Teaching residents about medical assistance in dying

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All family practice residents need to know the basics about discussing end-of-life care with patients, their caregivers, and loved ones. This might entail imparting knowledge, skills, and attitudes with respect to medical assistance in dying (MAID). Medical assistance in dying became legal in 2016 (2015 in Quebec), and in the past year, about 1% of all deaths in Canada were assisted by clinicians.[1,2] Different health authorities reported MAID rates of between 5% and 0.5%. As our laws and societies are similar to those of the Netherlands and Belgium, we can expect that within a few years, the rates of MAID across Canada will be 4% to 5%.[3,4] This translates to 13 000 deaths annually. All family doctors must be prepared to answer questions from patients about MAID and give accurate information regardless of their personal feelings and values. Some will want to do assessments and some will also want to provide MAID for their patients. Most health authorities will have a program in place to mentor those practitioners who wish to provide MAID.

Here is a reminder about our duty of care from the Canadian Medical Association Code of Ethics:

> 11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.[5]

> 21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.[5]

Early data from the Canadian experience indicate that the people who choose MAID are similar to those in other jurisdictions, in that the most common medical diagnosis is cancer, with neurologic disease and organ failure next most common.[1,2,6,7-9] The most common reasons for choosing MAID include desire for autonomy, lack of the ability to do enjoyable or meaningful activities, and symptoms such as pain.[7-10]

Assessment for eligibility

Two independent physicians or nurse practitioners (ie, they are not each other's employer, mentor, etc) must complete provincial forms documenting their assessments. Nurse practitioners cannot be MAID assessors or providers in Quebec.

The eligibility requirements are as follows:

- The patient is eligible for health services funded by a government in Canada.
- The patient is at least 18 years of age.
- The patient is capable of making this health care decision. (Patients might be capable of making this decision even if they have mental illness or dementia, provided they understand the nature of their medical conditions and the alternatives for treatment or palliation of their symptoms.)
- The patient has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the patient to endure physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the patient considers acceptable. The patient is in an advanced state of irreversible decline and natural death is reasonably foreseeable. (There is no time frame required, but the death should be reasonably predictable given all the medical information, according to the clinical practice guideline from the Canadian Association of MAID Assessors and Providers.[11]) In Quebec the patient must be deemed to be imminently dying (again without a clearly defined time frame).
- The patient has made a voluntary request for MAID that was not made as a result of external pressure.
- After having been informed of the means that are available to relieve their suffering, including palliative care, the patient has given informed consent to receive MAID. (Consent is required at the time of the request and again at the time of death, and provincial forms are used.)

Provision of MAID

Provision of MAID should be patient-centred and the patient should be given choices about when, where, and how to die, and who will be present. There is a 10-day waiting period between the request and the death, but this can be waived if the death or loss of capacity will likely occur within those 10 days. Some patients choose to die while they still are strong enough to care for themselves, because they value their autonomy highly, while others prefer to wait until the symptoms become unbearable. Some patients choose to be at home and others in the facility where they are receiving care. Except in Quebec, where only intravenous (IV) medications are used, patients can choose to self-administer oral medications or have the clinician administer IV medication. Standard protocols are available in each province and some provinces have preprinted prescriptions. The most common IV protocol is 10 mg of midazolam, then 1000 mg of propofol, followed by 200 mg of rocuronium. It is important to ensure that the patient is in full coma before giving

the muscle relaxant. A 15-g dose of secobarbital is one of the oral protocols, and it is essential that an antiemetic, such as ondansetron, is given ahead of time. The IV route takes 5 to 10 minutes to complete while the oral route usually takes 20 to 60 minutes. Both provide a very peaceful death and do not include agonal breathing (the death rattle). Some jurisdictions require that the clinician is present until death, even with an oral protocol. In such circumstances the provider might need to have the IV medications ready to give if death does not occur within an acceptable time frame. Very few Canadians have used the oral route to date.

Conclusion

Family practice residents must understand how to discuss end-of-life care with patients and their families. This includes an understanding of and approach to the assessment and provision of MAID, so that they can offer correct information to their patients. Ideally, residents should be given the opportunity to witness an assessment and, if they are comfortable, a provision as well. Often the knowledge that MAID is available allows patients to face their next treatment or their deaths with less anxiety and to help them feel more in control. This is true for the patients who receive MAID and for those who only have conversations about it.

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Competing interests
None declared

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Teaching tips

- Family doctors must be prepared to answer questions from patients about medical assistance in dying (MAID) and give accurate information regardless of their personal feelings and values.
- Ideally, residents should be given the opportunity to witness an assessment and, if they are comfortable, a provision of MAID.
- The knowledge that MAID is available often allows patients to face their next treatment or their deaths with less anxiety and to help them feel more in control. This is true for the patients who receive MAID and for those who only have conversations about it.

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