1. How are you personally feeling about this request?

Explore with the learners the different feelings that can arise from a request for MAID.

Discuss that a request can be emotionally provoking for all physicians no matter what they believe for a wide variety of reasons. Invite the learners, if they are comfortable, to expand on why they feel the way they do.

Explore different coping strategies (healthy and not so healthy) the learners have used or have observed to deal with the emotional impact of a request.

Are there trusted colleagues/team members that you could speak with to discuss and support your emotional reaction?

Emphasize that although a physician may not agree with MAID, it is important to respond in a manner that invites the patient to tell you more about why they are asking about MAID (See cases 1-3).

1. Remember that as physicians, we cannot abandon our patients
2. This does not mean we have to act against our conscience
3. This does mean we have an obligation to respond to a request and provide care and information in a non-judgmental manner
4. Treating patients compassionately and in a non-judgmental manner is only possible when we do not reveal moral indignation
5. When a patient and physician cannot find common ground, it is important for the physician to find someone who can care for the patient
Note: For a small number of physicians, they may feel that referring to another physician is still participating in a patient's MAID request. As the current CPSO policy stands, a physician must make an “effective referral.” Discussion around conscientious objection is beyond the scope of this module.

Back to the case...

After exploring what this request really means for the patient, you learn that Ms. M values independence and has a great deal of fear around losing that independence. She is single and has no children but has a very strong support group of family (mother, 2 brothers), colleagues and longtime friends. She witnessed her father deteriorate from multiple strokes and often spoke to those close to her that she would never want to live with such deterioration of body and mind. Dignity for her is related to independence. She also feels a great loss with not being able to teach at the law school. Being a professor at U of T was a large part of her identity and she really misses that world. Her goal knowing the natural progression of her disease is to die peacefully before she becomes completely dependent on others.

She has been researching other alternatives for end-of-life care and understands she has the right to refuse or stop treatments. She also understands that palliative sedation to make symptoms tolerable is an option in the last days to short weeks of life. However, she feels that these options are not as preferable to her and it would give her comfort to know that she can decide when and where she will die. Ms. M tells you that she spent the last month tying up loose ends with her friends and family.

You step out of the room to discuss with your attending staff what the next steps should be.

2. What are the policies and processes around MAID?

Take a few moments to discuss what your understanding is of the policies and processes are around MAID at the institutions where you have worked.

At the University of Toronto, the processes around MAID can vary significantly from institution to institution. Some may have a MAID consult team that will take on the role of assessing and providing medications. Other hospitals may not permit assessments and/or provision of MAID to take place onsite. If you are unfamiliar with your institution's policies please check with your attending staff, your institution's intranet, and liaise with the organization's ethics service.

Receiving MAID in the home adds another layer of complexity. It requires that an MD who provides MAID works in the area where the patient lives. At the time of writing, the MOHLTC has a care coordination toll-free line to access information about MAID including locating clinicians for assessments/provision of MAID and community pharmacies that will dispense medications for MAID.
Back to the case...

Your attending staff acknowledges that he has not assessed a patient for MAID eligibility before and is not comfortable with the process. He tells you that there is a MAID consulting service in the hospital and suggests that you liaise with Ms. M's neurologist first to see if they have any additional information.

In a telephone conversation, Ms. M's neurologist acknowledges that MAID had been discussed with the patient previously as a therapy. Ms. M's would be interested in when her ALS became more advanced and she became more physically dependent. Her neurologist has been an assessor before for MAID eligibility and would be open to assessing Ms. M if required.

2 months later Ms. M leaves a message for you to call her. Over the phone she tells you that she has become increasingly more short of breath and was finding it more difficult to manage at home alone. She is not interested in a g-tube or bipap. She handed her written request for MAID to her neurologist a couple of weeks ago and the assessments for eligibility had subsequently been completed. She requested to have MAID through IV drug administration and was waiting for bed availability in the hospital for admission and provision of MAID. Her brothers would be present for the intervention; however, her mother would be too medically frail. They had had a small gathering for family and close friends over the weekend to say their goodbyes.

Ms. M thanks you for the compassionate care you have provided her the past couple of years. She did not want to impose, but asked if you could be present when she received MAID. The physician who would administer the medications would be unfamiliar to her and she would feel more comfortable if you attended.

3. How would you feel about this request and scenario?

Reflect on how support of or opposition to MAID does not necessarily determine if someone feels comfortable being present when MAID is administered to a patient. You could feel strongly that MAID should be legal but not wish to be involved in the process including attending a MAID intervention. By contrast, you could be against MAID but see your role includes supporting your patients until they die regardless of the means.

Back to the case...

After much consideration, you decide you wish to attend and are able to be present to support Ms. M when she receives MAID. Your attending staff supports you in this decision and agrees to cover your practice and pager while you attend the procedure.

The next day, you are informed that Ms. M has been admitted and the procedure has been scheduled for 1 pm. At noon you arrive at Ms. M's bedside to find her surrounded by family members. They are sharing stories about her younger years and laughter fills the room. She is eating her favourite ice cream that her brother brought in for her.

The primary clinician, Dr. W is outside the room speaking to the pharmacist who has brought a “kit” containing the medications that will be administered as part of MAID. She asks the nurse to check if the two IVs are still patent.
4. **What are the typical routes of administration for medications used in MAID?**

MAID can be provided by the primary clinician via a cocktail of IV medications that generally include:

1) An anxiolytic (e.g. midazolam) to sedate
2) A coma-inducing agent (e.g. propofol)
3) A neuromuscular blocker (e.g. rocuronium)
4) A medication to induce Asystole (e.g. potassium chloride)

Generally, two IVs should be placed in the event one of them goes interstitial. Typically the patient will die within 5-10 minutes of medication administration.

Patients also have the option of requesting a prescription for a lethal dose of medication which they then self-administer. At the time of writing this module, this remains an extremely uncommon option due to choice and availability.

Regarding eating and drinking before MAID, some guidelines may suggest that the patient shouldn’t eat or drink for a certain period before MAID, but it is not supported by any evidence and some institutions have no restrictions on oral intake.

**Back to the case...**

Once the medications are drawn up, Dr. W asks Ms. M. again if she wishes to proceed, and confirms that the patient is capable of providing informed consent. Once this is confirmed, Dr. W begins to explain the process. She provides the names of the four medications that will be administered and what the purpose of each of them is, and explains that once the process begins, the patient will die within “5 or 10 minutes.”

When Ms. M says that she is “ready”, one of her brothers, visibly tearful, reaches over to hold his sister’s hands. The first medication administered is a sedative, and within about thirty seconds, Ms. M becomes visibly sleepier. Dr. W explains to the family that the next medication is like anesthesia before an operation, and will put her fully to sleep. She administers propofol and the Ms. M appears to be even more sedated, to the point that her breathing is barely perceptible and her colour noticeably changes.

Next, a paralytic agent is administered, and Ms. M stops moving completely.

Finally, Dr. W administers potassium to cause cardiac arrest, and after auscultating the precordium, tells the family that Ms. M has died. At this point, Dr. W asks all of the healthcare providers, including you, to leave the room so that the family can have privacy. She tells them to take as long as they need.

You are invited to attend a debriefing session for staff on the floor who were involved in her care, and return to the nursing station where one of the brothers is speaking to other team members. He thanks you for all the help you provided and that his sister had expressed how much comfort your support gave her in the past couple of years.

5. **What could be the impact on clinicians being involved in MAID?**

The literature in this area is scant, but a 2007 qualitative paper (Van Marjwick) interviewing primary care physicians demonstrates how emotionally stressful it can be for physicians who provide MAID. The interviewees cite feelings of loneliness, loss, anxiety. This underscores the importance of taking time to reflect, debrief, and grieve.