



Case # 3

You are an emergency medicine resident. Mr. L. is a 68 year old man with **colorectal cancer** who was diagnosed two years ago. He was initially treated with surgery and chemotherapy, and was symptom free for several months. A year later, he developed abdominal symptoms and was found to have a recurrence. He wasn't a candidate for surgery; his medical oncologist offered him chemotherapy with the hopes of extending his life. Mr. L soon developed pain, nausea, and low energy, and is now followed by palliative care. It is Friday evening and the patient presented to the emergency room for nausea and weakness.

His symptoms have typically been well managed with low doses of opioid analgesics, anti-emetics, and a hypnotic for sleep. He recently returned from his cottage and over the past 3-4 weeks, he felt increasingly worse. The nurse has informed you that his vitals are stable and there are no urgent issues. When you try to elicit a chief complaint, he responds: "Doctor, I'm done. I want to end it and I know it's legal in Canada now."

1. When a patient asks about MAID what is your initial gut reaction?

- a. This can be an emotionally challenging question and can impact residents in different ways. MAID is a controversial topic and physicians have varying viewpoints. These viewpoints are often based on the moral or religious beliefs that we acquire throughout a lifetime and can be deeply ingrained.
- b. When a patient asks a question that is so controversial and touches on our core beliefs, we can be quick to respond before understanding the entirety and complexity of a situation.

2. When a patient like Mr. D. asks about MAID: How would you initially respond?

Consider: The most important initial response is to validate the patient's emotions.

For example: "This sounds like a big change from how things had been going, would you mind telling me more?" or "I'd be happy to answer any questions that you have, but I'm wondering if you could first tell me more about what's been going on / what led you to feel this way."

Caution: It may be tempting to answer in a factual way.

For example: "Mr. D, Medical Assistance in Dying is legal. Do you want a referral for an assessment?"

This is a premature statement without a better understanding of why they are asking for hastened death.

Consider: That when initially responding to a request for MAID, it is an excellent opportunity to ask questions and explore what lead to the patient's request.

For example: "Maybe you could tell me a bit more about how you're feeling."

Caution: Even though as a physician you may not agree with MAID, it is still important to respond in a manner that invites the patient to tell you more about why they are asking about MAID.

- i. Remember that as physicians, we cannot abandon our patients.
- ii. This does not mean we have to act against our conscience.
- iii. This does mean we have an obligation to respond to a request and provide care and information in a non-judgmental manner.

3. What are the reasons that people request a hastened death?

A desire for hastened death is a complex, multifactorial phenomenon usually triggered by a physical or psychological exacerbation of symptoms which leads to emotional distress or suffering. The literature has described possible driving factors (*Monica's article*) which can be grouped into "loss of self" and "fear" (*ref is the 2012 systematic review*).

A sense of "Loss of self" can occur when people feel that they can no longer define themselves or what they were proud of due to various losses, such as loss of:

- Bodily functions
- Mobility
- Control
- Meaning
- Dignity
- Independence
- Quality of life

This "loss of self" could extend to them withdrawing from family/friends which can increase the risk of depression and anxiety.

"Fear" can be of:

- The dying process
 - > worsening symptoms
 - > progressive dependency and burdening loved ones
- Imminent death
 - > no treatment options
 - > feeling hopeless

When 'Loss' or 'Fear' drives a wish for hastened death, the actual request may represent one of three things:

- a. a way to "end suffering"
- b. a "cry for help" – a desire to live, just not in the current way
- c. "an ace up one's sleeve" – an exit plan in case the situation becomes intolerable

4. How would you evaluate the reason why Mr. L is expressing a desire for hastened death? What are some questions you can ask?

- a. Try to determine if this an impulsive request or has the patient been thinking about this for some time
 - For example: "How long have you felt this way?"
- b. Explore what is driving the desire for hastened death.
 - For example: "Usually when people ask me about 'assisted suicide' they are suffering a lot. Can you tell more about how you are feeling right now?"
 - For example: "Patients can experience suffering in many ways. For some it may be physical, for others emotional and for some both. How would you describe your suffering?"
- c. If the patient mentions a specific symptom (whether physical or psychological) you can ask if their symptoms are adequately treated. If the answer is no, this can be an opportunity to involve palliative care, psychiatry, social work, or spiritual care colleagues. Sometimes, untreated symptoms are what lead to patients expressing a desire for hastened death. But even if the patient is firm about their desire to choose MAID, we can still offer to treat symptoms as best as possible, for whatever time remains before they die.
- d. What are some of the psychological symptoms that patients such as Mr. L might be experiencing?
 - Many patients experience symptoms of depression towards the end of life (Sullivan MD, Ganzini L, Youngner SJ., Hastings Cent Rep. 1998 Jul-Aug;28(4):24-31). For some of them, treatment with an antidepressant, a stimulant, or psychotherapy can improve their wellbeing and quality of life.
 - Some patients might be experiencing anxiety, agitation, restlessness, or panic attacks, among other distressing psychological or psychiatric symptoms. As with all psychological or psychiatric symptoms causing distress, offer treatment so that patients can be as comfortable as possible, irrespective of whether these symptoms are the source of the suffering for which they are requesting MAID. Consider consulting psychiatry to help with these symptoms.
 - Delirium is not uncommon at the end of life (Sullivan MD, Ganzini L, Youngner SJ., Hastings Cent Rep. 1998 Jul-Aug;28(4):24-31). In addition to calling into question a patient's decisional capacity, delirium can be distressing to patients and can be a source of suffering.

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7. How would you respond to his wife?

You ask Mr. L to clarify, and he states that he is extremely fatigued; he no longer goes for walks and tires easily with little exertion. He often feels "queasy" which responds intermittently to ondansetron. His biggest complaint, though, is extreme fatigue and sleepiness. In his words, his low energy is "unbearable". He denies pain currently and states that pain is "not a problem" since starting low dose hydromorphone. He continues to use Mirtazapine at bedtime and reports good sleep. His palliative care doctor offered him a stimulant to try boosting his energy (modafinil) but he is not interested, and is still not interested in any medications for energy. He states "I just want to die, I'm ready to go."

You ask Mr. L. how long he has been feeling this way, and he says only about a week. His wife, who is also in the room, states "I can't believe this... I'm absolutely shocked... I don't know if I can listen to this."

a. Consider the setting

For example: Continue to have the conversation with both the patient and the family in the room. Both the patient and the family might be feeling particularly vulnerable hearing/speaking about MAiD, and separating them in this case would be unempathic and likely distressing.

b. This may be a huge shock if the wife is hearing this request for the first time. Try respond empathically.

- i. For example: Consider addressing Mrs. L directly: *"I can only imagine how surprised you must be to hear this. Is this the first time that the two of you have spoken about this?"*
- ii. For example: *"This must be a shocking thing to hear. I want to check in with you to see what's going on for you, to see how you're doing."*
- iii. For example: *"This must be hard to hear. I hope it's ok if I keep asking the two of you a bit more about this."*

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8. How could you assess Mr. L's mood?

Consider: Many patients have symptoms of depression towards the end of life. Depression might

Mr. L's wife looks very upset and is considering leaving the room. You are concerned that if the conversation continues without her, the fear of what might be said while she is gone might worry her even more. You acknowledge how hard it must be for Ms. L to hear this, and you ask her if she would like to still be a part of the conversation. She agrees. She stated that she just didn't realize that his condition had progressed so quickly, but admits that she had noticed him eating less and spending less time outdoors. She asks you if Mr. L could be in a depression, and if he's of sound mind to make this type of decision.

present with low mood, but it might also present with loss of interest in pleasurable activities. Consider asking Mr. L whether there are any activities that give him pleasure in life these days.

Example: *"Sometimes, when someone's body gets really sick, their mood starts to suffer too. In fact, many people towards the end of life have some degree of depression. Have you been feeling depressed? Is there anything that you're able to find enjoyable these days? Is there anything you look forward to?"*

Caution: Depression does not automatically mean that someone is incapable of choosing MAiD. Of course, if depression was severe enough, it could cloud a patient's judgment, but many patients with mild depression will still retain capacity to make medical decisions, including the decision to choose MAiD.

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You inquire about Mr. L's mood and he states that he is "depressed" because of how much he is suffering physically. He states that he still looks forward to visits from his grandchildren and his face brightens up when he speaks about them. He is an avid gardener, and he wants to teach his grandchildren some pearls of wisdom about gardening before he dies.

He and his wife ask if he can be admitted because they do not believe they can care for him at home in this state. You decide to admit the patient for weakness and nausea.

9. When reviewing the case with your staff, your staff asks you if the patient is suicidal, and whether or not they need a one-to-one observer for constant observation. Is MAiD the same as suicide?

Consider: Suicide and MAiD are conceptually different. Suicide is the act of killing oneself, and suicide risk is assessed based on the presence or absence of thoughts, plan, means, and intention to complete suicide. Because MAiD and suicide are not the same, asking patients about suicide may sometimes be appropriate, above and beyond asking them about MAiD specifically.

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You ask Mr. L about whether he had thoughts or intention to take his own life, whether or not he had a plan, had taken steps, or had access to any means, Mr. L responded by saying that he had no intention or even thoughts of committing suicide. In fact, you learn through the conversation that Mr. L does not consider MAiD to be the same as suicide. On the contrary, he is thankful that MAiD laws provide a legal avenue for him to hasten his death without having to engage in suicidal behaviors. He wants to continue receiving care from his trusted team of physicians and allied healthcare providers. He also hopes that his physician will agree to administer MAiD when the time comes.

Discussion Question

8. Do you need to consult psychiatry for this case?

Consider: The purpose of this question is to de-pathologize the nature of a MAiD request. A psychiatry consult is not mandatory for MAiD eligibility assessments, as outlined by the CPSO. However, for a patient with a psychiatric history, or if there are significant psychiatric symptoms, a psychiatrist may add value to the patient's care by identifying and treating any suffering related to underlying psychiatric symptoms.

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You decide, with Mr. and Ms. L's agreement, that his current presentation does not warrant a psychiatric consult, and you ensure that he is aware that if he would like, a consult can be requested in whatever time remains before his death.

Several days later, you speak to a colleague who is now caring for Mr. L on the oncology wards. Mr. L was eligible for MAID. His request was granted after the 10 day mandatory waiting period.

In accordance with federal legislation, for an individual to access medical assistance in dying, he/she must:

Eligibility Criteria	Does Mr. L qualify?
Be eligible for publicly funded health services in Canada	Yes
Be at least 18 years of age and capable of making decisions with respect to their health	Yes
Have a grievous and irremediable medical condition <ol style="list-style-type: none"> 1. They have a serious and incurable illness, disease or disability 2. They are in an advanced state of irreversible decline 3. 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 4. Their natural death has become reasonably foreseeable, taking into account all the medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining. 	Yes , recurring colorectal cancer and is not a candidate for surgery
Make a voluntary request for medical assistance in dying that is not the result of external pressure	Yes, you have not seen any evidence of external pressure
Provide 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	Yes , he would be able to provide informed consent