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MEDICAL ASSISTANCE IN DYING IN OLDER ADULTS: HAVING THE CONVERSATION ABOUT FRAILTY, DEMENTIA, AND ADVANCE REQUESTS

Gurmeet K Sohi
MSc, MD
Geriatric Medicine Fellow, Division of Geriatric Medicine, University of British Columbia Department of Medicine

Genevieve M. Casey, MSc, MBBS, FRCPC
Staff Geriatrician, Division of Geriatric Medicine, University of Ottawa Department of Medicine

Jocelyn Chase MD, MSc Bioethics
Clinical Assistant Professor, Geriatric Medicine, University of British Columbia Department of Medicine

Corresponding Author:
Genevieve Casey
gcasey@toh.ca

Abstract

Medical Assistance in Dying (MAID) accounts for 2.5% of all deaths in Canada in 2020. A proportion of these deaths are provided for dementia and frailty. Advance requests are not yet legal but are being considered for future legislative changes. This article provides an overview of who can access MAID and focuses on topics such as dementia, frailty, and advance requests to educate healthcare professionals who work in geriatrics.

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Introduction: MAID in Canada

In February 2015, with the landmark ruling of Carter v. Canada, the Supreme Court of Canada (SCC) decriminalized medical assistance in dying (MAID)[1]. The SCC provided the federal government until June 2016 to create new MAID legislation, which came in the form of Bill C-14, allowing eligible Canadian adults to access MAID.

In October 2020, The Minister of Justice and the Attorney General of Canada proposed further changes to Canada's MAID law. In the following months, extensive consultation involving the public, medical experts, provinces/territories, Indigenous groups, and other stakeholders was considered and a revised Bill C-7 was passed in March 2021. The changes focus on who may access MAID and the assessment process, expanding eligibility to include those whose death may not be reasonably foreseeable[2].

Current MAID Legislation (Bill C-7)

The current MAID legislation, Bill C-7, which has been effective since March 17, 2021, introduced a two-track approach for persons hoping to receive MAID: one for persons with a reasonably foreseeable natural death (RFND) and one for persons with a not reasonably foreseeable natural death (NRFND) [2].

All individuals seeking MAID must be[2]:

- Over 18 and mentally competent (capable of making healthcare decisions)
- A citizen of Canada and eligible for health services
- Have a grievous and irremediable medical condition
- have a serious illness, disease, or disability (excluding a mental illness as the eligible condition until March 17, 2023)
- be in an advanced state of decline that **cannot** be reversed
- experience unbearable physical or mental suffering from the illness, disease, disability, or state of decline that **cannot** be relieved under conditions that they consider acceptable
- Able to make a voluntary request
- Able to give informed consent

Reasonably Foreseeable Natural Death

For persons with a RFND, the following procedural safeguards are required[2]:

- A request for MAID must be made in writing: a written request must be signed by one independent witness (a family member, friend or a paid professional personal or healthcare worker can be an independent witness).
- Two independent doctors or nurse practitioners must provide an assessment and confirm that all the eligibility requirements are met.
- The person must be informed that they can withdraw their request at any time, in any manner.
- The 10-day reflection previously required for those with a RFND has been removed so there is no longer a waiting period between the MAID request and provision[2].

- The person must be given an opportunity to withdraw consent and must expressly confirm their consent immediately before receiving MAID (however, this "final consent" requirement can be waived in certain circumstances, as below).

The circumstances where waiver of final consent would be considered include[2]:

- The person has been assessed and approved to receive MAID.
- The person is at risk of losing decision-making capacity before their preferred date to receive MAID, and has been informed of that risk.
- The person arranges in writing with their MAID provider to waive final consent, detailing their preferred date to receive MAID if they have lost the capacity to provide final consent at that time.

It is important to note that the waiver of final consent was developed following "Audrey's Amendment", in response to a young woman with brain cancer who described receiving MAID sooner than she preferred, due to fear of losing capacity[2].

The appropriate application of waiver of final consent continues to be analyzed, because a reasonably foreseeable natural death has a broad interpretation (typically months to years). It is possible however that individuals with dementia who are still capable and found to have a RFND will be able to avail themselves of the waiver of final consent for a specific date, should they lose capacity prior to receiving MAID. However, waiver of final consent is not the same as an Advance Request for MAID (see below). Waiver of final consent applies to those who are closer to end of life (RFND), not to those who are well and planning far ahead for end stage dementia. It is unlikely that a provider would honor a waiver of final consent for a well person for some far date in the future, as it would contradict that their death is indeed reasonably foreseeable.

Not Reasonably Foreseeable Natural Death

In the second track, for those persons whose natural death is not reasonably foreseeable, the following procedural safeguards have been added in addition to the eligibility requirements listed above[2]:

- Two independent doctors or nurse practitioners must provide an assessment and confirm that all the MAID eligibility requirements are met.
  - If neither of the two practitioners who assesses eligibility has expertise in the medical condition that is causing the person's suffering, they must consult with a practitioner who has such expertise.
- The person must be informed of available and appropriate means to relieve their suffering, including counselling services, mental health and disability support services, community services, and palliative care, and must be offered consultations with professionals who provide those services.
- The person and the practitioners must have discussed reasonable and available means to relieve the person's suffering and agree that the person has seriously considered those means. However, the person is not obligated to try the options to relieve suffering to be eligible.
- The eligibility assessments must take at least 90 days, but this period can be shortened if the person is about to lose the capacity to make healthcare decisions, if both assessments have been completed.
- Immediately before MAID is provided, the practitioner must give the person an opportunity to withdraw their request and ensure that they give express consent. Those persons without a reasonably foreseeable natural death are not eligible for waiver of final consent.

Federal legislation on MAID is part of the Criminal Code and creates a framework for medical assistance in dying across Canada, including establishing eligibility criteria. Individual provinces and territories are responsible for the implementation and coordination of MAID services, including providing information about MAID availability, the use of specific forms, and the requirement for special medical training for MAID providers[2]. Policies and procedures can vary among the provinces and territories. For instance, in Quebec, MAID via self-administration is prohibited and only physicians can administer MAID [2].

Future Directions on MAID Legislation

A parliamentary review is currently being undertaken which will address further considerations around MAID including eligibility of mature minors, advance requests (including for those with dementia/major neurocognitive disorder), mental illness as the sole eligible condition for MAID, access to palliative care, and protection of Canadians living with disabilities. Further expert review will be done during this time to consider protocols, guidance, and safeguards for MAID in persons suffering from mental illness, though not including neurocognitive/neurodevelopmental disorders[2].

MAID in Older Adults

According to the Canadian Annual Report on Medical Assistance in Dying, in 2020, the average age at time of MAID provision was 75.3 years, which was similar across genders[3]. MAID accounted for 2.5% of all deaths in Canada in 2020[3]. The nature of suffering most cited was loss of ability to engage in meaningful activities and loss of ability to perform activities of daily living (ADL)[3]. The most common underlying illness was cancer (69.1%), followed by cardiovascular (13.8%) and respiratory conditions (11.3%)[3]. Neurological conditions accounted for over 10% of MAID deaths. Dementia diagnoses are included in neurological conditions and reflect 4% of cases[3].

Though the Canadian Annual Report on MAID doesn't have a specific category for geriatric syndromes, "multiple comorbidities" accounted for 7.8% of all MAID deaths in 2020[3]. This category incorporates diagnoses including frailty (no definition given), osteoporosis, osteoarthritis, or fractures. In the Netherlands Annual Report, "multiple geriatric syndromes" which is its own category, accounted for approximately 2% of all MAID deaths[4]. This category includes conditions like visual impairment, hearing impairment, osteoporosis, osteoarthritis, balance problems or cognitive deterioration[4].

What follows is a discussion about MAID specifically pertaining to issues in Geriatric Medicine, including issues relating to frailty, dementia (such as capacity and Advance Requests for MAID in dementia), advance care planning, and the roles and responsibilities within MAID legislation for clinicians who care for older adults. Two illustrative case examples are given to demonstrate the considerations and challenges faced by patients, families, and healthcare providers.

Case 1 – Frailty:

Mr. D is a 93-year-old male with non-insulin dependent diabetes, who lives alone and is independent for all activities of daily living in the community. At baseline, he goes for daily walks for 30 minutes and mobilizes with a cane. He presents to hospital after a fall and is found to have a non-operative pubic ramus fracture which requires inpatient rehabilitation. His recovery is limited by severe orthostatic hypotension, refractory to non-pharmacological and pharmacological therapies, and he is now mostly bed bound. He progresses to sitting independently for short periods of time and minimal ambulation with assistance over the next few weeks, and it is determined this is likely his new functional baseline. After 2 months in hospital, his care team believes he has plateaued in function at a long-term care level. He has no family or friends who can support him. When Mr. D learns that he will be unable to return home at his prior level of independence, he expresses distress and emotional suffering. He frequently states that he has had a good life and doesn't want to live like this. He expresses to the team that he would like "to get something to just make me die in my sleep". When the care team clarifies his emotional suffering further, it appears he is interested in pursuing MAID.

MAID and Frailty

People often confuse normal aging with frailty, which is an age-related syndrome of cumulative physiological deterioration with an increased vulnerability to endogenous and exogenous stressors[5]. Increasing degrees of functional impairment and dependence on others for ADLs is characteristic of frailty [6]. This vulnerability contributes to morbidity including increased risk of falls, institutionalization, and procedural complications, as well as increased mortality[7]. Considering a patient's medical and functional history, personality, and values, a sum of deficits in the context of an individual patient's experiences can result in substantial suffering, especially when the prospect of acceptable improvement to the patient is limited[8].

Case 1 Resolution:

Following his injury, Mr. D is suffering from moderate frailty as per the Clinical Frailty Scale[6], which qualifies as his grievous and irremediable medical condition for MAID request. With his advanced age, his life expectancy is limited, his frailty carries an elevated mortality risk, and his life expectancy could be predicted in months to several years.

Under Canada's MAID legislation, the definition of reasonably foreseeable is controversial and continues to evolve following several legal challenges[9]. Many providers now consider RFND to be applicable to people who have up to several years to live. A RFND is assessed on a case-by-case basis, considering the individual's medical circumstances, with the anticipated decline toward death being the expected trajectory[2].

Mr. D is assessed for MAID by two independent practitioners and is deemed eligible. He is informed that he can withdraw his MAID request at any time. Within the two tracks of Bill C-7, Mr. D's request falls under the RFND category. As the minimum 10-day reflection between the written request for MAID and MAID provision is no longer required, Mr. D is successful in receiving MAID within the next couple of days. If he was at risk of imminently losing capacity, a waiver of final consent would have been an option that would be made available to him.

Case 2 - Dementia:

Ms. K is a 74-year-old woman, with a history of hypertension and cerebrovascular disease who presents with a one-year history of increasing forgetfulness, which she describes as missing appointments, misplacing objects and getting lost on the way to one of her usual restaurants. She is accompanied by her son, who she has asked to take over her finances, after making some errors with paying her bills. She has cognitive testing and scores 20/30 on her Montreal Cognitive Assessment (MoCA)[10] with deficits in delayed recall and visuospatial domains. With her subjective and objective cognitive deficits and evidence of functional impairment, she is diagnosed with an early mixed vascular/Alzheimer's dementia. She shares that her father had Alzheimer's dementia and had been in a long-term care home for the last years of his life and suffered from significant behavioural and psychological symptoms of dementia. She states she would never want to live as her father did, as she believes that would be "a state worse than death". She fears being a burden on her family and if she ever got to the stage where she couldn't take care of herself, she would no longer want to live.

At a six month follow up visit, she has continued to deteriorate, and her family is considering relocating her to an assisted living environment where she could be more supported with her instrumental activities of daily living (IADL). Ms. K expresses that her diagnosis has been very difficult for her to accept, she is constantly worried about her progressive decline and that she would like to have MAID before things get any worse.

MAID in Dementia

The Canadian Association of MAID Assessors and Providers (CAMAP) provides recommendations regarding eligibility of persons with dementia for MAID under Bill C-14, which include whether the patient is in advanced state of decline in capability and whether the patient has capacity to decide to have MAID [11]. Life expectancy is considerably reduced with a diagnosis of dementia, with studies suggesting a median survival from diagnosis of approximately seven years in Alzheimer's disease, and shorter in other forms of dementia[12]. Predictors of increased mortality are a greater age at dementia onset, male gender, and medical or

psychiatric comorbidities[13]. Prognostication can be difficult as there is much variability with the rate of progression of the disease between different individuals[14].

When considering dementia, the patient's perception of progressive personality, function, and skill loss can be a source of profound anticipatory suffering in the present moment when these deficits may not have occurred[15]. There are also challenges in predicted versus lived experience of suffering for when the disease progresses. The disability paradox has demonstrated that people often underestimate quality of life with disability when they are able bodied or healthy[16]. Often the anticipation of capacity loss with dementia is sufficient to cause enough suffering for some people, which reflects more of an existential suffering rather than a neurocognitive suffering[17].

Due to prognostic uncertainty in dementia and insufficient advance care planning there are often delays in recommending palliative care and other end of life options[18]. Setting appropriate goals of care considering the patient's values and the expected course of the disease can help provide better patient-centered care[19]. Involving specialized medical and community supports may allow patients to stay in their homes longer and feel more supported. High quality palliative care in dementia has been shown to reduce symptom severity and improve quality of life[20]. Discussing options such as withdrawal or withholding aggressive care in later stages of dementia and shifting focus to maximization of comfort should be offered to patients with advancing dementia[19].

Capacity and Informed Consent for MAID in Dementia

For all MAID requests, informed consent is a prerequisite. This means the individual has consented (given permission) to MAID after they have received all the information necessary to make their decision, like their medical diagnosis, available forms of treatment, available options to relieve suffering, including palliative care[2].

Capacity to make medical decisions is task- and time-specific, and a patient could be incapable of some types of decision making but not others. To have capacity, a patient must: 1) understand information given to them, 2) retain that information long enough to be able to make the decision, 3) reason about treatment options, 4) appreciate how the information applies to the current situation, 5) weigh up the information available to make the decision, and 6) communicate a clear and stable choice[11,21].

It is the MAID assessor that assesses capacity for MAID, although a second opinion may be sought if there is uncertainty.

Capacity assessments in patients with cognitive impairment is a clinical challenge. There is no gold standard for assessing capacity to consent to treatment for patients with dementia. Several tools can be utilized however, including the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), which has a high interrater reliability[22]. The Mini Mental State Examination (MMSE) and MoCA are used for detection of cognitive impairment but on their own are not a suitable measure of capacity, although some studies suggest a MMSE score of less than 19 correlated with a designation of incapacity[23]. The MoCA has not been studied in its ability to predict capacity.

Understanding is a domain that relies heavily on short-term memory, so for those patients with amnestic deficits, this can pose a challenge. Memory aids that simplify information onto a single easy digestible page have been shown to increase rate of capacity[24]. Patients may exhibit word finding difficulty, expressive aphasia, dysarthria and previously multilingual individuals may lose their English abilities[11], further exacerbating ability to communicate a clear and reasoned choice.

Studies looking at capacity in mild cognitive impairment to mild Alzheimer's disease have found that overall capacity may be impaired in 9 to 30% of patients in these early stages[23,25]. From these studies, it can be concluded that most patients with mild cognitive impairment (MCI) and early dementia retain some capacity.

As the disease progresses overtime, this capacity deteriorates. The timing of deterioration, however, is difficult to predict. Decline in capacity is specific to the individual. The "10 minutes to midnight" approach suggests that serial assessments of capacity can help guide decision making and a decision regarding MAID provision should be sought as a patient is approaching loss of capacity[11]. In the Netherlands, people with early dementia who still have capacity constitute the vast majority of those with dementia who receive euthanasia[4]. Though these patients may have had decline in cognitive ability and functioning, they still had a sufficient understanding of their disease and were able to provide consent to euthanasia.

In Canada, capable patients with dementia accessing MAID through the RFND track (either for dementia or another condition that qualifies them for MAID with a RFND) would be able to use a waiver of final consent, to avoid a situation where unexpected capacity loss precludes them from completing MAiD. Patients with very early dementia or MCI who access MAID through the NRFND track will need to retain capacity throughout the entire process of assessment and provision. Once they have passed their 90-day waiting period, they could choose to access MAID right away or use the Dutch "10 minutes to midnight approach" to delay provision up to the point of approaching capacity loss.

If a patient is initially assessed to be on the NRFND track but has a significant change in health status (e.g., patient with MCI assessed as NRFND who receives a new diagnosis of metastatic cancer with poor prognosis), they could be reassessed by a MAID assessor to transition to the RFND track to waive the 90-day assessment period, and to have access to a waiver of final consent.

Case 2 Resolution:

Ms. K completes a written request for MAID and a geriatrician MAID assessor meets her for her first assessment. At that assessment, Ms. K is unable to tell the assessor about her medical conditions or any suffering that she is experiencing. When asked directly if she has a diagnosis of dementia, she tells the assessor that she is worried about dementia because her father had it and she would never want to live like that but doesn't appear to relate the diagnosis to herself. She informs the assessor that she is having a good day today and maybe gets some knee pain but denies any specific suffering. She knows what MAID is, knows that it makes you 'leave this world' and says she might want it 'one day'.

Her family is very upset when informed that today, Ms. K doesn't have capacity for MAID at this assessment. Her family report that for years Ms. K was always firm about 'never wanting to end up like her father'. The geriatrician spends time with the family and empathizes about this situation. The geriatrician reminds them that while dementia is a challenging diagnosis, at times people can have a good quality of life, especially with appropriate geriatric, palliative and end-of-life care services. In addition, the geriatrician provides counselling about not having to treat any of her current medical conditions or any other future medical conditions. For example, if she were to fracture her hip or have a heart attack, and her family had concerns about her quality of life, they could opt to take a palliative care approach at that time. The family is still upset but comforted that they don't need to prolong her life in future acute medical situations.

In this case, Ms. K has been informed of a grievous and irremediable medical condition but was not capable to consent to MAiD, therefore is ineligible. However, had she retained capacity, the MAID assessor would be responsible for determining whether Ms. K was eligible for MAID through the RFND track, or the NRFND track. Though we understand dementia to be a life-limiting condition, prognostication is difficult. Based on her slightly younger age, limited comorbidities and functional status, on average Ms. K's life expectancy could likely be years. However, as stated earlier, the interpretation of a RFND is quite broad and some assessors may suggest that she falls in that category and has access to the waiver of final consent[26].

Conversely, some assessors might feel that pursuing track two would be more reasonable in the early stages of dementia. As part of the NRFND track, one of the two MAID assessments would be done by a practitioner with expertise in her cause of suffering, which is dementia (e.g., geriatrician, care of elderly physician, geriatric psychiatrist, or neurologist), or expert consultation from a specialist in dementia would be required[2]. Further, she must be informed of all available counseling services, community services and palliative care services and should be offered consultation with these services[2]. The person and practitioners must agree that reasonable and available means of alleviating her suffering have been discussed and seriously consid-

ered, although she is not obligated to try them[2].Lastly, there must be a minimum of 90-days between the MAID request and provision, though this could be shortened if both evaluating practitioners agree that loss of capacity is imminent[2].

ADVANCE CARE PLANNING

An important part of care for patients with dementia is to ensure that they and their family/substitute decision makers are fully informed of the likely and possible trajectories of their dementia journey. Sharing information regarding the implications on their quality of life, as well as the impact on family and caregivers helps the patient develop a more holistic understanding of what their disease process may look like. There is often a spectrum of care options available through the dementia journey, including home and community care, caregiver support, medical care for behavioural and psychological symptoms of dementia, and palliative care during advanced stage and end stage dementia[27]. Although dementia can lead to troubling symptoms, not all patients experience significant suffering, and suffering can often be relieved to some extent with non-pharmacologic and pharmacologic treatment options[28]. The benefit of advance care planning is to ensure patients receive value congruent care after the point of losing capacity.

Care providers need to be prepared to engage in advance care planning and may require further education and support to gain these skills[29]. Generally, advance care planning is the process whereby patients reflect on and expressing wishes for future health and personal care decisions. This can often be informal with discussions with family and friend networks but can also include formal documentation with a primary care physician or other care provider[17]. Access to education and resources (such as www.advancecareplanning.ca) can help patients and their families navigate this process.

Advance directives (AD) formalize advance care planning into a legal document of one of two types: instruction directives or proxy directives[30]. An instruction directive involves formal documentation that specifies a patient's treatment preferences in various scenarios, which can be acted on in the event the patient no longer has capacity. A proxy directive involves assigning a substitute decision maker in the event the person loses decision-making capacity. Advance directives are often regulated through provincial or territorial legislation[17, 31]. For more information please see: Facilitating-Effective-End-of-Life-Communication-–-Helping-People-Decide.pdf (canadiangeriatrics.ca)[31].

Advance Requests for MAID in Dementia

Advance requests for MAID in dementia are not yet legal, and there is currently no formal definition of advance request for MAID in Canada. The expert panel in the Council of Canadian Academies, which is an independent, not-for-profit organization that that provides independent, science-based assessments to inform public policy development in Canada, refers to advance request for MAID as a "request for MAID, created in advance of the loss of decision-making capacity, intended to be acted upon under circumstances outlined in the request after the person has lost decisional capacity"[17].

The difference between advance requests for MAID and advanced directives is that advance requests for MAID only covers scenarios for which MAID should be provided, while advance directives cover other general scenarios where a person may wish to receive certain medical care, or have certain medical care withheld or withdrawn (e.g., critical care interventions). Further, advance requests for MAID requires that a third party must determine the exact timing and circumstances of a person's death based on a documented request. Though with advanced directives, withdrawing or withholding treatment may be a decision which then eventually results in death, advance directives don't directly compel a third party to decide that another person is ready to die at that moment.

In anticipation that advance requests for MAID be included in upcoming Canadian legislative changes[2], there are various issues that need consideration. Though public opinion polls reveal high support for advance requests for MAID[32], healthcare providers express greater levels of uncertainty, as well as logistical concerns related to the enactment of advance requests for MAID[32]. In a survey of Vancouver clinicians who care for patients with dementia, most participants agreed that advance requests for MAID should be available for pa-

tients with dementia, with the caveat that capacity assessment should occur at the time the advance request for MAID is being completed. Further, clinicians expressed concerns around assessing capacity, protecting the interests of the future individual with dementia (who may have an unanticipated good quality of life), navigating conflict between stakeholders, and identifying coercions. In a survey of MAID practitioners and the public, advance requests for MAID practice and policy considerations included a requirement for patient and family assent, evidence of suffering at time of MAID provision, demonstration that circumstances set out by requestor are stable over time, regular renewal of advance requests, and contingency plans should the patient resist or not provide assent to the procedure[34].

Other possible policy considerations would include the requirement for a formal diagnosis of dementia to complete an advance request for MAID for dementia, and completion of a formal education program on the dementia trajectory and alternatives of end-of-life care to ensure persons with dementia are aware of all their care options. Involving the MAID assessor/provider in the creation of the advance request for MAID and supporting them with access to medical records pertaining to the advance request would also be important[34]. Discussion with family and substitute decision makers as part of creating the advance request for MAID, with periodic reaffirmation, would increase practitioner comfort in providing MAID based on advance request[17,34].

Finally, although completing an advance request for MAID may give patients with dementia comfort that their current wishes will be followed following the loss of capacity, the Dutch experience reveals that advance requests for euthanasia are rarely followed[4]. Following a loss of capacity in dementia, it is more common for substitute decision makers and care providers to withdraw or withhold life-sustaining care than provide euthanasia based on an advance request[35]. Patients should be made aware that interpreting and enacting an advance request for MAID can be challenging, and that creating an advance request for MAID does not guarantee that MAID will be provided, particularly if the now demented individual appears to be content.

Roles and Responsibilities of Geriatricians and Care of the Elderly Physicians in MAID

In 2020, there were 1,274 physicians that acted as MAID providers, representing 94.7% of all provisions[3]. In some jurisdictions, nurse practitioners can provide MAID, and they accounted for 5.3% of all remaining MAID provisions[3]. Most MAID providers work within family medicine, palliative medicine, and anesthesiology, with a smaller proportion from backgrounds in internal medicine, geriatric medicine, and rehab medicine[3].

As part of the procedural safeguards with Bill C-7 NRFND, one of the assessors must have expertise in the condition causing suffering, and so for patients suffering from geriatric syndromes, geriatricians may be well suited as MAID assessors for older adults. If there is no MAID assessor with expertise in geriatric syndromes, geriatricians or care of the elderly physicians may be asked to provide expert opinion on MAID eligible conditions with NRFND, such as mild frailty and cognitive impairment, and provide information around diagnosis, prognosis, and treatment options. This consultation would assess whether eligibility requirements are satisfied and is not an assessment for MAID (for example, ensuring the patient is aware of all the potential treatment options for frailty, medical issues, and support of functional needs). Other geriatricians or care of the elderly physicians may be asked to give an opinion about patient capacity.

In anticipation of the inclusion of advance requests in Canada's MAID legislation as early as April 2022[2], we appreciate that patients with dementia and their families may have questions regarding MAID as an end-of-life care option. As our care usually involves some component of advance care planning, expanding the conversation to include advance requests for MAID will likely be necessary. Pending policy considerations regarding the generation, storage and sharing of advance requests, the role of geriatricians may be quite variable.

Generally, geriatricians, geriatric psychiatrists and care of elderly physicians will continue to provide education for patients regarding the trajectory of dementia, including expected changes in cognition, symptom burden and overall function. We will also continue exploring patients' values and care philosophies and provide counselling regarding goals of care throughout their disease journey. Introducing community supports and connecting patients with further specialized medical supports, such as geriatric psychiatry and palliative medicine, for symptom control and end-of-life support can help the patient feel supported. All end-of-life care

options, including withdrawing or withholding acute interventions, should be discussed with patients early in their disease when they can still meaningfully participate in advance care planning conversations.

Conclusion

MAID is a relatively new and evolving end-of-life care option for patients in Canada, presenting new opportunities and challenges to patients and care providers. Bill C-7 opened MAID eligibility to those who are suffering with a grievous and irremediable medical condition, but do not have a reasonably foreseeable death, with increased safeguards to protect those who are vulnerable. So long as capacity is retained, most patients with dementia and frailty can now access MAID, even if they are in the very early stages of their illness. Others with more progressed dementia could receive MAID after loss of capacity if they previously completed a waiver of final consent.

Some geriatricians, geriatric psychiatrists, and care of elderly physicians may choose to act as MAID assessors and providers, while others will be asked to give an expert opinion on capacity or the MAID eligible condition that causes suffering. All clinicians who look after older adults with dementia and frailty must be aware of ongoing and anticipated legislative changes, including the possibility of advance requests for MAID in dementia. Advance care planning is an integral part of patient centered care for individuals with dementia, with MAID now joining the spectrum of end-of-life care options.

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