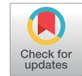
General Hospital Psychiatry 55 (2018) 15–19

Contents lists available at ScienceDirect

General Hospital Psychiatry

journal homepage: www.elsevier.com/locate/genhospsych

Consultation-liaison psychiatry and physician-assisted death



Donna E. Stewart[a,*], Gary Rodin[b], Madeline Li[b]

[a] University Health Network Centre for Mental Health, University of Toronto, Faculty of Medicine, 200 Elizabeth Street, EN7-229, Toronto, ON M52C4, Canada
[b] University Health Network Centre for Mental Health, Department of Supportive Care, Princess Margaret Cancer Centre, University of Toronto, Faculty of Medicine, Canada

ARTICLE INFO

Keywords:
Physician-assisted death
Consultation-liaison psychiatrists
Medical assistance in dying
Euthanasia

ABSTRACT

Objective: Consultation-liaison (C-L) psychiatrists are involved in physician-assisted death (PAD) teams in many permitting jurisdictions. This paper will describe our Canadian PAD experience over 2 years, highlighting the role of C-L psychiatrists, at a large hospital network that provides medical assistance in dying (MAID, as this is called in Canada).
Methods: We will describe the Canadian criteria for MAID, our multispecialty MAID team experience and the roles, issues and concerns experienced by C-L psychiatrists. Some brief patient examples will be provided.
Results: Our MAID team has managed 186 MAID inquiries, assessed 95 MAID requests and provided 49 MAID interventions over a 24 month period. The 2 co-leaders of the MAID team, 8 assessors and 1 intervention physician are C-L psychiatrists. Each of the MAID criteria: grievous medical condition, advanced state of irreversible decline, intolerable suffering, natural death reasonably foreseeable, voluntary request, capacity and informed consent pose specific challenges to be resolved in the assessment. Several unique MAID issues, including the role of education and mandatory psychiatric assessment and protocols will also be discussed.
Conclusions: Our experience shows that C-L psychiatrists are well-situated to provide vital expertise and leadership to multispecialty PAD teams.

1. Introduction

Medically assisted dying has become legal under various conditions in a growing number of jurisdictions. Switzerland, the Netherlands, Belgium, Colombia, Luxembourg, Canada, Victoria (Australia), California, Montana, Vermont, Colorado, Oregon, Washington, Washington DC, and Hawaii (USA) have all passed laws that allow physicians, under certain circumstances, to provide a means by which seriously ill patients may end their own lives [1–5]. In June 2016 Canada passed legislation (Bill C-14) permitting physician-assisted death (PAD), called medical assistance in dying (MAID) in Canada, for patients meeting specific criteria [1]. Other jurisdictions are considering similar laws [2].

We previously described the institutional framework we developed for the assessment and delivery of MAID in a Canadian setting [6]. C-L psychiatrists played a leadership role in the establishment and subsequent delivery and education for this MAID program. We will describe here the experience and role of C-L psychiatrists in this program and some issues and concerns for C-L psychiatrists who become involved in PAD.

2. The Canadian context

The specific legal criteria for MAID in Canada are that the patient must be: eligible for health services funded by a government in Canada, at least 18 years old, capable of making health care decisions and have a grievous and irremediable medical condition. The latter is defined as: a serious and incurable illness, disease or disability; being in an advanced state of irreversible decline in capability; causing enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and their natural death has become reasonably foreseeable. Applicants for MAID must make a voluntary written witnessed request and then give informed consent to receive MAID, after having been informed of other means available to relieve their suffering, including palliative care. An important safeguard is that two independent physicians or nurse practitioners are required to assess the applicant in terms of the legal eligibility criteria. There is a mandatory “reflection period” of 10 days that may be shortened only by the likelihood of imminent death or inability to give valid consent at the time of MAID implementation [1]. Under review and to be tabled in Parliament by late 2018, is whether the eligibility criteria for MAID should be extended to mature minors,

* Corresponding author.
E-mail address: donna.stewart@uhn.ca (D.E. Stewart).

https://doi.org/10.1016/j.genhosppsych.2018.08.011
Received 5 July 2018; Received in revised form 29 August 2018; Accepted 30 August 2018
0163-8343/ © 2018 Elsevier Inc. All rights reserved.

advance requests and for mental illness as the sole underlying medical condition, all presently excluded in Bill C-14 [7].

MAID is still controversial among the public and physicians in Canada, although opinions are changing. Early surveys of Canadian physicians and the public found a majority opposed to MAID [8]. However, a 2016 public opinion poll found 80% of Canadians supported the right to advance consent to physician assisted death [9]. A 2016 survey of 332 responding Canadian psychiatrists found that 73% supported MAID, although 54% did not support it if mental illness was the sole indication. Thirty-six percent of psychiatrists thought that a psychiatric assessment should be required as part of every MAID request, while 78% thought this should only be required when mental illness is either known or suspected to be comorbid with the primary illness [10]. At least 3714 MAID deaths, equally divided between men and women, occurred in Canada between legalization on June 17, 2016 and December 31, 2017, constituting 1.07% of total deaths [11]. The average age of these individuals was 73, with most having cancer, cardiorespiratory disorders and neurodegenerative diseases.

3. Our hospital context

The University Health Network (UHN) consists of 2 large quaternary general hospitals (specializing in cardiovascular, multi-organ transplants, neurological, and musculoskeletal diseases), a comprehensive cancer centre, a hospice, a rehabilitation complex and a health sciences education institute [6]. UHN had 1270 beds and 1,129,346 ambulatory visits in 2017. Our psychiatric consultation liaison (C-L) program consists of approximately 20 psychiatrists and several allied health professionals. The expertise of C-L psychiatrists in treating psychological suffering in the medically ill, liaising with nursing/medical/surgical colleagues, and in assessing mood, cognition, decisional capacity, informed consent and voluntariness uniquely qualified them to conduct MAID assessments. The UHN MAID co-leaders are C-L psychiatrists who specialize in psycho-oncology.

Our MAID Assessment Team now consists of 20 voluntary assessors, 8 of whom are C-L psychiatrists. In Canada, MAID is considered to fall within the scope of practice of physicians from all disciplines. The clinical experience of C-L psychiatrists in assessing and intervening with existential suffering, reported to be the main reason for assisted dying requests in all legal jurisdictions (2), suggests there is an important role for psychiatrists beyond that of capacity assessment. Other assessors are from palliative care, oncology, family medicine, internal medicine and advanced care nursing.

Assessors are directed to evaluate each applicant based on the legislated criteria for MAID and to rely not only on the clinical interview but also the medical record, and collateral information. Of the 10 physicians on the MAID Intervention Team, who deliver the lethal injection, one is a C-L psychiatrist and the others are from anesthesiology, family medicine, emergency medicine, internal medicine and critical care. The C-L psychiatrist who serves on the MAID Intervention Team volunteered to do so based on the needs of the team.

A registered nurse with a graduate degree facilitates access, navigation and coordination of MAID for patients, families and staff across UHN MAID service.

Our institution only provides euthanasia, by inpatient intravenous lethal medication administered by a qualified physician or nurse practitioner. To date, our institution has managed 186 MAID inquiries, assessed 95 MAID requests and provided 49 MAID interventions. Approximately 60% of MAID inquiries were not formally assessed, because mental illness was the sole indication, they were delirious, or actively dying and unable to participate in assessment. Among those assessed, 15% did not meet eligibility criteria, either because of lack of capacity or because they were seeking pre-approval for MAID for the future, but were not providing consent to receive MAID close to the time of assessment [6]. Psychiatrists were involved in 85% of assessments. MAID eligibility rates were similar whether or not a psychiatrist was an assessor. We will provide here a distillation of our experience as C-L psychiatrists, illustrate some issues with brief examples, and highlight some concerns. We will describe our role in education and opine on mandatory MAID psychiatric assessments and protocols.

4. The assessment of eligibility for MAID

4.1. Grievous and irremediable medical illness, disease or disability

Most individuals referred for MAID in our setting clearly have a grievous medical condition, most frequently terminal cancer, cardiorespiratory or neurologic disease [6]. However, there has been uncertainty about what is “irremediable” in some neurologic diseases, multiple co-morbidities, age-related frailty, or those with uncertain expected survival who are “tired of living”. Disentangling personal biases and moral positions from the rigorous application of MAID eligibility criteria has been challenging for some assessors, as will be illustrated in the cases described. Disagreements between assessors are usually resolved by discussion, which may involve the MAID co-leaders or occasionally by a third assessor who is an expert in the specialist field.

The Canadian legislation does not compel any person to accept treatment in order to be eligible for MAID and clarifies that both the “incurable” and “enduring suffering” criteria should be interpreted as “by means acceptable to the patient” [12]. Contact with appropriate specialists may be needed to clarify possible treatments, the chances of improvement and likely prognosis. Refusal of treatment late in the disease process, such as a further course of chemotherapy or more extensive surgery when chances of improvement are unfavorable, has been more easily understood and accepted than refusal of all treatments for a potentially curable disease.

In that regard, a request for MAID by a 40-year-old man who refused surgery, chemotherapy or radiotherapy for a potentially curable stage III rectal cancer, generated distress and doubt about eligibility. However, multiple consultants across specialties all concluded that he met the legislated criteria for MAID. Extensive discussion among the MAID clinicians and oncology staff was helpful in understanding the patient's psychology and values, and the need to separate these from healthcare providers' personal values and opinions.

When there is concern that treatment refusal is secondary to a comorbid psychiatric disorder, the assessor will ensure that the patient is aware of treatment options for this and is able to give informed consent for MAID. However, the presence of such a disorder does not necessarily mean that the patient cannot provide informed consent and be eligible for MAID if the mental disorder does not exert undue influence, impair voluntariness or capacity.

4.2. Advanced state of irreversible decline in capability

Many of the patients referred for MAID assessment were in the process of dying and clearly meet the criterion of being in an advanced state of irreversible decline. However, others not yet in such a state sometimes sought approval for MAID to obtain a sense of certainty and control about the process of dying. MAID approval may provide psychological reassurance for such individuals, although they may still intend to continue active treatment. MAID is being held in reserve by them as a “Plan B” option, if desired in the future. Some patients, including those with primary or metastatic brain tumours, seek early approval for MAID because they fear becoming incompetent to give consent at the time of intervention.

Concern about losing the capacity for consent was evident in a 50-year-old man with an inoperable multifocal glioblastoma multiforme who was referred for MAID. He appeared physically robust, but had experienced grand mal and focal seizures, intermittent mild memory disturbances and an episode of delirium soon after diagnosis. He was understandably worried that he might become unable to give informed

Download English Version:

https://daneshyari.com/en/article/10138031

Download Persian Version:

https://daneshyari.com/article/10138031

Daneshyari.com