MAiD: Medical Assistance in Dying

Illustration by Steve Derrick

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"I'm a bit distracted today," my primary-care preceptor once admitted. "My patient Helen has decided to pursue medical assistance in dying. She was diagnosed with pancreatic cancer just a few months back, and it has really progressed. I've known her for years, and she's just so incredible and has such a lovely family. It is truly so heartbreaking. … Do you know much about the process?"

As the daughter of veterinarians, I grew up hearing stories from my parents about euthanizing animals when they were suffering from debilitating diseases. This practice is commonplace for veterinarians and one that is nearly universally thought of as ethical, though still emotionally difficult for everyone involved. The unique complexity of humanness—the human capacity for sophisticated thought, abstract reasoning, intense emotion, language, culture, and interpersonal connection—was what inspired me to stray from my parents' path to pursue human medicine. And that same human complexity is what forces society at large to reckon with the morality of physician-assisted death for people. When asked about the process for medical assistance in dying halfway through my fourth year of medical school, I was surprised to answer my preceptor by saying no—I knew nearly nothing about it.

In between patient visits, my preceptor brought me up to speed with the general rules and regulations for Act 39 in Vermont, which requires an eligible person to

- Be at least 18 years of age or older
- Have a terminal illness with a prognosis of six months or less to live
- Be capable of making their own health care decisions
- Be able to make an informed and voluntary request to their physician
- Be able to self-administer the medication.[1]

After the first physician verifies these criteria, a second physician must be consulted to confirm them. Next, the patient must make two oral requests to a physician no less than 15 days apart and sign a written request in the presence of two unbiased witnesses. Then, the physician will write the prescription for the patient to self-administer the medication either orally or, if the patient is unable to swallow, rectally. The patient may change their mind at any time.[1]

In 2013, Vermont became the fourth state in the United States to legalize Medical Aid-in-Dying—equivalent to medical assistance in dying (MAiD)—and in 2023 Vermont became the first state in the U.S. to pass legislation that permits qualifying patients to receive MAiD services from a physician regardless of the person's state of residence.[1] Between May 2013 and June 2023, the Vermont Department of Health reported 203 cases of MAiD, with 75 percent of those cases involving cancer diagnoses and 13 percent involving neurodegenerative conditions.[3]

In terms of the medications used, patients are instructed to take pre-medication of ondansetron and metoclopramide for prevention of nausea and vomiting 30–60 minutes prior to the Aid-in-Dying medications. These include a powdered mixture of digoxin, diazepam, morphine, amitriptyline, and phenobarbital, a protocol recommended by the American Clinicians Academy on Medical Aid-in-Dying (ACAMAID).[2]

After Helen had submitted all the necessary documents, my preceptor managed to fit in a conference call during a busy day with Helen and her family for Helen's final decision, and the process of obtaining Aid-in-Dying medications began.

History of Medical Assistance in Dying (MAiD)

Reports of human euthanasia and assisted suicide date back almost two millennia.[4] In 399 BCE, the Greek philosopher Socrates famously drank hemlock, a poison his jailer gave Socrates after he was imprisoned and sentenced to death, an incident that sparked debates over what constituted euthanasia as opposed to suicide or assisted suicide.[4,5] In both Ancient Greece and Rome, "many people preferred voluntary death to endless agony," and physicians commonly gave poisons to patients for this purpose, suggesting assisted suicide had widespread acceptance at the time.[6] But in the centuries to follow, such practices became controversial due the rise of Christianity and religious beliefs that the taking of God's gift of life was fundamentally wrong.[4] Doctors cited a specific section of the fifth-century Hippocratic oath, "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect,"[7] despite that oath itself coming from a time when physician-assisted death was largely accepted. Over the course of the 17th and 18th centuries, writers throughout Europe, as a part of a general attack on religious authorities, argued against the prohibition of suicide, though physician-assisted death was not specifically discussed.[6] After the development of ether in the mid 1800s, physicians began to advocate for the use of anesthesia to relieve the pains of death. Dr. John Warren performed the first surgery with ether in 1846, after which he published Etherization, with Surgical Remarks, in which he suggested that ether might be used "in mitigating the agonies of death."[8]

The modern debate over MAiD can be dated back to 1870, when a man named Samuel Williams argued for the practice of "mercy killing"[4] in cases of non-treatable diseases, a proposition that was widely discussed and debated in the medical community.[6,4] Over the next three decades, debates about the ethics of euthanasia were rampant across the U.S. and Britain, and involved lawyers and social scientists in addition to physicians. There was an editorial in the *Journal of the American Medical Association* suggesting that pro-euthanasia doctors "don the robes of an executioner," and a 1906 bill to legalize euthanasia in Ohio that was ultimately defeated.[6]

During the 1900s, the intensity of euthanasia debates dwindled as the ascendence of social Darwinism and individualism made way for the Progressive movement in the U.S. and the election of Liberals in Britain.[6] In the 1930s, these debates briefly came to the fore mostly in Britain with Dr. C. Killick Millard's founding of the Voluntary Euthanasia Legislation Society (VELS). The combination of Millard's failed euthanasia bills, the outbreak of World War II, and the discovery of the role that German physicians played in Nazi death camps pushed the pro-euthanasia movement to the background again.[6] In the 1970s and 1980s, euthanasia returned as a topic of academic debate due to the greater support for patient autonomy around the world. And in 1988, the historic "It's over Debbie" column was published in the "A piece of my mind" section of the *Journal of the American Medical Association (JAMA),* where an anonymous gynecology resident recounted giving a large dose of morphine to a suffering 20-year-old patient who was terminally ill with ovarian cancer, ending her life.[9] In the 1990s, a doctor named Jack Kevorkian, the self-proclaimed "Dr. Death," illegally practiced physician-assisted suicide, and video recorded himself administering medication to one of his patients, a man named Thomas Youk who suffered from ALS. Kevorkian prepared this video recording for national television to support the movement and was imprisoned for eight years on the charge of second-degree homicide.[4] At the

end of the decade, in 1997, Oregon became the first U.S. state to enact the Death with Dignity Act, allowing terminally ill individuals to end their lives through the voluntary self-administration of medication.

Modern-day MAiD

MAiD is currently legal in 10 U.S. states (California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington) and in Washington, DC. From 1998 to 2017 in the state with the longest period of legalization, Oregon, 1,857 people received prescriptions for life-ending medications, 64 percent (1,179) of whom died from ingesting them.[10] Around the world, many countries—including Switzerland, the Netherlands, Belgium, Spain, and Luxembourg in Europe, Canada and Colombia in the Americas, and New Zealand and parts of Australia—have legalized MAiD.[11] People living in other countries will travel to those countries to access MAiD, most commonly Switzerland, where approximately 150–200 people travel per year to participate in what is known as "suicide tourism."[12]

Ethics of MAiD

Interestingly, ethical arguments for and against MAiD have remained relatively consistent over time.[6] Proponents of MAiD maintain that it preserves individuals' bodily autonomy and self-determination during the end of their life. Additionally, MAiD is a safer and more comfortable alternative to suicide for some people, and may be the only reliable option for ending their unbearable suffering and diminished quality of life.[13,11] Indeed, in a study in Oregon and Washington, loss of autonomy, diminished quality of life, and loss of dignity were found to be the factors most frequently associated with requests for assisted dying.[14] A *New York Times* article about Marieke Vervoort gives an intimate, in-depth look at this reality from the Belgian Paralympian's point of view. Vervoort suffered from a degenerative muscle disease that prevented her use of her legs, stripped her of her independence, and caused her agonizing, unrelenting pain. After Vervoort and her family wrestled with her decision to pursue MAiD, she eventually went through with it, dying surrounded by those she loved.[15]

Opposition to MAiD is not just religious in nature. Some argue that physician-assisted death violates the Hippocratic Oath taken by all physicians to do no harm, damaging the patient-physician relationship and undermining public trust in the health-care system.[13,11] Still others argue that suffering and pain can be managed through palliative care, and that MAiD is a slippery slope putting vulnerable populations, such as those with disabilities like dementia or chronic mental illness; the elderly, minors, and minorities; or people with low socioeconomic status, at the highest risk of coerced or improperly informed decisions.[11,16] Though a study found no evidence of increased rates of MAiD for vulnerable groups in Oregon and the Netherlands,[17] the historical prevalence of medical coercion, experimentation, and abuse of vulnerable populations around the world cannot be disregarded. The debate remains heated on whether suffering from dementia or psychiatric conditions should qualify as an indication for MAiD and how those without decision-making capacity can truly consent. Currently, MAiD for dementia and psychiatric disorders is legal only in the Netherlands, Belgium, and Luxembourg, but Canada passed legislation to include mental illness as a qualifying disorder for MAiD beginning in 2027.[11,18,19]

Final reflections

Physicians play a vital role in guiding patients through suffering and sickness. This role requires grappling with difficult ethical decisions that are rife with historical complexities and societal implications, while also restraining any personal biases influencing patient care.

MAiD is philosophically akin to the animal euthanasia of my veterinarian parents, but profoundly different due to the complexity of human sentience, the basic rights granted to humans over animals, the health inequities confronting marginalized social groups, and the homocentric and hierarchical view of the world making humans value their own lives higher than those of others. In comparing animal euthanasia to MAiD, psychiatrist Dr. Mark S. Komrad observes, "We humans can bring some of the same sentiments, intentions, and postures towards animals that we have towards each other: compassion, pity, tenderness, nonmaleficence, even love. Yet, the way love and compassion justify killing in the veterinary setting, cannot be translated to the human clinic."[20] Of course, ethical debates involving MAiD are far more nuanced than those involving the euthanasia of animals, but that greater nuance does not preclude doctors and veterinarians from arriving at similar conclusions regarding how best to act in the face of suffering.

The first principle of the most recent code of ethics from the American Medical Association (AMA) states,

"A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."[21] Canadian MAiD provider Dr. Ellen Wiebe, when asked in an interview if she had ever regretted providing MAiD, said:

> I don't agree with all of my patients' choices. Sometimes I struggle when I see a young, beautiful person choosing to leave earlier than they needed to. Because it's hard, especially on their parents. But I believe strongly in basic human rights. If that person says that they can't live with this condition, then once we've gone through the whole process, I will honor their wishes.[19]

On the day when Helen's Aid-in-Dying prescription needed to be filled and sent to the pharmacy, my primary-care preceptor reflected, "Of course I'm sad. But I know I am supporting Helen and her family through the most difficult experience of their lives, and that's why I became a doctor." Helen died later that week, in the comfort of her own home, and surrounded by those she loved—just as she had chosen to do.

Author's Note: For patient privacy, the name "Helen" is a pseudonym. Conversations with the "preceptor" in this story are not direct quotations, but rather reflect the main ideas discussed in conversation.

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