

PERSPECTIVE

Medical Assistance in Dying Our Lessons Learned

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Author Audio Interview

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On February 6, 2015, the Supreme Court of Canada struck down the prohibition of physician-assisted dying and ordered the federal parliament to enact legislation to allow it within 12 months.¹ On June 17, 2016, Bill C-14² received royal assent, the final step by which a bill becomes both an Act of Parliament and Canadian law. This act made it legal for physicians to provide assistance in dying to individuals in an advanced state of irreversible decline whose natural death was “reasonably foreseeable.” Canada’s health care system rapidly developed protocols for Medical Assistance in Dying, which became known by its acronym, MAID. Like many physicians, each of us felt that changing the law and delivering this service was the right thing to do for the right kind of patient (and there was vigorous debate about who that was). At the same time, we both felt that for at least the near future, we would likely be reluctant to directly or indirectly participate in MAID ourselves.

A few months later while working together on an inpatient internal medicine team we met Wayne Chubb, a 64-year-old man who came to Toronto, Ontario, from a small town in Newfoundland for treatment of gastric cancer. During the course of receiving 2 rounds of chemotherapy, he developed intractable ascites, renal injury, persistent hypoglycemia, and was unable to eat enough calories to maintain his weight. The palliative care team was involved early in the hospitalization, and helped with the management of his pain, nausea, and anxiety about future suffering. We were his hospital physicians twice over a 10-week period, so we got to know him, his wife, and his children well. When the oncologist recommended stopping the chemotherapy, he asked us to initiate the MAID process. We agreed to perform 1 of the 2 required staff physician assessments (the palliative care physician performed the other) because we fully understood his predicament and felt that we were, in fact, his doctors.

The assessment requires following a structured interview prepared by each hospital that allows the physicians to determine if the patient is eligible for MAID. As we started the interview, we told him and his family that this was our first time and that we were uncomfortable. The interview schedule asks only a few questions. “What problem is bothering you the most?” “How would you describe your suffering?” “Why are you requesting MAID?” His answers focused on 2 issues. First, he felt that the energy was slowly being drained from his body and that he was fading away. Second, he wanted to be in control of his death, both the timing and the circumstances. Previously, he recounted his experience with putting his dog down—he indicated that this was how he envisioned his death.

When we left the room, we talked about how we wished that all patients and families could be as clear in their decision making. The next day, Mr Chubb was discharged to his temporary home in an apartment 1 block from the hospital. We told the palliative care physician that if and when he made his request to proceed, we might come along for support.

About a week later, we were informed that MAID would occur in 3 days, on February 2, 2017, almost exactly 2 years after the Supreme Court decision. It was earlier than expected, but Mr Chubb told his palliative care physicians that he had already said his goodbyes and that the time had come. We agreed to go, but felt tremendous trepidation and anxiety for the next 3 days. One of us (A.S.D.) is a senior physician who has cared for very sick patients since 1976 and is no stranger to watching people die, comfortable withdrawing active treatment of underlying illness, and moving to palliative and comfort care plans. The other (K.L.Q.) is a senior resident who still sometimes feels as if he is playing doctor. Neither of us had ever purposefully done something active to end someone’s life. We were not sure how that would feel.

A biting wind made the walk from the hospital to his nearby apartment quite unpleasant. When we arrived, Mr Chubb was in the bedroom with his wife and daughter, and we faced a crowd of 10 people in the living room. There were trays of cheese and fruit laid out on a table. The mood was somber. While the other physicians and the nurse prepared the medications in the dining area, our role was to talk to the assembled family. We asked them to tell us more about Mr Chubb. He had worked for a telephone company, and his family described him as a “fixer of all things.” He was regarded as one of the nicest men in all of Newfoundland, and his wife would later remark, “The only friend he didn’t have was someone he hadn’t met.”

We both have some familiarity with Newfoundland, so we engaged them in a discussion of topics about the province. We knew that families there are often large, so asked how many here were siblings. Seven hands went up to which one of us replied, “a medium-sized Newfoundland family.” They laughed and told us that the other 6 siblings were unable to be present.

After all the preparations were complete, we entered the bedroom. Mr Chubb was lying under a bright green blanket. One of his daughters and his wife were sitting beside him on the bed. His other daughter and only son were in school in New Zealand and Australia, respectively, although we had talked to them repeatedly in the preceding months when they were present.

Mr Chubb looked very tired and much more wasted than when we saw him last. He greeted us and thanked us profusely for coming and helping him. He said, “Dr

Detsky, I know that I am ruining your day," and received the following reply, "Yes you are, I didn't sleep well last night, but thank you for acknowledging that." Everybody laughed. He said, "I am not sure how I can thank you." We replied, "You don't need to." After obtaining consent, he told us he was ready. Somewhat miraculously, the sun came out and peaked through the vertical blinds, lighting up the entire room. We all gasped.

The more senior of us sat in the chair next to his arm, and connected the syringe into the port of his peripherally inserted central line, while the other stood quietly at the end of the bed. We told him what to expect from the midazolam, and he seemed at peace. As it was injected into his arm, he closed his eyes and became very quiet. The palliative care physician proceeded with the rest of the injections: lidocaine, propofol, and rocuronium. After a small amount of the propofol was injected, he let out 2 sighs, and then stopped breathing. His hand turned blue. And then his face turned from pink to blue to dusky purple, from the bottom to the top like his life was being drawn out of his body. His wife and daughter kissed him, and then

hugged each other. The entire set of injections took less than 5 minutes. Before the event we worried that that after he died we would feel awful. To our surprise, we didn't. It was a very peaceful death. But during the walk back to the hospital, we were both silent.

We learned the following lesson from this experience. When many of our other patients died, the hardest part for the family was dealing with the uncertainties; when will they die, how would they die, what will it look like, is he or she in pain? And they have to make serial decisions; when to stop blood work, intravenous hydration, vital signs, and remove tubes? All of these uncertainties and decisions induce enormous distress. With MAID, all of that uncertainty and agonized decision making is removed. As a result, the family and the patient undergo much less stress.

"Today we did a good thing," one of us remarked to the other during a mentoring moment when leaving the hospital that evening. We're not sure if we'll ever do this again, but we believe that in this circumstance it was the right care, for the right patient, at the right time.

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2. Statutes of Canada 2016. Chapter 3. http://laws-lois.justice.gc.ca/PDF/2016_3.pdf. Accessed May 8, 2017.