Request for medical assistance in dying from a geriatric patient in primary care

Understanding eligibility and promoting a patient-centred approach

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The introduction of medical assistance in dying (MAID) legislation in Canada in June of 2016[1] brought some of the unease physicians feel around end-of-life care to the forefront. The "reasonably foreseeable" wording of the legislation allowed for a considerable degree of physician discretion with regard to which patients qualified for MAID in Canada.[2] In particular, *completed life*[3] MAID requests—a term originating in the Netherlands referring to MAID requests from elderly patients without serious medical conditions—walk a very fine line between medical suffering and existential distress. Our case, which occurred before changes to the eligibility criteria in the legislation on March 17, 2021,[4] offers some illustration of such challenges.

Case

Mrs X. was a 92-year-old widow living in a house with personal support worker assistance. Her medical history was relevant for arthritis, macular degeneration, and depression. In the past 3 years she had suffered from incremental vision loss, worsening mobility, and substantial intrusion on her sense of autonomy. Her driver's licence had been revoked 2 years ago, and she was unable to read. She could walk short distances with a walker and otherwise used a wheelchair. Her medications included mirtazapine and escitalopram, and acetaminophen for pain. She came in for routine visits with either of her 2 sons. Her depression was reasonably well controlled. Her functional status was optimized to her circumstances. She participated in community activities and family events, although this had become increasingly difficult. During a routine visit in 2019, her son mentioned that if his mother qualified for MAID, he thought she would want it. In fact, she had mentioned to him that she did not see the point in living anymore. Mrs X. had nodded in agreement. Her son reported that he did not believe his mother qualified because of the "reasonably foreseeable" clause in the MAID legislation.

Like her son, Mrs X.'s primary care team presumed she did not meet criteria for MAID because, as she did not have a terminal diagnosis, her death was not reasonably foreseeable. Through further inquiry, the team learned that such cases often did, in fact, meet the criteria, and follow-up was organized.

During follow-up, Mrs X. was accompanied by both her sons. The previous visit was reviewed and misconceptions around MAID eligibility criteria were addressed. Mrs X. reported feeling considerably better since her last visit; her expression of wanting to die was a feeling of hopelessness and frustration. The week before her last appointment, she had newly been unable to go to the bathroom on her own. She had resented the increase in care needs. On the morning of her appointment, she had had a near fall and had been feeling particularly vulnerable.

Both of Mrs X.'s sons listened attentively, offering appropriate suggestions and support. Made aware of their mother's need for visitors and family

Editor's key points

- This case report demonstrates the complexity of medical assistance in dying (MAID) requests among geriatric patients. It illustrates how the subjective language of the legal criteria is challenging and, at times, confusing for both physicians and patients.
- A MAID request does not always represent a request to die, but always opens an opportunity to discuss the nature of suffering and goals of care.
- Involving family, with consent and when appropriate, is important to facilitate patient engagement and discern and address underlying issues contributing to the MAID request.

Points de repère du rédacteur

- Ce rapport de cas met en évidence la complexité des demandes d'aide médicale à mourir (AMAM) pour les patients gériatriques. Il illustre la mesure dans laquelle le langage subjectif des critères juridiques est problématique et porte parfois même à confusion pour les médecins et les patients.
- Une demande d'AMAM n'équivaut pas toujours à une demande de mourir, mais elle offre toujours la possibilité de discuter de la nature de la souffrance et des objectifs des soins.
- Avec le consentement du patient, et si la situation s'y prête, il importe d'impliquer la famille pour faciliter la participation du patient, de même qu'élucider et aborder les éléments sous-jacents qui ont amené à présenter une demande d'AMAM.

care, they made plans to have out-of-town family visits on a more frequent rotating schedule.

When the subject of MAID was revisited, Mrs X. reported that she was not ready to die. She believed she had much to look forward to and enjoy—in particular, her sons and other family. She expressed hope about the future. Mrs X. and her family were provided with MAID pamphlets and referral information for possible future purposes.

At her next visit, Mrs X. was in better spirits. Her son from Montreal, Que, had been staying with her, and she was looking forward to another upcoming family visit. Her son from Toronto, Ont, had arranged for several alterations in the house to enhance her mobility, which she initially resisted but came to appreciate. She continued to feel frustrated by some of the things in which she could no longer participate; in particular, she missed skiing in the winter months, and she complained about personal support workers not giving her enough independence.

Discussion

Mrs X.'s case represents a particularly challenging scenario for family physicians. Like her son, many would have presumed she did not qualify for MAID in the absence of a terminal diagnosis. However, when one carefully reviewed the previous legislation, many of these cases did, in fact, meet criteria for MAID. Before changes to the legislation, patients had to meet the following criteria:

1. have a serious and incurable illness, disease, or disability;
2. be in an advanced state of irreversible decline in capability;
3. experience unbearable physical or psychological suffering from the illness, disease, disability, or state of decline that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
4. be at a point where their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a specific prognosis as to the length of time remaining.[1]

Mrs X. could have met criterion 1 by virtue of her arthritis, macular degeneration, or clinical frailty. She certainly met the second criterion. Suffering is subjectively determined in the legal criteria, and if she refused further interventions, then she would have met criterion 3. Criterion 4 is part of what created a tremendous amount of leeway with respect to eligibility for MAID. Without requiring a specific prognosis, many, if not all, of our frail, elderly patients might have been eligible. Such patients now are much more clearly eligible for MAID under the new legislation, which removes criterion 4. The presence of a reasonably foreseeable natural death now determines only the route of access to MAID, as under the new legislation those without a reasonably foreseeable natural death must undergo a more rigorous evaluation process requiring a minimum of 90 days and expertise in the condition causing the patient's suffering, either on the part of the MAID assessors or through consultation with an expert. Identifying the nature of such medical expertise in a case such as Mrs X.'s could pose a challenge for many family physicians.

Many requests for MAID from geriatric patients will meet criteria for eligibility, and patients intent on pursuing MAID should be provided with access to options. However, like any "presenting problem" in family medicine, a MAID request can be an invitation for further exploration that leads to a deeper understanding of the patient and their situation. One should not presume that a stated wish to die is equivalent to a MAID request. Requests for MAID can represent an expression of suffering or frustration, or a plea to be heard. As with other geriatric issues, and as illustrated in this case, involving family, with consent and when appropriate, is important to facilitate patient engagement and discern and address underlying issues contributing to the request.

The new legislation will open eligibility to MAID for many patients who would not previously have thought it was an option. The definition of what constitutes a reasonably foreseeable natural death remains entirely left to the judgment of the evaluating physician or nurse practitioner, although rather than determining eligibility for MAID, it now determines how safeguarded the route to accessing MAID should be. This only underscores the importance of having thoughtful, compassionate, patient-centred conversations with our geriatric patients and their families.

In the Netherlands, where "unbearable suffering" is a criterion for euthanasia, it was found that it is often the combination of physical suffering and psychosocial distress that causes the suffering to become "unbearable."[5] It therefore behooves us, as physicians, to provide our patients with the time, space, and support in which to explore these different components of their suffering. This exploration provides a unique moment for truly patient-centred, meaningful geriatric care. It can serve as an opportunity to restore dignity and a sense of control to patients who feel they have lost so much of it.

While these conversations are not easy to have, engaging in them allows us to deepen our understanding of our patients, their families, and the difficult challenges of living, aging, and dying. Some clinicians might even choose to introduce the topic of MAID to inform capable patients with clinically significant frailty of the option, although this is a controversial practice that is neither clinically required nor prohibited. It is our duty and unique privilege as family physicians to support our patients and their families in this process.

Conclusion

Despite changes to the legislation, the eligibility criteria in Canada can be confusing for both patients and physicians, and require careful consideration, particularly in the primary care setting. While MAID requests can represent a request to die, they can also be an expression of suffering that warrants attention, exploration, and potentially treatment from family physicians.

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Competing interests
None declared

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