Clarifying MAID eligibility

In his article centred on advance directives in the June issue of *Canadian Family Physician,*[1] Dr Joel Wohlgemut makes 2 important errors about medical assistance in dying (MAID) eligibility.

His first mistake is in his understanding of what constitutes a reasonably foreseeable natural death (RFND). *Reasonably foreseeable* is best understood as reasonably predictable. Patients with dementia who are close to losing capacity almost always have a reasonably predictable natural death, given the average life expectancy of 5 to 6 years from the time of diagnosis, let alone from the time of loss of capacity. Some clinicians are under the assumption that the patient must be terminally ill to be found to have an RFND. This is not the case, as is clear from the law itself and also from the findings of *A.B. v Canada*.[2]

The second mistake is that even if an RFND is deemed not to exist, the change in the law in March 2021 allows MAID for patients without an RFND after a 90-day assessment period, although a waiver of final consent may not be signed by patients in this group.

Patients choosing to have MAID must have a grievous and irremediable condition. This is defined as having a serious and incurable illness, disease, or disability; an advanced state of irreversible decline in capability; and intolerable suffering due to the illness or the decline and as judged by the patient rather than the assessing clinician. Patients with dementia do have a serious illness. The anticipated loss in the near future of decisional capacity—the right to make decisions about one's own care—is, in and of itself, evidence of their advanced state of irreversible decline in capability. It is for the patient to decide if they are suffering intolerably; those who choose to have MAID because of their dementia have decided that they are.

Dr Wohlgemut's main argument is around the issue of advance requests for MAID within the more general issue of advance directives. I fully support his sensible call for careful discussions about the issue. However, the discussions should be informed by accurate information about the status quo and it is important that clinicians and patients alike should not be misled into believing that MAID is currently unavailable for patients with dementia who still have capacity but who lack other conditions leading to an RFND. It is especially important that clinicians in positions such as Dr Wohlgemut's do not provide patients, their families, and other supporters with erroneous information about MAID for dementia.

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Competing interests
None declared

References

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Head-to-head IUS comparison needed

I was excited to see an article about a subdermal etonogestrel implant (Nexplanon) in the August 2022 issue of *Canadian Family Physician,*[1] as this form of long-acting reversible contraception is less well known, having been approved in Canada in May 2020. Upon further reading, however, I found the takeaway points of increased amenorrhea (29% vs 9% [low-dose levonorgestrel intrauterine device]) as well as a fairly similar discontinuation rate (27% vs 20%)[1] to be misleading. The randomized controlled trial examined in this article compared Nexplanon with the Jaydess intrauterine system (IUS) (13.5 mg levonorgestrel),[2,3] which is no longer available in Canada and has a lower progesterone concentration of 13.5 mg compared with the Kyleena (19.5 mg)[4] and Mirena (52 mg)[5] options, which are available in Canada. Additionally, Jaydess is approved for contraception for 3 years compared with 5 years for the Mirena and Kyleena.

My hope is that providers counseling on contraception options take the article's comparisons with a grain of salt. Better conclusions would be drawn when Nexplanon can be compared head to head with our standard Canadian progesterone IUSs. In fact, research comparing the implant with short-acting contraception options (pill, patch, ring) in terms of patient satisfaction, effectiveness, and bleeding profile is paramount, as it is often those who are not considering an IUS who decide on the implant, in my clinical experience.

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