Physician stress in the context of medical aid in dying

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We have now completed a vigorous public and private debate regarding the right-to-die in Canada as Parliament has passed legislation (Bill C-14) following the Supreme Court decision in the Carter case.[1] Quebec has already passed and implemented a legal process for right-to-die.[2] There are numerous terms describing practices whereby a physician participates in a patient's death via an action that intentionally hastens, enables, or causes that death. Whereas some stakeholders distinguish between various physician actions—for example, physician–assisted suicide versus euthanasia—the proposed Canadian legislation does not make this distinction and provides for both activities. Therefore the term chosen for C-14 is medical aid in dying (MAID).

One issue that has received relatively little attention in the ongoing debate, whether in Canada or elsewhere, is the impact of MAID on physicians' mental health and well-being. Switzerland has had a legislative umbrella for MAID since 1942, followed by Oregon in 1997, and since then eight other jurisdictions. Nevertheless, the debate so far has been either exclusively political or ethical, while relatively little has been published regarding the impact on practitioners. Most of the research comes from the Netherlands and from Oregon, but socio-economic and cultural context could arguably make a difference to how Canadian physicians experience MAID.

Early studies of impact showed that MAID is an emotionally stressful undertaking for physicians, even within a structured legal framework.[3-5] Physicians have demonstrated a wide range of emotional responses after providing MAID, mentioning contradictory feelings of comfort and discomfort.[6] The stress and discomfort may have many sources, but two are worth noting. The first is that the physician must confront unbearable suffering directly. In turn, he or she may feel inadequate in preventing that suffering in the first place. Secondly, being asked by a fellow human to help them end their life directly raises worries about one's own mortality. It is difficult to be shielded by professional distance when being asked to end a person's life through direct intervention.

Another stressor is more familiar; the request for MAID directly challenges the teaching that physicians receive throughout training and is reinforced by the healthcare system—to first do no harm, and certainly to do all possible to save a life. These ethical concepts are foundational for medicine. Physicians are socialized from the beginning to focus their energy on cure and living. Acceptance of MAID undermines and challenges the ethical foundation framing that socialization.

A study from Oregon confirmed that MAID is emotionally intense for physicians, regardless of whether they assisted the patient in dying or turned down a patient's request for MAID.[7] In this study, many sources of stress were identified, including ethical questions, trying to be certain of both prognosis and of the seriousness of the request for MAID, and lastly, feeling competent with the technical skills to carry out MAID. Being unprepared, both emotionally and clinically, for MAID can be a major source of stress. It is noteworthy that while physicians in this study found requests for MAID very challenging for many of the reasons described, none of those who assisted in a death regretted participating. Of special concern however, is that when faced with stress, none of the physicians sought support from colleagues or professional organizations, turning to spouses instead.

It is known that both dealing with death on a constant basis and dealing with very challenging deaths can have significant impact on clinicians.[8] These impacts can include intense memories, self-doubt about competence and responsibility, and at times, a disconnection from patients. The direct effect of this may be burnout and depression. The indirect effect may be reduced compassion and communication with patients and families at times of great need.

From the perspective of pediatrics, my own specialty, the challenges raised by MAID will be significant. The key characteristic of pediatric practice is that the physician must engage with the parents and with the child in determining the course of treatment. While British Columbia has no medical age of consent, physicians are obligated to obtain at least a reasonable form of assent from children before starting treatment.[9] It is not until adolescence, vaguely defined, that there is actual consideration of formal consent. Determining the best interests of a child, especially non-verbal, developmentally impaired children, is already a challenge. Adding MAID, which is effectively active euthanasia since children will not have the cognitive or physical competency to carry out an assisted suicide, will add to the complex challenges facing clinicians.

Care of children, especially in palliative/end–of–life situations, is highly contextual and socially linked. For example, withdrawal of ventilator support at end–of–life in neonatal intensive care units differs by location across three countries (The Netherlands, United States, and Canada).[10] Differences include the use or non–use of neuromuscular blockade medications at the time of extubation.[11] Therefore, decisions and approaches to MAID in pediatrics are unlikely to have consensus or consistency across centres, adding more uncertainty for clinicians.

How should physicians address the real possibility of stress related to MAID? One response is to increase knowledge about the practice of MAID—given that we now have Federal legislation, province–by–province guidelines are in place and the practice is already occurring. Physicians are already being informed about the guidelines and standards, the nature of requests, options for refusal, and lastly, the technical skills needed. This education, however necessary, will not be sufficient. Even with education, and even in jurisdictions where MAID has been well-established for over a decade, physicians continue to report significant personal stress.

Turning to one's family members for support, while natural, is not sufficient. This approach assumes that a clinician has a partner to turn to or one who can be supportive. Physicians need to avail themselves of the many resources to support them in stressful situations. Each province has a physician support program. In British Columbia., the Physician Health Program of British Columbia operates a 24 hour support line and a website with resources: www.physicianhealth.com

As a general preventive measure, physicians should engage in the

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types of wellness activities they routinely recommend to patients. The Ontario Medical Association has developed a number of resources through its Professionals Health Program, addressing physician wellness: http://php.oma.org/wellnessResourcesP.html

Whether we are ready or not, MAID will be here. We need to recognize the lessons from other countries that increased stress, and for some, increased self-knowledge and personal growth, will accompany this great change.

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