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Reflections on Voluntary Assisted Dying, Victoria 2018

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Preparatory work: International experience

Some key points:

- From Oregon and California: no Doctor administered
- Canada: both dr- and self-administered available, very few self-administered.
- Canada: doctor must be present when person dies
- California: most hospitals say cannot do within hospital
- Small numbers of doctors choose to participate
- Finding a doctor can be onerous
- For Palliative care services : substantial increase in workload – 'relentless'

Questions for consideration in preparing to respond to patient requests for EOLOA. Petrillo et al. 2017

For all health care professionals

- My feelings about physician-assisted death? Affect interactions with requesting patients?
- Would I attend a patient's death?
- My approach talking with patients/families?

For physicians

- Will I prescribe?
- My confidence in prognostication?
- Comfortable discussing all options available? Can I confidently explain, initiate palliative measures?
- Do I know - colleagues who may participate? Referral for capacity / mental health evaluations / PC?

All health care institutions / clinics

- Will facility allow physicians to prescribe?
- Can inpatients begin the process of making a request while hospitalized?
- Can patients ingest an aid-in-dying drug at the hospital?
- Education needed to respond to requests - all HCPs - whether participate or not?
- How make requesting patients aware of all options ?
- If institution participates, managing conscientious objection? Support all involved - objectors and providers? Patient continuity of care?
- Credentialing for participating physicians - additional?

All health care clinics and facilities – cont'd

- Require additional steps beyond legislation ? Eg. Mandated mental health evaluation ?
- New resources required - clinical and administrative?
- Individual patient vs family model of decision making?
- Manage communication with family, especially if patient does not include them in decision process?
- How should we manage conflict - within families, within health care teams, between health care teams? What about professional noncompliance?
- If institution chooses not to participate, plans around referral?
- Make all employees aware of the institutional policy?
- How should ED respond to patients presenting with complications of aid-in-dying drug ingestion?

Outpatient clinics

- New patients request or only ‘established’ ie our patients ?
- Which specific drug prescribed?
- Which pharmacy and role of hospital pharmacy?

Long-term-care facilities

- Will residents be permitted to ingest an aid-in-dying drug on the premises?
- If facility not participating, plans? Care elsewhere? And how facilitate this?

Community /Home agencies, including palliative care services

- Can health care workers be present at the time of ingestion?

Accessibility: Who will provide VAD?

- Will institutions such as hospitals participate?
  - How is decision made
  - On wards? In clinic?
- Who will prescribe / administer?
  - MAiD team model (in hospital / beyond hospital)
  - If 'usual' doctor – how will they be identified?
    - Within institutions
    - Within the community
- Navigating the referral process – if not participating, at what point? What will be ongoing role?
  - Will a service be willing to be a 'destination' clinic / service

Workforce and collegiate issues

What is effect on relationships between doctors (participate and not)

- Many strong views – impact of this public disagreement
- Likely 3 groups of doctors: those willingly participate, those conscientiously object, group who perhaps do not feel so strongly either way and will not participate
- If not participating, are colleagues comfortable taking on these patient

Impact on Workload

Interdisciplinary colleagues:

pharmacy

nursing colleagues in the hospital / in the community - how do you manage staffing issues

Models of support for clinicians?

What is the training and assessment required?

For those participating

Any additional requirements above legislation:

- requirement for psychiatry / psychological assessment

- understanding of EOL care

- palliative care

For those not participating

- poor understanding of VAD, EOLC across medical field

- significant need for training in how to navigate a conversation that explores issues facing people at the end of life.

Conversations: when someone asks to die.....

This is an open and full conversation, an opportunity

What are they asking?

- Can you tell me a bit more about what's on your mind?

Why and why now?

- Help me to understand what's happening for you at the moment?
- What is the most concerning / frightening thing for you?
- This is very important. I'm glad you have raised it. Can you tell me is there something that is making you raise it now in particular?

Mood, sense of possibility?

- What are the worst things? What are the things that are giving you joy?

Hudson 2006; www.vitaltalk.org

Conversations: when someone asks to die.....

Family/social support

- Is this something you have talked about with [ ]? What are his/her thoughts?

Potential for improvement of situation?

- Symptom measures / depression / if uncertain ask to involve a colleague

What are your limits / stance?

- What will you do / not do? At some point, after exploration need to say what your position is.

Ongoing conversation

Hudson 2006; www.vitaltalk.org.

Now at the personal level.....

Spent much time discussing and thinking through ‘big’ issues - now thinking about this at practical and deeply personal level between us and our patients.

Must remain open and seek opportunity to improve care – and not, through our response, limit care.

Responding and relief of suffering must remain our core focus.

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Thank you

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