MEDICAL AID in Dying

A Physician's Perspective

LEARNING OBJECTIVES

- 1) Understand the legal requirements around MAiD
- 2) Understand the MAiD process from assessment to provision
- 3) Appreciate the role of MAiD in end-of-life-care

OUTLINE

- Brief review of the law
- Review of the process
- Patient stories
- Challenges
- Personal reflections

A bit about me….

- 400 bed McGill affiliated teaching hospital
- Mostly hospital-based, practicing on Internal Medicine and Oncology Ward
- Long standing interest in end of life care, particularly MAiD
- Many presentations to residents and staff, as well as FMF
- Current member, past chair of ethics committee

Only a patient who meets all of the following criteria may obtain medical aid in dying:

- (1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
- (2) be of full age and capable of giving consent to care;
- (3) be at the end of life;
- (4) suffer from a serious and incurable illness;
- (5) be in an advanced state of irreversible decline in capability; and
- (6) experience constant and unbearable physical or psychological suffering which cannot be relieved **in a manner the patient deems tolerable.**

Before administering medical aid in dying, the physician must:

- (1) be of the opinion that the patient meets all the criteria of section 26, after, among other things,
- *(a)* making sure that the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure;
- *(b)* making sure that the request is an informed one, in particular by informing the patient of the prognosis for the illness and of other therapeutic possibilities and their consequences;
- ***(c)*** **verifying the persistence of suffering** and that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals given the progress of the patient's condition;
- *(d)* discussing the patient's request with any members of the care team who are in regular contact with the patient; and
- *(e)* discussing the patient's request *with the patient's close relations*, if the patient so wishes;

Criteria and conditions prescribed by law
QUEBEC Act respecting end-of-life care – ARELC

26. Only a patient who meets all of the following criteria may obtain medical aid in dying:
(1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
(2) be of full age and capable of giving consent to care;
(3) be at the end of life;
(4) suffer from a serious and incurable illness;
(5) be in an advanced state of irreversible decline in capability; and
(6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.
[...]

(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.
241.2 (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 that cannot be relieved under conditions that 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 that they have remaining.

Federal vs. Quebec

- + nurse practitioners
- + assisted suicide
- + independent 2 witnesses
- “reasonably foreseeable” (vs “imminently dying”)
- Reporting

End of Life

- The Quebec legislator insisted on this criterion, which restricts access to MAID to a certain category of patients, without providing an explicit prognosis, allowing the variability of end-of-life trajectories to be taken into account

Ever changing Landcape…

- Judgement Sept 2019 by Justice Baudouin essentially saying the provision requiring RFND (or terminally ill) violates the rights to liberty of the individual
- Case involved Mr Truchon, age 51, with spastic cerebral palsy and Ms Gladu, 73, with poilo
- Quebec government also reviewing possibility of allowing some form of advanced directive/request
- Mental illness/dementia (Ms Wilson, B.C.

Physical Suffering

- Cachexia
- Dysphagia
- Dyspnea
- GI obstruction
- Pain
- Paralysis
- Exhaustion
- Hemorrhage
- Severe Wounds

Psychological Suffering

- Despair in a hopeless situation
- Loss of Dignity
- Loss of Autonomy/Dependency

Assessment of capacity

- Must understand diagnosis/prognosis
- Must know about alternatives to assisted death

Same as we do for every other medical procedure

The « GIS »

- Groupe Interdisciplinaire de Soutien
- The GIS offers close clinical, administrative, and ethical support to health care professionals involved in MAD.

Benoit Morin *PDG*	Lynne McVey *PDGA*	*Médecin soins pall.*
Gestionnaire de projet	Chantal Côté, *Adjointe à la PDGA*	*Ombudsman*
Éthicienne	Nathalie Tétrault, *Communication*	Venise Calluzzo, *Adj. Dir. Services multi*
Dir. Adjointe SAPA PROGRAMME SOUTIEN À L'AUTONOMIE DES PERSONNES ÂGÉES	Manon Allard, *Dir. Adjointe DSI*	*Cons. Soins inf.*
agent spirituel et religieux	Karine Gimmig *Infirmière pivot*	*Pharmacienne*
CC DPS	*Travailleuse sociale*	*Travailleuse sociale*

THE PROCESS

- Patient makes request; GIS team is informed
- Patient signs legal document requesting MAiD
- GIS team then identifies 1st MD who will accompany patient through the process
- MD meets with patient, reviews the chart, determines if patient meets criteria, completes forms
- GIS (ideally) identifies second MD for opinion who assesses patient, and fills forms
- Ongoing meeting with patient (+/-) family to affirm patient's wishes, decide a date and time (with documentation in the chart),…minimum 10 days after request (exceptions possible)

THE PROCESS

- Plans are made, including meeting with other members of health care team, moving patient to private room, etc
- May require a teleconference with GIS team to review details of the patient's case
- 1 day prior to the planned event, meeting with pharmacist to review the kit, sign forms.
- Ensure proper IV access
- Finalize decision with patient, with any particular wishes/concerns

THE PROCESS

- On the day of, meet again with patient, confirm time etc
- At the appointed time, walk to the patient's room, accompanied by nurses and carrying the kit
- Explanation provided to all who are present
- Encourage family to be as "present" as they wish to be
- Confirm patency of IV
- Administer medication

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Québec

Name: _____
RAMQ N° : _____
Address: _____
_____
Known severe allergies _____
_____
_____

Medical Prescription
Medical aid in dying (MAD)

Scheduled date and time of administration:

_____

NOTE :
The medications must be ready for administration without further handling. They must be placed in two identical kits.

ANXIOLYSis					
		Total quantity (divided between 2 kits)	Dosage	Notes	Physician initi
	Midazolam 1 mg/ml	2 x 10 mg (10 ml) syringes	2,5 to 10 mg (2,5 to 10 ml) IV over 2 minutes	Titrate according to patient's response	

COMA INDUCTION					
Select **ONE** local anaesthetic:					
		Total quantity (divided between 2 kits)	Dosage	Notes	Physician initi
	Lidocaïne without epinephrine 20 mg/ml	2 x 40 mg (2 ml) syringes	40 mg (2 ml) IV over 30 secondes	1st choice	
	Magnesium sulfate 500 mg/ml	2 x 1000 mg (2 ml) syringes NaCl 0,9 %) slow IV injection (5 minutes)	1000 mg (2 ml) (combined with 10 ml	2nd choice, if allergic to Lidocaïne	
Select **ONE** coma inducer:					
		Total quantity (divided between 2 kits)	Dosage	Notes	Physician initi
	Propofol 10 mg/ml	2 x 4 x 500 mg (50 ml) syringes	1000 mg (100 ml) slow IV injection (5 minutes) Use 2 x 500 mg (50 ml) syringes In any doubt with respect to coma induction, increase the dose	Shake before using Do not refrigerate Double dose in each kit in case of doubt with respect to coma induction	
	Phenobarbital 120 mg/ml (25 x 1 ml)	2 x 2 x 3000 mg (25 ml) syringes	3000 mg (25 ml) (Combined with 50 ml NaCl 0,9 %) slow IV injection (5 minutes) In any doubt with respect to coma induction, increase the dose	2nd choice, Double dose in each kit in case of doubt with respect to coma induction	

INJECTION OF NEUROMUSCULAR BLOCKING AGENT					
Select **ONE** neuromuscular blocking agent:					
		Total quantity (divided between 2 kits)	Dosage	Notes	Physician initials (1)
	Rocuronium bromide 10 mg/ml	2 x 200 mg (20 ml) syringes	200 mg (20 ml) fast IV	1st choice	
	Atracurium besylate 10 mg/ml	2 x 100 mg (10 ml) syringes	100 mg (10 ml) fast IV	2nd choice	

RINSE THE INJECTION DEVICE					
before starting the protocol, after administering the coma inducer, and after injecting the neuromuscular blocking agent					
		Total quantity (divided between 2 kits)	Dosage	Notes	Physician initials (1)
	NaCl 0,9 %	2 x 4 x 10 ml syringes	1 x 10 ml IV to check catheter permeability 2 x 10 ml IV after injecting the coma inducer 1 x 10 ml IV after injecting neuromuscular blocker		

ESTABLISHING VENOUS ACCESS

Select the necessary materials:

Total quantity (to be divided between 2 kits)	Material	Indication	Physician initial (1)
2 x 3	Disinfecting pads	Skin disinfectant	
2 x 2	Gauze compresses 10 x 10 cm		
2 x 1	Short catheters 18 G		
2 x 2	Short catheters 20 G		
2 x 1	Short catheters 22 G	If difficulty inserting a bigger catheter	
2 x 1	Short extensions	If using an intermittent venous access device intermittent	
2 x 2	Intermittent venous access devices		
2 x 2	Clear sterile eye pads		
2 x 1	Adhesive tape		
2 x 15	Syringes with 1-inch 18 G needles		

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Québec

Log for the use of medications for medical aid in dying, for the physician and the pharmacist

Kit No. 1

RISK MANAGEMENT: THE ADMINISTRATION SEQUENCE MUST BE SYSTEMATICALLY RESPECTED

PATIENT	ATTENDING PHYSICIAN	PHARMACIST
Name: _____	Name: _____	Name: _____
RAMQ No: _____	Permit to practice No.: _____	Permit to practice No.: _____ Contact info.: _____
File No: _____	Contact information: _____	Lock #: _____ Preparation pharmacist: _____
Date of death: _____		Case pharmacist: _____

KIT NO. 1 – MEDICATIONS

Prescription No.	Kit (seal No.)	Medication		Dosage	Handed to physician			Injected		Returned to pharmacy			Destroyed		
Date:					Date:			Date:		Date:			Date:		
		Name	Strength		Qty (ml)	Md*	Phm*	Qty (ml)	Md*	Qty (ml)	Md*	Phm*	Qty (ml)	Md*	Phm*
	KIT NO. 1														
	1 ANXIOLYTIC AGENT – BENZODIAZEPINE														
111-221		*Midazolam*	*1 mg/ml*	*2.5 to 10 mg titrated*	*10 ml*										
	LOCAL ANAESTHETIC (SELECT ONE)														
111-225		*Lidocaine 2% (without epinephrine*	*20 mg/ml*	*40 mg*	*2 ml*										
		Magnesium sulfate	*500 mg/ml*	*1000 mg*	*2 ml*										
	2 COMA INDUCER (select one)														
111-224		*Propofol*	*10 mg/ml*	*4 x 500 mg*	*4 x 50 ml*										
		Phenobarbital	*120 mg/ml*	*2 x 3000 mg*	*2 x 25 ml*										
	3 NEUROMUSCULAR BLOCKER (SELECT ONE)														
		Cisatracurium	*2 mg/ml*	*30 mg*	*15 ml*										
		Atracuronium	*10 mg/ml*	*100 mg*	*10 ml*										
111-222		*Rocuronium*	*10 mg/ml*	*200 mg*	*20 ml*										
	SYRINGE FLUSH														
111-223		*NaCl*	*0.9 %*	*4 x 10 ml*	*4 x 10 ml*										

KIT NO. 1 – MATERIALS

Prescription No.	Kit (seal No.)	Materials	Handed to physician Seal #2) _____			Returned to pharmacy Seal #3) _____			Destroyed		
			Date:			Date:			Date:		
			Qty	Md*	Phm*	Qty	Md*	Phm*	Qty	Md*	Phm*
111-226		Skin disinfecting pads	3								
111-227		Short catheters 20 G	2								
111-228		Short catheter 22 G	1								
111-229		Short extension	1								
111-230		Intermittent drip access devices	2								
111-231		Sterile clear occlusive bandages	2								
111-232		Adhesive tape	1								
111-233		Gauze compresses 10 x 10 cm	2								
111-234		Tourniquet	1								
111-235		Numbered seals	3								

THE PROCESS

- After patient has died, similar to any patient's death (mostly)
- Comfort/support to family
- SP 3 form filled, cause of death is underlying illness
- Online forms completed
- Debrief with staff (including PABs, nurses, Physio), with help of Spiritual Care, Psychologist, and/or ethicist
- Return to other clinical work

Patient M.B. (1)

- 92 y/o male, ex-journalist
- 1 daughter here, rest of family in France
- End stage lung cancer, bed ridden, but mostly in no "physical" distress
- Very articulate (La mort, c'est naturel)
- Met him on my first day on service, though I was told he had brought up the subject of MAiD
- Very supportive family, though stressful for daughter
- Waited for rest of family from France
- He conducted an interview with Radio Canada concerning his decision
- Thursday at 13:00, right after my clinic
- Kids, spouses in the room 8 in total; he was comforting them!
- Subsequent letter from government requesting clarification of competency

Patient R.D (2)

- 85 y/o woman
- Progressive ILD and CHF
- Visited in Vivalis
- Met with patient and daughter
- Comfortable at rest, marked dyspnea on minimal exertion
- Helped me gain insight as to nature of suffering

Patient F.N. (1)

- 58 y/o male, known to me from before
- Colon Cancer, spinal mets, paralyzed
- Marked deterioration, physically and psychologically over 2 weeks
- Not very expressive verbally, but I had no "doubts"
- Wife present, not really speaking English/French
- I was contacted prior to my actual return on service
- Unable to locate second physician
- Concern was around the 10 day waiting period; advocating for patient with GIS
- Patient requested flowers and music
- About 15 people when I walked in the room

Patient K.G. (1)

- 85 y/o male, end stage lung cancer
- Known to me, multiple admissions over previous 3 months
- Was under PCU
- Again, contacted by GIS prior to me being on service
- Patient was weak, with language difficulties
- Had already started to starve himself
- After my first assessment, I didn't feel he was competent, since he was essentially too weak/confused to articulate his wishes
- Reassessed the following week (he started eating); difficult to talk with patient; long discussion with family who confirmed his wishes (he had actually 3 different plans)
- With some reticence I agreed to start the process…but his condition deteriorated, so received palliative sedation, and died shortly thereafter

Patient T.J. (2)

- 78 y/o male
- Medical ward, end stage COPD
- Met with patient; I agreed he satisfied the criteria as per the law, but I sensed an uncertainty from him. I shared this with the GIS team.
- My "responsibility" was complete upon filling the form; the subsequent outcome would be left to the 1st MD and GIS team

Patient D.G. (1)

- 80 y/o male on the medical ward
- HCC, underlying cirrhosis
- I was contacted while I was about to leave town for the day (Friday)
- Concern from the treating team about how to medicate him for his pain while still ensuring he would be "competent" to engage in the MAiD process
- I was able to meet him 4 days later; I reviewed the chart, and met with the patient
- At that time he was confused and drowsy (?encephalopathic), therefore not a candidate to receive MAiD. He died within 3 days

CHALLENGES

- Defining "end of life"
- Offering MAiD as an option
- Understanding/accepting suffering from the patient's perspective
- Finding an "appropriate" physician for the second opinion
- Verifying "persistence of suffering"; requires ongoing discussions; balance need to control sxs with need to maintain "competence"
- Recognizing the impact on the other members of the multi-disciplinary health care team
- Balancing the 10 day delay with the patient's needs
- Resolving potential conflicts with family or other concerned individuals

PERSONAL REFLECTIONS

- The end of a long journey; theory into practice
- Gratifying to help, sense of peace and calm (when all in agreement)
- Understanding my own biases
- The reality of giving the second opinion
- Unexpected sequlae (assassin)
- Feeling the burden (when you see a text from…)
- How do others see me?
- Home visits
- Support (?encourage) others; mentoring

Final Thoughts

- I am grateful to those who have been by my side supporting me, in particular Chris Morin and Jennifer Wilson
- Having witnessed, and been "present", for many deaths, this seems familiar, and yet very different
- Affirms what I always thought about what it means to choose how and when to die; reflected in the faces of the patients when then they are told their wishes will be respected, and in the final moments
- The benefit to friends and family cannot be underestimated
- Professional and personal…

Canadian Association of MAiD Assessors and Providers

www.CamapCanada.ca

QUESTIONS?

Mr W

- 59 y/o male, Chinese origin
- Metastatic colon CA, with cord compression, persistent paralysis despite chemo/radiation
- First looked after him for 2 weeks; never really discussed end of life issues
- Generally not very open to sharing feelings
- Remained optimistic as to recovery as he waited for chemo
- I was contacted 10 days after leaving service that he expressed wish for MAiD
- Visited him; marked deterioration: weaker, lost weight, more discomfort

Mr W

- Difficult to have him express in depth his feelings, but clear he was ready to die, didn't want to continue waiting for the inevitable
- Had been told no further chemo
- Wife was present, in agreement, though she spoke very little English or French
- Struggled to find the required second opinion; I ended up recommending a colleague, after being asked to find someone in my capacity as Division Director (they didn't know I was the primary MD)
- By new Quebec regulation, 10 days wait required between request and act; I felt this couldn't wait because of his suffering, and I was afraid he would lose ability to consent
- Advocated for waving of this, which was supported

Mr W

- Patient requested flowers and music in his room
- He was moved to a private room
- Prior day met with pharmacist to review the “kit” as proscribed by law
- Following day arrived in his room with the “kit”, and 2 nurse colleagues; there were 12-15 family members in the room
- Wife remained at bedside holding his hand during the act; took about 10 minutes ; no complications
- Family grateful afterwards
- Debrief with floor staff, including psychologist, spiritual care, ethicist and nurses

Summary

- Patient dying with end stage cancer received his wish for a planned and peaceful death, on his terms, with family present
- Challenge of balancing legal requirements (10 day delay, maintaining competence) with best interests of the patients
- Challenge of insufficient number of physicians, and inefficient system to recruit and/or identify more
- Thankful to have nursing support
- Overall a very positive experience for all