent in all of this, and I want to die by my own hand, I do not wish to have a drawn out, agonizing death. Thank you to all my loved ones and friends, all of my affairs are in order".

The patient has cold, clammy skin, appears peri-orally cyanotic, and is responding only to moderate painful stimulus with a groan. He is breathing around 8 breaths per minutes and has a weak radial pulse that feels tachycardic. The nurse calls for the physician who is on site and for the other available help. While the physician arrives, the nurse is placing a Sp02 monitor that reads 78% R/A, at the same time, on calling 911 they are informed the local ambulance is on the way to the city with a STEMI and the next resource will have at least a 15 min response time. The son, daughter-in-law and daughter arrive and stats, "Please just leave him, he just wants to die".

The physician acknowledges the family and patient's distress and explains she has a duty to treat him, particularly because she is worried the patient has been depressed following his spouse's death and his desire for hastened death might reverse with treatment. She administers naloxone and the patient's respiratory rate, oxygenation and consciousness level improves. The patient is transferred to hospital for further treatment.

Summary

In this example, the duty of care and responsibility as healthcare providers was to provide interventions during the apparent suicide attempt and not to take direction from the family bystanders.

5. What should I do when the person attempting suicide is conscious and asking me not to aid them?

Key Considerations

During an active suicide attempt, because of time-sensitive potential clinical interventions and lack of clear information, providing clinically indicated emergency care to preserve life is appropriate.

A paramedic or other health care provider may encounter an individual who is refusing assistance during an apparent suicide attempt or be asking that the provider actually assist in ending their life. In an active suicide attempt, clinically appropriate intervention to preserve life is indicated. If time is of the essence for emergency care to preserve life, such treatment can be provided under emergency care laws since there is no time to assess whether the patient has a mental illness and lacks capacity. Common law (judge-made law) also authorizes restraints if necessary to prevent serious bodily harm.

If police are at the scene, police may decide to issue a Form 10 under the *Mental Health Act*, which authorizes the restraint and detention of the patient for transport to hospital.

In a healthcare facility, with a physician or nurse practitioner available, an immediate request can be made for assessment whether they meet certification criteria under the *Mental Health Act*. Furthermore, in hospital the patient's decision-making capacity should be assessed by their Most Responsible Health Practitioner as one of the factors which will help inform the care provided.

For example, in the case example above, *family object to intervention during attempted suicide*, if the naloxone was administered by paramedics and the man became combative and confused as the naloxone reversed his opioid overdose, then a peace officer may have to be called to assist.

The compassion and empathy that you provide to the person who has attempted suicide is also a key part of your therapeutic response.

See the algorithm "Adults who Lack Capacity – Emergency Health Care" available on insite Teams → Health Professions Strategy & Practice → Clinical Practice → Interprofessional → Consent to Treatment/Procedure.

Other resources about the consent to treatment policy: see AHS Consent to Treatment Policy on insite

CASE EXAMPLE

A 70-year-old male with metastatic bowel cancer is getting chemotherapy and radiotherapy and concurrent palliative care supports. While at home, his wife hears a bang come from the garage. She goes to investigate and finds him on the floor of the garage; beside him is his rifle. He looks at her and says, “I’m sorry, I just couldn’t stand it any longer”.

Paramedics are called and after holding back for law enforcement to create a “safe scene”, they enter the garage through the back alley. Upon arrival the wife tells the paramedics she thinks he has been depressed lately, that he has had a long fulfilling career in the film industry and is worried about his mortality, she presents the paramedics with GCD of C1.

The patient is found alive with significant blood loss to the floor and a single gunshot wound to the right side of his chest. A law enforcement officer is holding a dressing over the wound.

The patient presents with a patent airway, is breathing at a rate around 24 BPM, he has a radial pulse that is palpated at around 100 BPM. He appears semi-lucid raising his head and responding to his name, he keeps saying, “Just let me die”, but does not resist the paramedics treating him.

The police officer on scene completes the MHA Form 10 and the paramedics stabilize the patient and transfer him to hospital.

Summary

This case illustrates providing emergency care to preserve life during a suicide attempt, even though it was not aligned with the patient's expressed wish and using Mental Health Act Forms.

6. Should I call a Code Blue if I find someone pulseless in a healthcare facility who has a non-R1 GCD and appears to have attempted suicide?

Key Considerations

In general, it is appropriate to call a “Code Blue” and start the resuscitation attempt. This is based on the Background Considerations (page 2) that when responding to an apparent suicide attempt, healthcare providers may need to provide emergent interventions (such as resuscitative measures), even when there is some suggestion that the patient might not have wanted such interventions. This acknowledges the principle that in trying to preserve the lives of those who did not mean to die, some who wanted to die may be prevented from doing so. Calling a Code Blue is also consistent with AHS’s duty of care to keep patients in our care safe from harm.

However, there may be situations where the responding team may deem it appropriate to withhold Cardiopulmonary resuscitation (CPR) or other life-preserving interventions. Nuances about when CPR might be withheld, e.g. because natural death was imminent at the time of the suicide attempt, are considered in question 3 above (“Are there times when a response to an apparent attempted suicide might not include CPR and intubation?”)

7. Does the legalization of Medical Assistance in Dying change how I should respond?

Key Considerations

Broadly speaking the legalization of Medical Assistance in Dying (MAiD) does not change how first responders or care providers should respond to cases of suspected suicide attempts outside of legally compliant actions within a defined MAiD process. Health care providers also have professional responsibilities, code of ethics, and professional standards to meet.

Here are four types of situations to consider:

a) MAiD eligibility status is unknown by the paramedic, first responder or healthcare provider;
b) A person has declared a wish for MAiD verbally or in writing, but no formal process has yet been undertaken;
c) A person has been declared eligible through a formal process, whether or not arrangements for provision have been made;
d) A paramedic is asked to attend a MAiD provision that is in progress, to assist with complications.

In situations a), b), and c) the actions of a healthcare provider should be as in any other suicide scenario using the principles outlined above. As in all cases, they should respond with the provision of clinically indicated interventions, including interventions to preserve life. The exact interventions provided may be influenced by the proximity to natural death as described in question 3 above ("Are there times when a response to an apparent attempted suicide might not include CPR and intubation?").

In situation d) there are infrequent occasions where a paramedic may be asked to attend to help manage complications when a MAiD provision is not proceeding as expected, for example during a self-directed oral provision. In Alberta, in such a situation, a provider (MD or NP) would normally be in attendance to assist the patient. Intervention that frustrates the intention of the patient, in the midst of the legal provision of MAiD, would not be appropriate. A paramedic should not administer medication to cause death nor take action to prevent the death of the patient, but may be asked to insert an intravenous or assist in management of symptoms that are felt to be causing suffering of the patient.

See: https://abparamedics.com/wp-content/uploads/2020/02/Position-Statement-MAID-October-2017.pdf

The formal process to access MAiD is clearly laid out elsewhere. See Formal MAiD Process

CASE EXAMPLE – attempted suicide in the setting of a declared wish for MAiD

A female in her 50's with a long-term progressive, irreversible degenerative disorder is becoming more and more debilitated and expressing to her husband her wish not to be "a burden on him" and her desire not to allow the disease to kill her slowly. She has expressed an interest in MAiD. She has not yet gone through the assessments for MAiD and has no GCD order in the home. She has had amitriptyline for symptom and sleep control.

Her husband finds her unconscious in their bed and calls paramedics – the empty bottle of amitriptyline, which was filled recently, is on the bedside table. She appears to have taken 50 of the 10mg tabs. The husband presents the paramedics with the bottle he found and a brief history of her illness and the GCD discussion, which was going to happen today with their physician. He tells the paramedics on scene he is her agent on her Personal Directive (not enacted) which states that she would not want "life prolonging measures when her death is imminent" and that her GCD was going to be an M2 (which he understood as she wanted treatments at home for reversible issues and to allow natural death if there was nothing reversible).

The paramedics assess the patient to be unresponsive with a respiratory rate around 8 BPM and a radial pulse palpated at around 110 BPM. The paramedic's ECG shows a broad QRS consistent with TCA cardiotoxicity. They stabilized and transferred her to hospital where she was provided with medical treatments and she slowly regained consciousness. Later she went on to formally request and receive MAiD.

Summary

This case illustrates appropriately intervening to attempt to preserve life during an apparent suicide attempt and that was not part of a legally defined MAiD process.

CASE EXAMPLE #2 – suicide attempt with a considered decision to end one's own life, absent any impairing mental illness

A man with intractable suffering and a reasonably foreseeable death has been assessed and found eligible for MAiD, but he decides that he should have ultimate control over the mode and time of his death and that the doctors and pharmacist should not play a part in this. He writes a note that states his reasoning for why he has chosen to die by self-asphyxiation: "Should I be found while I am still alive I want you to know that I do not want to be resuscitated and that I am making this decision in sound mind and with full awareness of the consequences. I would consider any attempt to resuscitate me as a physical assault against my explicit wishes." His wife is comfortable with his decision, has witnessed his note and has left the home for the day to allow him to die in peace. Moments after he takes his own life his homecare nurse arrives at the home. She has known him for 2 years and was aware he had been approved for MAiD, but did not know that he was planning to end his life on this day. She finds him pulseless and apneic, but warm. She reads his note and decides not to attempt resuscitation because she considers this not as a suicide attempt but as a considered decision to end his own life, absent any impairing mental illness. She contacts his doctor, who calls the Office of the Chief Medical Examiner and the police. No illegal activity is deemed to have occurred.

Summary

This is an example of the rare, exceptional situation mentioned in the background section (page 2) that there is no mental illness, the person had no capacity issues, has been deemed eligible for MAiD and the healthcare provider interprets this situation as a thoroughly considered decision by a person to end their own life.

8. What education or review are available to my team to explore these issues further?

The AHS Clinical Ethics Service provides education about ethical issues, like responding to attempted suicide, and can also help teams debrief after an ethically challenging case has arisen. Information about the Clinical Ethics Service is at Clinical Ethics Service. Additional information can be found on insite.

Advance Care Planning, Goals of Care Designations and Personal Directive education is available via Conversations Matter.

9. I've had a challenging encounter, who can I talk to?

If a challenging encounter has occurred, the first step is to acknowledge and honour the fact that this distressing experience is beyond the ordinary parameters of our practice. If such an experience is minimized or disenfranchised, the impact on the individual can be compounded. It is normal for people to be significantly impacted by such an encounter, both personally and professionally. It is common to experience distress, grief, and even trauma.

As such, it is important to seek support in processing any concerns or feelings that might arise. Please reach out to debrief with your colleagues and team leads, and connect with your Employee and Family Assistance Program or other mental health practitioner to more fully process the impact of the experience, and keep reaching out until you find what you need.

AHS staff, including paramedics, can use the resources at the Employee and Family Assistance Program. More information can be found on insite by searching: Employee and Family Assistance Program (EFAP).

Physicians can use the Alberta Medical Association Physician and Family Support Program or telephone 1-877-SOS-4MDS (1-877-767-4637)

Other non-AHS healthcare providers, please go through your supervisor and local support networks.

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