Medical aid in dying is 'madness,' JGH doctor says

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From left, Dr. Michael Bouhadana, Jonathan Breslin, Nikki Mann, Rabbi Ron Weiss and Lisa Kronenberg took part in a panel on end of life care.
JANICE ARNOLD PHOTO

Jewish General Hospital (JGH) physician Michael Bouhadana left little doubt on where he stands on medical aid in dying (MAD). The acronym is apt, because requiring doctors to end the lives of patients who request it is "madness," he believes.

Bouhadana, a family practitioner who is a palliative and pain care consultant to the JGH, was speaking Sept. 19 at a national conference on aging organized by Jewish Federations of Canada-UIA, held in Montreal.

"A doctor's job is to cure sometimes, relieve often, comfort always – kill never," he said during a panel discussion on "End of Life Care: Ethical, Cultural and Legal Dilemmas Facing Practitioners and Families."

Bouhadana, an expert on Jewish medical ethics, resorted to a bit of satire to get his point across. "What do I think of euthanasia [his preferred term to MAD]?" he asked, and answered his own question by showing on his PowerPoint presentation a T-shirt with the slogan "I support youth in Asia."

MAD – also known as "physician-assisted death" or "physician-assisted suicide" – has been legal in Quebec since December 2015, with the implementation of Bill 52, the first jurisdiction in Canada to enact such legislation. In June, this option became a right for consenting gravely ill adults across Canada.

All health-care institutions in Quebec, including acute-care hospitals and long-term facilities, must provide MAD, and the JGH is no exception.

Bouhadana said there are two physicians attached to the JGH who will provide MAD, either within the hospital or at home – to his knowledge. Individual doctors and pharmacists – who supply the lethal cocktail – are permitted to refrain.

No one knows how many JGH patients have undergone MAD or how many have done so elsewhere in the province, he said, because the procedure is not being entered on death certificates as the cause, according to guidelines issued by the Collège des médecins du Québec.

"Instead, you write the disease... This is a lie, because you provoked the death," he said.

Bouhadana made a plea for greater access to quality palliative care. Only 16 to 30 per cent of Canadians, depending on where they live, can get such care, he said. There are many misconceptions about palliative care, not only among the general public, but among health care and social services professionals, he added.

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By his definition, palliative care should provide the best quality of life possible "without hastening or postponing death."

He believes it should be offered at an earlier stage of a person's disease, while they are still being treated. Studies have shown that when curative or life-prolonging measures are combined with palliation, patients live somewhat longer and are less depressed, he said.

He also advocates greater use of opioids, maintaning it's a myth that they shorten life. Correct administration of morphine has been shown to actually prolong life, he said.

From an economic point of view, Bouhadana said palliative care can save the health care system money. The average daily cost of keeping a patient in an acute-care hospital is $1,100. In a palliative care unit or hospice, it's $770 and, if the care is provided at home, less than $100.

His fellow panelists included three officials associated with Toronto's Jewish Hospice Program (JHP), which has been offered by Jewish Family & Child (JF&CS) for close to 25 years.

Co-ordinator Lisa Kronenberg said the program provides in-home psychosocial and spiritual support to those with "progressive life-limiting illnesses" and their families, including bereavement counselling, at no fee.

> *Who wants an appointment with the death squad?*
>
> **Lisa Kronenberg**
> **Jewish Hospice Program co-ordinator**

It serves about 200 ill people a year, and current clients range in age from 20 to almost 100, she said.

While the program has received high satisfaction ratings from clients, their relatives and from the health professionals who refer them, Kronenberg said there is still reluctance in the Jewish community to seek its services.

"Who wants an appointment with the death squad?" she joked.

More public education about hospice services and more communication between hospital and community-based providers are needed, she said, to avoid the current "disjointed delivery."

Rabbi Ron Weiss, JF&CS' chaplaincy services director who works with JHP clients, said this reluctance has much to do with the Jewish attitude to dying. The old Woody Allen line "I'm not afraid of dying, I just don't want to be there when it happens," is pretty common, he said.

Palliative care has been a particularly "tough sell" among the Orthodox, with whom he identifies, he said, because of the belief that "every moment of life is precious and of infinite value."

Rabbi Weiss's task has been to show that palliative care is about "living as well as possible, for as long as possible" and is consistent with Halachah and normative Jewish values.

Another panellist, Jonathan Breslin, a health-care ethics consultant to Toronto hospitals, noted that 70 per cent of Canadians die in hospital. He provided grim information on the treatment of the elderly in hospitals, specifically, what he called "assault by CPR."

On the elderly, this procedure is, in the great majority of cases, without benefit and often harmful, he said.

Among those over 75, only 15 per cent who undergo CPR get well enough to be discharged, he said. If they have a serious illness, that figure drops to 10 per cent, and to virtually zero if they have multiple problems.

Of those who survive, half go into nursing homes afterward and only one-quarter continue to live independently, he said.

Breslin also described the horror he calls "rotting in the ICU," the prevalence of the elderly being subjected to "aggressive and harmful medications and interventions" in intensive care, "despite no reasonable hope that they will leave alive."

This is largely due to family's insistence that treatment continue, sometimes for religious reasons, he said.

Breslin also noted that 15 per cent of acute-care beds in Ontario are occupied by patients waiting to go into long-term care institutions, which is bad for them and means longer waits for those who need acute care.

Bouhadana indicated the situation may be worse in Quebec. At the JGH, it's not uncommon for patients to wait "many months" to get into long-term care. Meanwhile, the acutely sick can wait three or four days in emergency to be admitted, he said. ■