

FEATURE

Palliative sedation and medical assistance in dying: Distinctly different or simply semantics?

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Abstract

Medical assistance in dying (MAiD) and palliative sedation (PS) are both legal options in Canada that may be considered by patients experiencing intolerable and unmanageable suffering. A contentious, lively debate has been ongoing in the literature regarding the similarities and differences between MAiD and PS. The aim of this paper is to explore the propositions that MAiD and PS are essentially similar and conversely that MAiD and PS are distinctly different. The relevance of such a debate is apparent for clinicians and patients alike. Understanding the complex and multi-faceted nuances between PS and MAiD allows patients and caregivers to make more informed decisions pertaining to end-of-life care. It is hoped that this paper will also serve to foster further debate and consideration of the issues associated with PS and MAiD with a view to improve patient care and the quality of both living and dying in Canada.

KEYWORDS

end of life, medical assistance in dying, palliative care, palliative sedation, terminal sedation

1 | INTRODUCTION

Since June 2016, the legalization of medical assistance in dying (MAiD) in Canada affords those suffering from grievous and irremediable suffering an option to end such suffering (Government of Canada, 2018). Palliative sedation (PS), also legal in Canada, is another possible option for patients with intolerable, refractory symptoms at end of life (EOL) (Glauser, Tierney, & Nolan, 2015). Considerable controversy exists pertaining to the ethical and practical similarities and differences between PS and MAiD (Broeckaert, 2011; Carvalho, Rady, Verheijde, & Robert, 2011; Hahn, 2012; Janssens, Delden, & Widdershoven, 2012; Lipuma, 2013). The purpose of this article is to explore both positions, that is, that MAiD and PS are essentially similar and that MAiD and PS are distinctly different. Our aim is not to take a stance regarding this debate, but to present current thinking and foster further discussion and contemplation. Given that both MAiD and PS are legal treatment options in Canada, it is critically important that nurses have an understanding of the intricacies of these

end-of-life options in order to best support patients and families in their decision-making. Failure to recognize the nuances of MAiD and PS may result in care that is incongruent with patients' wishes and may adversely influence family and caregiver outcomes. We begin by providing an overview of the relevant terminology and current landscape of MAiD and PS in Canada, proceed to illustrate the positions both in support of MAiD and PS as similar options as well as being distinctly different, and finally explore the overall implications for nursing (Table 1).

2 | DEFINITIONS

2.1 | Medical assistance in dying (MAiD)

The Supreme Court of Canada ruling in February 2015, in the case of *Carter versus Canada*, that changes to the Criminal Code were required pertaining to MAiD, led to federal legislation being passed in June 2016 to allow eligible Canadian adults to request MAiD

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(Government of Canada, 2018). The legislation permits two types of MAiD: clinician-administered MAiD (also known as medically assisted suicide, or assisted suicide) and self-administered MAiD (also known as voluntary euthanasia). Both require either a physician or nurse practitioner to either administer or prescribe the medications intended to bring about death (Government of Canada, 2018). Between June 2016 and October 2018, the majority of patients who underwent MAiD did so via clinician-administered MAiD ($n = 5,079$) compared to self-administered MAiD ($n = 6$; Health Canada, 2019). Medically assisted deaths ($n = 1,961$) accounted for 0.71% of total deaths in Canada in 2017 and for 1.12% of all deaths in Canada between January 2018 and October 2018 (Health Canada, 2018, 2019; Statistics Canada, 2018).

2.2 | Palliative sedation (PS)

Palliative sedation first emerged in the literature in the 1960s when Neder, Derbes, Carpenter, and Ziskind (1963) described its use for patients with status asthmaticus. Approximately three decades later, PS resurfaced in the literature, this time, in the context of managing intractable symptoms in patients with advanced cancer (Ventafriidda, Ripamonti, DeConno, Tamburini, & Cassileth, 1990). Additional terms have appeared in the literature that include terminal sedation, continuous PS therapy, continuous deep sedation, and slow euthanasia, to name a few (Papavasiliou, Brearley, Seymour, Brown, & Payne, 2013; Rhys et al., 2012; Rietjens et al., 2006; ten Have & Welie, 2014). No universal term has been accepted in the literature although PS and terminal sedation are perhaps the most common iterations (Papavasiliou, Brearley, Seymour, Brown, & Payne, 2014). Terminal sedation is reported by some to have negative connotations as some might interpret "terminal" to mean the condition of the patient or the goal of the treatment; the latter aligns terminal sedation more closely with assisted death (Papavasiliou et al., 2014; Rady & Verheijde, 2010).

It is important to note that some authors use variants of the terminology to reflect the duration of sedation (intermittent, continuous), depth of intensity of the sedation (mild, moderate/intermediate, deep), and/or onset of administration of sedation (rapid, gradual; Hahn, 2012; Lipuma, 2013; Olsen, Swetz, & Mueller, 2010; Raho & Miccinesi, 2015). In addition, sedation may be described in relation to particular contexts, such as procedural sedation (Kon, 2011) or emergency sedation, the latter of which may occur with overwhelming symptoms such as catastrophic hemorrhage, severe terminal dyspnea, or pain crisis (Cherny, 2014).

For the purposes of this article, we are using the term PS where PS is "the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health-care providers" (Cherny & Radbruch, 2009, p. 581). This definition is congruent with what others have termed "continuous deep sedation (CDS)" (Hahn, 2012; Raho & Miccinesi, 2015).

The prevalence of PS reported in the literature is incredibly variable, likely owing to an array of factors, including but not limited to:

how PS is defined, patient population, clinical setting, and existence of and adherence to institutional practices and/or guidelines (Prado et al., 2018). A systematic review by Maltoni et al. (2012) examined 10 articles that reported on non-randomized studies involving adult patients with terminal cancer who had been referred or not referred for PS ($n = 1,807$). The authors reported the mean frequency of PS to be 34% with a range of 14.6% to 66.7% (Maltoni et al., 2012).

2.3 | Definitions of death

Particularly germane to the discussion of the similarities and differences between MAiD and PS are the concepts of death and personhood (Krishna, 2013; Lipuma, 2013; Materstvedt, 2012; Raho & Miccinesi, 2015). Consensus regarding how human death ought to be defined remains elusive (Youngner & Arnold, 2001). Historically, death was thought to occur with cessation of cardiopulmonary function but this definition shifted with the discovery and implementation of mechanical ventilation and organ transplantation (Lipuma, 2013). More recently, brain death has been considered to reflect death but has been felt by some to be inadequate (Lipuma, 2013; Raho & Miccinesi, 2015). The recent publication that scientists were able to restore microcirculation as well as molecular and cellular functions of pig brains (ex vivo) up to four hours post-mortem (Vrselja et al., 2019) may further challenge our notions of what constitutes death. Notably, the authors indicated that they did not observe evidence of "organized global electrical activity associated with awareness, perception, or other high-order brain functions" (Vrselja et al., 2019, p. 342). Nevertheless, the ability to restore cellular function up to four hours after death is contrary to the previously held understanding that oxygen stores, global electrical activity, and, at least theoretically, consciousness cease after seconds of interrupted blood flow (Vrselja et al., 2019).

While the biological definition of death has been and continues to be somewhat of a moving target, ontological and philosophical considerations are also noteworthy (Materstvedt & Bosshard, 2009). For example, as Raho and Miccinesi (2015) explain, it is "...more plausible to declare a human being dead after that individual has lost, irreversibly, the anatomical structure responsible for maintaining whichever essential function(s) we hold to be morally significant"

TABLE 1 Summary of similarities and differences between PS and MAiD

<i>Perceived Similarities</i>	<i>Perceived Differences</i>
Shared intentions & outcomes	Indications
Hastening death	Role of prognosis
Patient level of consciousness	Proportionality
Patient autonomy	Elements of consent
Impact on family	Public awareness
<i>Perceived Overlap</i>	
Doctrine of double effect (DDE)	
Reversibility	

(p. 544, emphasis added). It is unclear who the authors are referring to in terms of “we” but this statement highlights the importance of not only the biological aspects of death but also the loss of function. Is death defined as the death of the human organism (biological death) or the death of the human person (social death)? If death is socially constructed (Youngner & Arnold, 2001; Zimmermann & Wennberg, 2006), whose definition of death matters when it comes to MAiD and PS? Is it possible to be alive but not living? If so, how should quality of life be conceptualized?

While fully addressing these questions is beyond the scope of this paper, they are reflected in the debates surrounding PS and MAiD. With these questions and beginning definitions in mind, we proceed to explore current views on the similarities and differences between PS and MAiD.

3 | PERCEIVED SIMILARITIES BETWEEN PS AND MAiD

It has been reported that some physicians and nurses consider PS and MAiD as essentially equivalent (Anquinet et al., 2012; Papavasiliou, Payne, & Brearley, 2014). Our focus addresses clinicians' views since little is known about patient and family perspectives. However, Materstvedt and Bosshard (2009) surmised that from a patient standpoint, it “might make little difference if they [patients] are dead or continuously sedated from a given point in time” (p. 623). Four key areas of similarities are addressed and include: perceptions of shared intentions and outcomes, patient level of consciousness, patient autonomy, and impact on family and bereavement. These are discussed in turn.

3.1 | Similarities of shared intentions and outcomes

Much of the debate around PS and MAiD hinges on arguments addressing the intent and outcome of PS and MAiD. Those who assert strong similarities between PS and MAiD suggest that PS aligns closely with assisted death whereby “sedation [is] prescribed continuously to induce a total loss of consciousness until death occurs (i.e., continuous sedation until death)” (Papavasiliou et al., 2013, p. 692). Others have referred to deliberately inducing deep sleep, where food and water are not taken, as slow euthanasia that has led to considerable ethical debate (Battin, 2008; Hasselaar, Verhagen, & Vissers, 2009).

In contrast, those who focus on the differences (Cherny, 2014; Daly, 2015; Hahn, 2012; ten Have & Welie, 2014) have suggested that intent with MAiD is death of the patient, and consequently, the measure of successful MAiD is death of the patient. However, this view seems to be challenged. First, some authors suggest that the intent of *both* MAiD and PS is to end the suffering of the patient (DeMichelis, Zlotnik Shaul, & Rapoport, 2018; Juth, Lindblad, L n e, S jstrand, & Helgesson, 2013; Quill, Lo, & Brock, 1997) and the successful outcome of both is the alleviation of suffering. Death that occurs with MAiD can be viewed as a secondary consequence

of the primary aim to end grievous suffering. Likewise, the aim of PS is to use medically induced unconsciousness in order to alleviate the burden of intractable suffering (Cherny & Radbruch, 2009). There appears to be consensus that both PS and MAiD should only be considered as options of last resort, when all other measures to alleviate suffering have been pursued and have been inadequate (Materstvedt, 2012; Riisfeldt, 2019) though again, a question that arises is who determines the adequacy and acceptability of the interventions.

3.1.1 | Hastening of death

Another element is the intention of hastening death; while we acknowledge the disparate perspectives in the literature, we consider this an overlapping element of PS and MAiD. While the intention to hasten death is integral to MAiD, it has been reported that clinicians *have* also intended to hasten death with PS (Anquinet et al., 2012; Rietjens et al., 2004; Riisfeldt, 2019). For example, Rietjens et al. (2004) describe how hastening death was partly the physician's intention in 47% of cases and was the physician's explicit intention in 17% of cases of PS. Accordingly, whether or not PS actually does hasten death becomes moot. Intent is subjective, often ambiguous, and some have suggested that the meaning of intent may differ (Janssens et al., 2012; Juth et al., 2013; Quill et al., 1997; Rhys et al., 2012). For example, does intent reflect one's aim to hasten death or does intent reflect one's awareness of foreseeability (Daly, 2015)?

The question of whether hastening death is an actual outcome of PS remains unclear. Studies have examined the potential for PS to hasten death and reported equivocal findings with some authors stating that PS does hasten death (Carvalho et al., 2011; Rady & Verheijde, 2010; Raus, Chambaere, & Sterckx, 2016) while others have found that PS does not hasten death (Maeda et al., 2016; Maltoni et al., 2012). A Cochrane review that examined palliative pharmacological sedation for patients with a terminal illness described 14 studies that involved 4,167 adults, the majority of whom had cancer (Beller, Driel, McGregor, Truong, & Mitchell, 2015). The authors report that 1,137 patients received PS and of the studies that measured survival time ($n = 13$ studies), there were no significant differences in survival between the sedated and non-sedated groups. Of note, survival was measured from time of admission or referral to time of death rather than time from onset of PS to time of death (Beller et al., 2015). The majority of studies to date that have examined the impact of PS on survival have been of poor or fair quality (Beller et al., 2015; Maltoni et al., 2012). What seems less contentious is that if given too early, PS may hasten death through the subsequent inability of the patient to eat or drink (Daly, 2015; Rhys et al., 2012; Twycross, 2017). However, if given within the last days of life, it is felt that PS is not as likely to induce dehydration and hasten death (Hahn, 2012; ten Have & Welie, 2014).

A separate issue concerning the direct impact of PS on hastening death is the outcome that when sedatives are titrated to the level of a patient being unconscious, vital functions such as respiration,

maintenance of blood pressure, and function of airway and swallowing reflexes can be impaired (Rady & Verheijde, 2010). Further, deep sedation can lead to diminished control of muscles in the face and throat, leading to changes in pharyngeal and airway muscle tone, impacting patients' ability to swallow and/or cough which may contribute to aspiration and hypoxia (Carvalho et al., 2011; Rady & Verheijde, 2010). Therefore, it appears that it is indeed possible that PS may hasten death, and in this regard, PS and MAiD may be similar.

And finally, the evidence about intent, as related to PS, is considered primarily from the perspective of clinicians. What about the patient's intent? If the patient intends to undergo PS with a view that it will bring about death, does that change the intent of PS being provided by the physician? To illustrate, consider a patient who requests PS prior to voluntarily stopping eating and drinking (Daly, 2015); it is anticipated that death can occur within 1 to 3 weeks after a patient voluntarily stops eating and drinking (Quill et al., 1997). In this situation, the lack of hydration and nutrition while the patient is sedated may be the reason for death, rather than the underlying medical condition and ultimately, such a death could be considered similar to MAiD.

3.2 | Patient level of consciousness

Another element of similarity is patients' level of consciousness. That PS induces unconsciousness, and ultimately, the social death of the person, is felt by some, to confer similitude to MAiD (Janssens et al., 2012; Lipuma, 2013). As Holm (2013) stated, "the last time I am conscious is the last time I will experience myself as alive" (p. 236). PS to unconsciousness means that the patient can no longer make autonomous choices, experience the world around them, or interact with family/friends (Materstvedt & Bosshard, 2009). Lipuma (2013) states that loss of consciousness and cognition is equivalent to death and that because "continuous sedation until death (CSD) permanently eliminates consciousness...it eliminates human life" (p. 199). The role of consciousness in determining one's personhood is likely very individual and may vary depending on numerous factors such as cultural beliefs and religion (Krishna, 2013). Nevertheless, if one conceives of consciousness as being important to personhood, the elimination of consciousness may be considered a type of death, and in that regard, PS could be seen as similar to MAiD.

3.3 | Patient autonomy

Similarly, the element of autonomy addresses how PS and MAiD both honor patients' autonomy and respect their wishes for EOL care (Li et al., 2017; Olsen et al., 2010). At the same time, both approaches also effectively erode autonomy with PS inducing unconsciousness and the subsequent inability of the patient to participate in any decision-making (Leboul et al., 2017) and MAiD causing death, thereby eliminating any and all autonomy (Raus et al., 2016). Based on these lines of reasoning, PS and MAiD can be regarded as similar in their support and constraint of patient autonomy.

3.4 | Impact on family or bereavement

Lastly, although the literature on the impact of both PS and MAiD on family members remains scarce, some authors have found that bereaved family members of those who have passed away after receiving PS or MAiD report better outcomes in terms of coping and grief (Bruinsma, Rietjens, & Heide, 2013; Ganzini, Goy, Dobscha, & Prigerson, 2009; Swarte, Lee, Bom, Bout, & Heintz, 2003). Other authors report increased distress, guilt, or regret (Bruinsma et al., 2014; Cherny, 2014). Studies from the UK and Netherlands examined contextual factors that appeared to complicate bereavement after assisted death such as social disapproval (Wagner, Müller, & Maercker, 2011), family conflict (Kimsma & Leeuwen, 2007), and stigma (Fish, 2017). These findings relate to assisted death rather than PS. There are likely many confounders at play, including the positions that family members hold on either PS or MAiD from a personal, cultural, and religious perspective. Both the limited nature of and variability in findings represent an opportunity for further research.

4 | PERCEIVED DIFFERENCES BETWEEN PS AND MAiD

The above section has addressed some of the similarities between PS and MAiD. Conversely, authors also argue that PS and MAiD are distinctly different EOL options that should not be conflated. To this end, we found two central arguments related to what is called the "doctrine of double effect" and the question of "reversibility" used by authors to support the "distinctly different" stance. We begin by discussing these two arguments (with critical counter-arguments), followed by five areas in which differences between PS and MAiD are highlighted. These include the different indications for each option, the role of prognosis, proportionality of PS, elements of consent, capacity, and public awareness that differ between PS and MAiD. What follows is an exploration of these key differences.

4.1 | Doctrine of double effect (DDE)

Frequently cited in discussions where PS is differentiated from assisted dying is the doctrine of double effect (DDE; Daly, 2015; Hahn, 2012; Janssens et al., 2012; Olsen et al., 2010; Rhys et al., 2012). The DDE harkens back to the issue of intention and holds that if a moral and good act results in an unintended bad outcome, such an act is acceptable because the good outcome outweighs the bad effect—even though the bad effect was anticipated, it was not intended (Hahn, 2012). While this has been applied to sanction the use of PS in the courts when hastening death was thought to occur (Lo & Rubenfeld, 2005), we question why this doctrine would not also apply to MAiD, where the intent to relieve grievous suffering is the primary intention? The doctrine raises questions about assumptions that may no longer apply, that is, the assumption that death is necessarily a bad (negative) outcome. Death might be considered by some to be a negative outcome, especially in Western medicine where

the biomedical model still predominates (Arnup, 2013). However, death may not always be considered as a negative outcome from the perspective of patients or families, particularly in the context of enduring, intolerable suffering (Sokol, 2019). Further, from a philosophical perspective, some authors, particularly those aligned with an Epicurean perspective (Burley, 2008; Suits, 2001), contend that death is not intrinsically bad for the dying person because "our common experience does not include our death...at death, there is suddenly no longer a subject as there is in all other cases of harm" (Suits, 2001, p. 82).

Regarding the assumption of the DDE that the intention of the act is "good," it matters considerably whose intention is being considered (Rhys et al., 2012). While the physician's intent may be not to hasten death, the patient's intent may be different. For example, some authors have reported that patients may request sedation knowing they will not be able to eat or drink, which may hasten their death. Even though the mechanism of death is different from MAiD (the patient may die of dehydration), in DDE it is the intent that is relevant—but whose intention? Are sufficient efforts made to ensure that the patient's intent is given due weight?

Another consideration is that the DDE assumes the intended action is good because the relief of suffering is "good." However, if the intended action is not actually resulting in the relief of suffering, is the action still considered good? The efficacy of PS in relieving symptoms and distress has been questioned (Kon, 2011; Quill et al., 1997; Raho & Miccinesi, 2015). For example, Kon (2011) asserts that "it is unquestionable that some patients receiving moderate or deep sedation also suffer and are unable to express their suffering to providers" (p. 41). His claim is based on his own experiences in providing deep sedation to pediatric patients undergoing procedures where a "nontrivial minority" are able to recall conversations that happened while they were sedated and also report having felt "pain, fear or anxiety without the ability to express their symptoms" during the procedure while under moderate or deep sedation (Kon, 2011, p. 41). Kon distinguished deep sedation from moderate sedation based on airway status where moderate sedation allows the patient to maintain an airway and spontaneous ventilation remains adequate while with deep sedation, the patient may not be able to maintain an airway and spontaneous ventilation may be inadequate.

In their phenomenological study exploring the perceptions of 14 patients who had been intubated while sedated, Clukey, Weyant, Roberts, and Henderson (2014) found that patients who had been given medications to induce light to moderate levels of sedation reported marked discomfort, in spite of also having been given analgesics. The authors surmised that sedation may have influenced pain assessment and management and in fact, may have masked uncontrolled pain as patients were unable to adequately communicate because they were so sedated. Indeed, authors have reported that health care providers find it difficult to determine the effectiveness of PS when patients are no longer responsive (Leboul et al., 2017; Twycross, 2019). It has been suggested that there is limited understanding of the physiological mechanisms that occur in processing pain or distressing symptoms in patients who are unconscious

(Carvalho et al., 2011). Similarly, with MAiD, it is not possible to assess efficacy in terms of relief of suffering. We can assume that because death has occurred, suffering has ended. However, there are, at present, no grounds for questioning such a conclusion. It is difficult to ascertain with any certainty that suffering has definitively been eradicated with either PS or MAiD (Materstvedt, 2012).

4.2 | Reversibility

An additional distinguishing factor between PS and MAiD is the reversibility of each. For example, some have claimed that the irreversibility of MAiD renders it as fundamentally different from PS where reversibility of PS is, at least in theory, possible. However, reversing a state of deep sedation may subject the patient to significant distress and is rarely done in practice (Lipuma, 2013). Thus, if one does not ever intend to reverse PS, it is difficult to conceive of PS as truly reversible (Juth et al., 2013; Lipuma, 2013). Further, it can be contended that MAiD is also technically reversible; the difference lies in the short window whereby reversibility could occur (Lipuma, 2013).

4.3 | Differences of indications

As with MAiD, the primary indication of PS is intolerable pain and grievous suffering; however, the nature of suffering appears to differ. It has been reported that intractable physical symptoms most often compel the initiation of PS, with delirium, dyspnea, and pain being the most commonly reported physical symptoms (Rietjens et al., 2006; ten Have & Welie, 2014). By contrast, requests for assisted death typically are less likely due to symptoms and more likely due to a patient's inability to enjoy life, loss of autonomy, loss of dignity, and/or worry about being a burden to others (Blanke, LeBlanc, Hershman, Ellis, & Meyskens, 2017; Li et al., 2017).

Historically, existential distress alone has not been considered an indication for PS in the absence of physical symptoms (Bruce & Boston, 2011; Cherny, 2014; Olsen et al., 2010). However, there is growing recognition that existential suffering can impact physical suffering as well as a rejection of so-called reductionist treatment where the mind/body are dichotomized (Cassell & Rich, 2010; ten Have & Welie, 2014). While controversial, it has been reported in the literature that some clinicians do feel that PS should be offered for existential distress (Anquinet et al., 2014; Cassell & Rich, 2010; Rady & Verheijde, 2010; Voeuk, Nikolaichuk, Fainsinger, & Huot, 2017). The legislation pertaining to MAiD stipulates that MAiD is not permitted for existential distress in the absence of additional criteria (such as death being reasonably foreseeable). Untreated mental illness (such as severe depression or anxiety) may preclude eligibility for MAiD, particularly if it is felt that the patient's mental status adversely impacts capacity. Further, a patient with mental illness as a sole diagnosis, even if it is felt that such illness is contributing to irremediable suffering, would not satisfy the requisite criterion of a reasonably foreseeable death (Government of Canada, 2018). Notably, the notion of irremediable suffering secondary to mental illness has been contested in the literature and public media alike

(Martin, 2017; Simpson, 2017). For now, however, PS and MAiD differ in that someone suffering from existential distress alone could possibly be considered for PS but not likely for MAiD.

4.4 | Prognosis

The question of prognosis is another element differentiating the two EOL options; when PS is being considered, death is typically thought to be imminent with prognosis anticipated to be 2 weeks or less (Anquinet et al., 2012; Janssens et al., 2012). However, prognosticating time to death is no easy task and is intrinsically subjective (Cellarius, 2011; Janssens et al., 2012; Rady & Verheijde, 2010; ten Have & Welie, 2014). Although uncommon, there have been some reports in the literature where PS has been intentionally given when prognosis exceeds 2 weeks, such as with “early terminal sedation” where prognosis is thought to be more than a month or so (Cellarius, 2011). In addition, there is a report of two patients with advanced cancer having received what the authors describe as intermittent sedation over a period of several months (Song et al., 2015). Changes to guidelines have been proposed (United States) or implemented (Norway) altering the requirement of prognosis to be <2 weeks (Twycross, 2017). In comparison, the Canadian regulations for MAiD do not require the diagnosis of a terminal illness nor do they quantify prognosis aside from the vague requirement that death is “reasonably foreseeable” (Government of Canada, 2018).

4.5 | Proportionality

While unique to PS, the notion of proportionality is cited by many authors as a distinguishing characteristic where PS is titrated in a manner proportionate to the patient's symptoms (Broeckeaert, 2011; Cherny, 2014; Hahn, 2012; Olsen et al., 2010; Raho & Miccinesi, 2015; Rhys et al., 2012). The notion of proportionality has been reported to be important in terms of balancing risks of causing harm with the potential benefits (Quill et al., 1997). By contrast, MAiD is felt to be disproportionate to the patient's symptoms (all or none). However, proportionality is an ambiguous term (Rhys et al., 2012). Could it not be disputed that MAiD is also proportionate to the alleviation of suffering associated with a grievous and irremediable condition?

Nevertheless, the principle of proportionality only works in arguments of difference between PS and MAiD if proportionality is adhered to. For example, while some guidelines recommend starting with mild and intermittent sedation (Raho & Miccinesi, 2015) before proceeding to continuous, deep sedation, it has been reported that sedation is often deep and continuous from the outset (Anquinet et al., 2012). As an example, the Alberta Health Services (2018) guidelines for PS state that aim of sedation should be to attain a Richmond Agitation-Sedation Score of -4 (deep sedation) or -5 (un-arousable). In the absence of mandatory palliative care consultation with PS, there is concern that non-specialists or those unfamiliar with PS guidelines and principles may initiate PS too early or, may titrate PS disproportionately; either could then create a situation where PS

is indistinguishable from MAiD (ten Have & Welie, 2014). Given the specialist knowledge and skill required for effective PS (de Graeff & Dean, 2007), more research is needed to determine whether proportionality is applied and effective when PS is provided.

4.6 | Consent and capacity

While some authors indicate that patient (or alternate decision-maker [ADM]/surrogate) consent is required for PS (Alberta Health Services, 2018; Hahn, 2012; Olsen et al., 2010), this does not always appear to be the case, with some suggesting that the decision to initiate PS can be made by families (in the absence of an official ADM) or even clinicians (in the absence of the patient, ADM or family consent) (Harrison, 2008; Olsen et al., 2010; Quill et al., 1997). Concerns arise with the ability to provide consent if the patient is experiencing profound suffering as such suffering may impair judgement (Dean, Cellarius, Henry, Oneschuk, & Librach, 2012; Materstvedt & Bosshard, 2009). In addition, informed consent requires that patients possess an understanding of their prognosis as well as all treatment options (including no treatment as an option) before providing consent (Schafer, 2013). In the context of MAiD, in contrast to PS, consent is mandatory and must be provided by the patient immediately before the provision of MAiD (Government of Canada, 2018). This requirement highlights another important difference between MAiD and PS: that of capacity.

Because consent is required immediately prior to the provision of MAiD, capacity must also be intact (Government of Canada, 2018; Li et al., 2017). No such mandatory requirement exists for PS in Canada, although most guidelines recommend that consent be obtained prior to initiating PS. PS, thus, represents a potential option for those unable to consent, such as when capacity has been lost, to have their suffering relieved. The predominant concern with the patient or ADM not providing consent is the potential for abuse or inappropriate use, particularly concerning vulnerable individuals (Schafer, 2013). Indeed, it has been argued that it is much easier and less expensive to initiate sedation rather than to manage complex symptoms (Bruce & Boston, 2011; Rady & Verheijde, 2010). Consider the following quote from ten Have and Welie (2014) that there is “no question that sedating a patient to unconsciousness is a far cheaper form of relief than a comprehensive package of physical therapy, nursing care, spiritual support and various carefully titrated pharmacological forms of symptom relief” (p. 130). Consent and capacity, therefore, represent distinct differences between PS and MAiD.

4.7 | Public awareness of PS and MAiD

And lastly, the degree of public awareness differs between these two EOL options. In a Belgian study, it was revealed that patients were not aware of PS as an option but were aware of assisted death (Anquinet et al., 2012). In Canada, it is unclear if the general public has any awareness of PS. Certainly, MAiD has been in the media frequently as assisted dying legislation and policies have been debated in the public domain. In our own experiences as a palliative

care consultant (RB) and nurse educator (AB), patients and students have demonstrated extremely limited awareness of PS. The exception is when there has been experience with a family member or friend who has undergone PS. Awareness of both PS and MAiD is essential in order to ensure patients and families have access to information about all possible treatment options integral to informed consent (Schafer, 2013).

5 | IMPLICATIONS FOR NURSING

The shared goals of relieving grievous suffering and unmanageable pain are available through PS and MAiD. The question of whether PS and MAiD are fundamentally the same or different options remains open to interpretation and debate. Nevertheless, engaging the question itself has implications for nurses. We believe treatment decisions should be the purview of every patient and family in conversation with their health care provider and include discussion of the differences/similarities between PS and MAiD. In order for patients to feel adequately prepared and supported in making these important decisions, there needs to be sufficient education and provision of information about PS, MAiD, and where they fit in overall EOL care. Ensuring that patients have access to a multidisciplinary team (including palliative care, psychosocial and spiritual care clinicians) is of critical importance, especially for those considering PS or MAiD. Patients should be apprised of both PS and MAiD as options and informed of the risks and benefits with each. Importantly, at this time, nurses in Canada are not permitted to initiate discussions on MAiD but may respond to patient or family inquiries about MAiD. By contrast, no such restriction exists for initiating discussions on PS. Nevertheless, providing information about what to expect with PS and MAiD can be profoundly helpful for patients and family members (Bruinsma et al., 2013). Exploring the patient's goals and wishes for EOL is central to advance care planning and falls within the scope of nursing practice (Booker, Simon, Biondo, & Raffin Bouchal, 2018).

Nurses may also be involved with families during bereavement follow-up. In Canada, few formal processes exist for support of bereaved family members following a loved one's death by MAiD or PS (Wu, Pinilla, Watson, Verma, & Olivotto, 2018). While findings have been variable in terms of outcomes for family members following a loved one's death after PS or MAiD, there have been some reports of distress and guilt, particularly if the family member feels they had a role what might be perceived as a hastened death (Bruinsma et al., 2014). Research is needed into the experiences of families after a death involving PS or MAiD and the role of nurses therein.

6 | CONCLUSION

Both MAiD and PS in Canada are legitimate, legal options to alleviate suffering at the EOL. However, while some scholars and clinicians highlight the differences between these treatment

options for unbearable suffering or intractable pain, others focus on the similarities. Notwithstanding the dissent that surrounds the perceived similarities and differences between PS and MAiD, there seems to be unanimity regarding the need to ensure access to comprehensive palliative care for all Canadians with adequate efforts to alleviate physical, psychosocial, and/or existential suffering being undertaken prior to considering either PS or MAiD (Buchman, 2019; de Graeff & Dean, 2007). Greater understanding of both options and current debates is required to ensure patients, families, and clinicians have informed conversations. End-of-life decision-making warrants deep consideration and intentional planning by health care providers and the public alike so that the experience of death and dying may be as good as possible for all involved.

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