

Medical assistance in dying: time for physicians to step up to protect themselves and patients

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■ Cite as: *CMAJ* 2017 June 26;189:E849-50. doi: 10.1503/cmaj.170462

Requesting medical assistance in dying (MAiD) is a profound personal decision. Although some physicians do not feel that MAiD should be the responsibility of our profession, a patient who is eligible for MAiD should expect timely access to the service through a simple, well-organized and high-quality process that is compassionately and respectfully delivered. The reality is anything but.

As we near the end of the first year of legal MAiD in Canada, regular reports of problems related to the accessibility and quality of MAiD abound. Institutional policies have forced dying patients to be transferred to other facilities, and physicians to seek employment elsewhere.¹ A report from Quebec has indicated that regional rates of MAiD approval vary between 28% and 79%,² which suggests that the ability of Canadians to access MAiD depends as much on geography as it does on their medical condition and degree of suffering. This wide variability in access and approval is a warning to our profession that between policy and provision, all is not going according to plan. Yet, because we have neither the data nor a Canadian gold standard with which to compare it, we don't know where it is going wrong.

The eligibility criteria for MAiD are vague; this is concerning for our profession because of the dire potential consequences. In Quebec's recently published first-year report, physicians were found to be noncompliant with provincial MAiD regulations in 14% of cases.³ This finding should raise some eyebrows: not because it suggests that doctors are playing fast and loose with the rules, but because — as they submitted the paperwork — these doctors clearly thought they were following the rules. It simply underscores the degree of subjectivity inherent in terms such as “independent,” “serious and incurable” and “end of life” (or “natural death has become reasonably foreseeable,” as it is worded in the rest of Canada), especially when interpreted by an oversight panel that comprises mostly nonphysicians who have never seen or participated in MAiD.

Part of the problem is that the MAiD laws were written and revised by lawyers and politicians, in terms that are all but meaningless to clinicians. As a result of the failure of our profession to define these terms or establish norms of practice, 21 providers are now facing possible professional sanction from the Collège des médecins du Québec, despite apparently acting in good faith.³

KEY POINTS

- Medical assistance in dying is legal, but reports and evidence to date suggest substantial problems with access, quality and oversight.
- These problems have taken, and will continue to take, a major toll on physicians if not addressed.
- Important revisions are needed to the system of MAiD provision and oversight in Canada, and physicians must step up and participate to ensure that these revisions are made.

Many Ontario physicians have taken their names off the official list of willing providers of MAiD.⁴ This is unlikely to have resulted from a newly discovered sense of moral repugnance, but rather from a sense that there is too much “grey zone” and a fear of lack of support. Unless something changes, they won't be the last.

In Holland, the Support and Consultation on Euthanasia in the Netherlands (SCEN) system is an easily accessible network of 600 trained and experienced physicians who can provide information and assessments on short notice, and MAiD when necessary.⁵ SCEN is an enviable model, not only because it is flexible and responsive, but because it constitutes a community of practice that supports the medical community and provides the highest standards of care to the patient. In Canada, by contrast, physicians currently bear most of the burden of navigating a poorly developed referral system to find willing and capable providers for their patients. Some Canadian jurisdictions have developed relatively efficient access systems, but others are still struggling. Alberta has four dedicated full-time coordinators who handle any MAiD requests province-wide and are then responsible for ensuring easy access, compassionately assisting individuals who wish to learn more about MAiD, and connecting them with willing providers of this service in their areas. Ontario's physicians-only referral service has been less successful; with no easy access for the public, many patients and family members are left to navigate the complex system on their own, leading to frustration that often gets directed toward physicians. Recognizing this shortcoming, Ontario is now moving to an Alberta-style referral system that can be accessed by any member of the public. Other provinces should

follow suit as a first step in reducing the burden on all physicians, whether they are conscientious objectors or not.

As a profession, our own abiding interest is standardization of practice in the eligibility and delivery of MAiD across Canada. We need to learn from those regions that are delivering a quality MAiD experience and transfer those learnings to other regions that are struggling. Already, a year of practice has identified a number of unresolved questions related to eligibility — questions that could easily lead to misunderstandings and professional consequences for experienced physicians acting in good faith. For example, in what situations does a patient with a serious and incurable illness and an advanced state of irreversible decline in capability *not* have a natural death that is reasonably foreseeable? Furthermore, if patients do not wish to proceed with MAiD immediately after the reflection period ends, do we assume that they do or did not have “intolerable suffering” and, if so, can physicians be sanctioned for agreeing that a patient’s suffering was intolerable if the patient then chose to tolerate it longer than they had to? What about opinions on the curability of illness? Can a physician consider an illness to be “incurable” if there is a small possibility (< 5%) of cure with very aggressive and burdensome therapy that the patient is not willing to receive? Subjectivity in the notion of intolerable suffering is particularly tricky. If patients report suffering solely from the prospect of admission to a long-term care facility, can this be considered “intolerable suffering” (e.g., “I’d rather die than be admitted to a nursing home”)?

The questions posed above are relatively straightforward compared with questions that we may have to answer if eligibility for MAiD is expanded. If primary mental illness, advance consent and patients younger than 18 years old were to be included, questions would arise about situations in which mental illness could be considered “incurable”; specific additional documentation and safeguards that must be in place for patients requesting MAiD by advance consent, to be implemented in a future anticipated state of illness; and the nature of additional safeguards to ensure competence in mature minors.

Our experience so far should have taught us that we don’t want these questions answered for us by lawyers and politicians. The Canadian medical community did not lead the movement to legalize MAiD, but we are one of the most important stakeholders in the process. We don’t experience the suffering of dying

patients and their families, but we feel disappointment and impotence when our treatments cannot relieve it. We did not set the eligibility criteria, but we are the only ones who face professional and legal sanction when there is a disagreement about eligibility or something doesn’t go according to plan.

Education and training of licensed physicians will be important.⁶ But MAiD training must also extend to undergraduate and postgraduate medical education, where it is currently all but absent, and sometimes actively resisted on a moral basis. Medical curricula cannot avoid the topic of MAiD simply because it is morally controversial. If we fail to train our future physicians because of moral reluctance, we will put them and their future patients at risk.

As physicians, we may not have supported the legalization of MAiD, or fully accepted our assigned role in providing it, but we must bear our share of responsibility for the problems of poor access, unclear eligibility and low quality of MAiD in Canada. This change in the Canadian medicolegal landscape was led mainly by other stakeholders, and our relative lack of involvement has led to negative consequences for our patients and ourselves. When someone decides to make a request for MAiD, we need to be at our very best. We are not there yet, but it’s not too late to do better.

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Competing interests: James Downar reports personal fees from Joule, Inc. (a subsidiary of the Canadian Medical Association), outside the submitted work. He is a current member and former co-Chair of the Physicians Advisory Committee for Dying with Dignity Canada, a not-for-profit organization that advocates for legalization and access to medical assistance in dying in Canada.

This article has been peer reviewed.

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Contributors: James Downar and Louis Francescutti both conceived the idea for this manuscript, drafted and revised it, and approved the final version to be published. Both agree to be accountable for all aspects of the work.

Disclaimer: James Downar is a paid consultant and instructor for Joule Inc. (a subsidiary of the Canadian Medical Association), which is currently offering an educational course on Medical Assistance in Dying for physicians. He was not involved in the editorial decision-making process for this article.

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