EDITORIAL

MAiD in Rheumatology

By Philip A. Baer, MDCM, FRCPC, FACR

"Without health life is not life; it is only a state of langour and suffering – an image of death."
– Buddha

"People fear death even more than pain. It's strange that they fear death. Life hurts a lot more than death. At the point of death, the pain is over. Yeah, I guess it is a friend."
– Jim Morrison

As I alluded to in our last issue, the applicability of medical assistance in dying (MAiD) to rheumatology may come as a surprise to many of our colleagues. While I followed the debate on euthanasia and assisted dying from the Sue Rodriguez case in the 1990s through the dying pleas of Dr. Donald Low and his wife Maureen Taylor more recently in 2013, I never really associated our specialty with this issue. My wife, who practiced palliative care medicine for decades, was far more likely to be involved, I thought. Certainly, no one was going to approach rheumatologists to actually provide MAiD services.

With the passage of bill C-14 in June 2016 after the Supreme Court ruling in the Carter case, MAiD is a reality in Canada, now accounting for about 0.9% of all deaths, and over 2000 deaths in total in the first year after legalization.[1] Cancer, neuro-degenerative disorders and circulatory or respiratory failure drive most requests. Controversies persist regarding MAiD for mature minors, those with psychiatric illnesses, and those who want to provide an advance directive fearing dementia or other incapacity.

The current law requires that adult patients must meet four criteria:

- Having a serious and incurable illness or disability;
- Being in an advanced state of irreversible decline;
- Enduring intolerable pain; and
- Facing a "reasonably foreseeable" death.

In 2017, an Ontario patient known as A.B. suffering from severe osteoarthritis with chronic pain applied for MAiD. She was initially turned down, as her physician did not feel that her death was reasonably foreseeable, as required by the law. She applied for judicial review, and Superior Court Justice Paul Perell ruled that a person does not need to have a terminal condition or be likely to die within a specific time frame to access medical assistance in dying. A.B.'s wishes were granted and implemented, with her death widely publicized, at least in Ontario, when it occurred in August 2017.

The latest development was reported on April 1, 2018, in The Globe and Mail.[2] In another somewhat controversial scenario, an elderly couple opted for a joint MAiD procedure, carried out in Toronto in the presence of two attending physicians and their families. This was only the second joint MAiD performed in Canada. Another couple had undergone the procedure four days apart on the advice of the CMPA, who were worried about the appearance of coercion of one spouse by the other in the case of a simultaneous MAiD procedure.

In this case, George and Shirley Brickenden were both well into their 90s and living together in a Toronto retirement home. According to the Globe, Mrs. Brickenden's body was "wracked by rheumatoid arthritis, an inflammatory condition that turned her hands into swollen purple claws." Combined with heart failure, the requisite two independent physicians concluded she was eligible for MAiD. However, she had to wait for her husband to deteriorate sufficiently, as only one of two physicians initially felt that his age and frailty alone qualified him for MAiD. After she broke her hip and he developed syncopal episodes, other heart issues and recurrent infections, they both were assessed as qualifying. Kelly Grant, the Globe reporter interviewing them and their family days before their planned deaths still found them "sharp, vibrant, and elegant …they seemed so happy…" and was perplexed by their plan to die now. However, Mrs. Brickenden called the reporter later to indicate she could not sleep "through rheumatoid arthritis pain that was like some sort of awful animal gnawing at her joints."

Within one year, two highly publicized cases of MAiD have focused on arthritic conditions. While pain is the cardinal symptom of arthritis, the portrayal of OA and RA as conditions warranting assisted dying may come as a surprise to most practicing rheumatologists. While more progress has been made in changing the natural history of RA than OA, I am sure most clinicians feel that we can deliver a management plan that can favourably impact pain, other symptoms, function and quality of life in both conditions for most of our patients. Yet we know that patient and physician thinking regarding RA may be discordant, as was highlighted by a recent Arthritis Society survey.[3] The lesson

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current and future members, along with operational excellence, innovation and financial sustainability.

What have been the most rewarding aspects of this new role so far, and what have been the most challenging aspects?

Most rewarding is working with volunteers who are dedicated to the mission of this organization. Most challenging. . . working from home where you just never leave the office.

What do you foresee as challenges to Canadian rheumatologists in the future? What can individual rheumatologists and the CRA do to help meet these challenges?

One of the biggest challenges I anticipate is a growing population without an increase in the number of rheumatology training spots. Add to that the fact that within the next 5-10 years, 30% of rheumatologists will be at retiring age. This will amplify the shortage of rheumatologists and, in turn, put a higher burden on already busy practices, which will only lead to increasing wait times for patients.

The CRA is already supporting multiple projects in models of care, which has the potential to alleviate this pressure. Furthermore, we are working on highlighting regional variations in access to rheumatologists; facilitating the discussion between trainees and community rheumatologists practicing in rural and underserved areas is another focus of ours.

If you had an extra hour in the day, how would you spend it?

Goofing around with my kids.

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of these MAiD cases is not that rheumatologists will necessarily be much more involved in future MAiD cases, but that we may have to do better at examining the suffering wrought by rheumatic diseases from the perspective of our patients.[4,5]

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