Myths About MAiD (Medical Assistance in Dying)
For UHN Staff and Physicians
by UHN Bioethics team
prepared July 27, 2016

Physician Assisted Death and Medical Assistance in Dying are the same thing.

No. Initially, the Supreme Court of Canada case (*Carter v. Attorney General*) was about “physician assisted death” (often called PAD). But the Court ultimately held that other health professionals, such as nurse practitioners, may be involved because some Canadians do not have ready access to physicians. The federal government’s Bill C-14 refers to Medical Assistance in Dying (MAiD). This language reflects the fact that different health specialties are now legally permitted to be involved in the care of patients requesting and receiving this intervention.

MAiD is the same as physician assisted suicide.

For decades, “physician assisted suicide” was a common label, given the Criminal Code of Canada’s general prohibition against aiding or abetting suicide. And this label was used in the early 1990s when Canadian Sue Rodriguez, who had progressive ALS, sought legal exemptions so a physician to help her end her life via prescribed medications. Today, however, the terminology is about certain health professionals assisting death as requested by certain patients in certain limited circumstances.

Bill C-14 legally permits only one method of causing death.

Patients can request one of two methods: (1) self-administration, wherein the patient himself ingests a concoction of lethal medications; (2) a lethal series of medications injected by physician or nurse practitioner. At present, UHN is able to provide access to MAiD via the second method.

As a side point, method (1) has often been called “physician-assisted suicide” because the patient himself is directly involved in administrating the medications. Method (2) has often been called “active euthanasia” because (a) someone other than the patient is actively involved in bringing about death and (b) death and the method of dying are what the person wants (“euthanasia” means “good death” in Greek). Quebec’s *Act Respecting End-of-Life Care* permits only method (2).

The Supreme Court of Canada’s ruling means Canadians now have a legal right to die.

Not quite. Instead of a right to die, the Court focused on safeguarding Canadians’ existing rights to life, liberty, and security of the person. These three rights are enshrined in Canada’s *Charter of Rights and Freedoms*.

The Court held that for certain people, these rights are violated by the Criminal Code sections that prohibited all access to medical assistance in dying.

All the Colleges—in Ontario and nationally—of regulated health professions are adopting the same position on MAiD.

No. Some Colleges have created specific guidelines for their members concerning MAiD requests; others have not yet done so. These are still “early days” and some Colleges may be waiting for more clarity as to what healthcare organizations will expect their staff members to do when patients ask for information about MAiD or want to pursue access to that intervention. Some Colleges believe their existing codes of ethics and professional responsibilities are already broad enough to address MAiD questions and cases.
MAiD is the same thing as palliative sedation.

Not quite. Palliative sedation strives to make the person unconscious to the point of no longer feeling pain and discomfort. As such, death may be a foreseeable consequence of the effort to relieve suffering, but is not the primary intent. MAiD strives to bring about the person’s death so they no longer have to endure unbearable and irremediable suffering.

A person must have a terminal illness or be at the end-of-life to qualify for access to MAiD.

Again, not quite. The federal legislation (Bill C-14) says it must be “reasonably foreseeable” that the person will die from their illness or injury. But this does not mean the person has been told they have a limited number of days, weeks, or months to live. In fact, the person need not have a firm prognosis in order to qualify for access to MAiD.

This is an example of how the current federal legislation differs from the Supreme Court of Canada’s ruling: the Court did not restrict eligibility to only those whose death is foreseeable or imminent.

People can access MAiD if they have a mental illness such as chronic depression or schizophrenia.

Mental illness cannot be the sole underlying medical condition for accessing MAiD. This is another example of current differences between the legislation and the Court's ruling. However, Bill C-14 does indicate that further analysis and discussion about mental illness and MAiD are needed.

As per Bill C-14, to be eligible for MAiD, a person must:

- be eligible for health services funded by the federal government, province or territory
- be at least 18 years old and mentally competent/capable of making healthcare decisions
- have a grievous and irremediable medical condition, which means the person:
  - has a serious illness, disease or disability
  - is in an advanced state of decline that cannot be reversed
  - is suffering unbearably from the illness, disease, disability or state of decline, and
  - is at a point where their natural death has become reasonably foreseeable, which takes into account all of their medical circumstances

- make a request of MAiD which is not the result of outside pressure or influence, and
- provide informed consent to receive MAiD

Only physicians and staff working in UHN’s ICU or Critical Care units need to be trained on MAiD.

No. Given that mainstream media has covered the unfolding of MAiD in Canada and Ontario, and various aspects are still being debated, it is foreseeable that any in-patient or out-patient could ask their physician or care team for their views about MAiD or for more information about accessing it. Some people living with intolerable suffering may have been waiting for MAiD to become legally permissible and so will be interested in accessing it now, either as out-patients or in-patients.

Discussing MAiD with patients is very different from other medical discussion with patients.

They should be the same. The patient who requests MAiD will typically have a grave health-related problem for which there are a number of medical measures that promise to help end suffering, pain, loss of personal dignity, integrity, and so on. Like other medical measures, MAiD is an option available only to certain patients. It must adhere to high quality and safety standards, be provided by qualified and trained healthcare workers, and be offered under limited circumstances.
A patient’s substitute decision maker can request access to MAiD.

No. At this time, the request must be from the capable patient herself. No one else can request access to MAiD and health care providers are to ensure patients who do request it are free from undue pressure and coercion.

Staff should not ask a patient who is accessing MAiD about possible organ donation.

Quite the contrary, as with all hospital deaths, staff are required to refer all patients accessing MAiD to Trillium Gift of Life Network to discuss the option of organ donation. However, a guideline has already been developed by UHN’s MAiD working group, transplantation staff and Trillium Gift of Life staff to handle this situation. It explains how MAiD and possible donation can be sequentially separate, but appropriately linked, processes and who should be involved in each one.

A physician or staff member who decides not to be directly involved in providing MAiD to their patient will not be involved in providing any other treatment or care to the patient.

Usually, these will be separate sets of responsibilities. For instance, daily wound care, gastric or urologic management, or physiotherapy would be part of a general treatment /care plan and not directly tied to the MAiD procedure.

A physician or other healthcare worker cannot identify or recommend MAiD as a possible option to their patient who is suffering unbearably.

This is still being worked out, but these are some initial insights:

Re: identification. Perhaps a patient is unaware that MAiD is a medical option now. Fundamental to informed consent processes, and patient-centered care, are expectations that clinicians will advise patients of available standards of care that can help achieve the patient’s personal goals with respect to their lives, relationships, and identity. If palliative care measures and palliative sedation are explained to patients as medically available alternatives, MAiD becomes a new option for the patient to be aware of.

Re: recommending. Patients must never feel pushed to consider or to pursue MAiD. A health professional ought to refrain from recommending MAiD to her patient, but instead focus on answering the patient’s questions and offering supports for to help them think this option through (e.g., bioethics consultation, spiritual care consultation).

To volunteer to be involved in providing MAiD to a UHN patient, you must have no doubts that it is “the right thing to do”.

MAiD is an ethically complicated issue for patients, families, and clinical staff. Many of us are still not sure about our own views and values about it. Clinicians currently involved with UHN MAiD teams have voiced their commitment to the patient’s perspective, suffering experience, life narrative, and dignity while acknowledging the importance of personal reflection and discussion on the professional and personal meaning of MAiD for themselves.

This is likely to be an ongoing source of reflection and conversation for some time to come. UHN has Bioethics and Spiritual Care staff available for confidential, non-judgmental support for staff facing this and other value-laden questions in their personal and professional lives.

Canada is going to become a “death tourism” destination, like Switzerland.

One of the requirements for accessing MAiD is the patient already being eligible for publically-funded health services in Canada. This means people from other countries will not be able to access MAiD.