Canadian Psychiatric Association
Association des psychiatres du Canada

# MEDICAL ASSISTANCE IN DYING (MAiD)

# Results of Member Consultation

# 2020

The views represented herein represent the views of survey respondents, and do not necessarily reflect the policies and opinions of the Canadian Psychiatric Association.

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**Translation:** Josée Tremblay, Trad. a.
**Graphic designer:** Elizabeth Payne

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# ABOUT THE WORKING GROUP

In 2020, the Canadian Psychiatric Association (CPA) convened a working group co-chaired by the Public Policy and the Professional Standards and Practice Committees to lead additional member consultation on the topic of medical assistance in dying (MAiD) and develop a discussion paper.

## CO-CHAIRS

Dr. Manon Charbonneau, Public Policy Committee
Dr. Alison Freeland, Professional Standards and Practice Committee

## MEMBERS

Dr. Peter Chan
Dr. Justine Dembo
Dr. Dianne Godkin
Ms. Francine Knoops
Dr. Mark Lachmann
Dr. Louis Morissette
Dr. Derryck Smith
Dr. Donna Stewart
Dr. Michael Trew
Dr. Melanie Wong

# BIOGRAPHIES

**Peter Chan:** A geriatric and consultation-liaison psychiatrist at a large teaching hospital in Vancouver, Dr. Chan is valued locally as an expert in capacity assessments. He has presented on the topic of MAiD as it pertains to the elderly patient with debilitating physical and psychiatric conditions, and has helped review the BC Psychiatric Association's recommendations for the role of psychiatrists when dealing with MAiD.

**Manon Charbonneau:** An associate professor at the University of Montreal and a psychiatrist who practises in a rural setting, Dr. Charbonneau is a CPA past-president and an international mental health advocate who lectures and publishes on the issues of stigma and discrimination. A former member of the Mental Health Commission of Canada's Board of Directors, Dr. Charbonneau recently became a Bell Let's Talk ambassador, which allows her to apply her lived experience of mental illness and professional expertise to make a difference.

**Justine Dembo:** An early-mid career psychiatrist from Toronto, Dr. Dembo has been a MAiD assessor since 2015 and was an expert witness for the Truchon and Lamb cases, where questions about appropriate safeguards and managing capacity assessment in mental illness were explored in depth. Dr. Dembo teaches, publishes and is involved in research related to MAiD.

**Alison Freeland:** Dr. Freeland is an associate professor of psychiatry, Associate Dean of the Temerty Faculty of Medicine's Mississauga Campus at the University of Toronto, and Vice President of Education, Academic Affairs and Patient Experience at Trillium Health Partners. She has worked across hospital, community and academic settings, and is a seasoned advocate and leader regarding policy and practice around mental health care systems as well as psychiatrists' roles within them.

**Dianne Godkin:** As the Senior Ethicist at Trillium Health Partners, Dr. Godkin has been involved in the development of policy and practices related to the implementation of MAiD in a large community academic hospital. Dr. Godkin has been involved in the education of many clinicians, and, working with clinicians who provide MAiD, has developed a tool to support the evaluation of capacity.

**Francine Knoops:** Ms. Knoops has had a career in mental health policy since the late 1980s, and has extensive lived experience as the principal caregiver of a sibling with severe mental illness (schizophrenia).

**Mark Lachmann:** Dr. Lachmann is a geriatric psychiatrist and coroner in Toronto with a diverse practice at the University of Toronto, community, and hospital. He has an MHSc in Bioethics and writes and publishes in this space. His interest in MAiD is in capacity assessment, having done many of these in a variety of contexts. As a hospital administrator he has also witnessed how the provision of MAiD has challenged psychiatrists in unexpected ways.

**Louis Morissette:** A forensic psychiatrist from Montreal, Dr Morissette's primary interests are in assessing patients' capacity to make a free and deliberate request for MAiD, in informed consent to receive MAiD, and to accept or refuse medical or psychiatric treatment in general. He has presented on this topic as well as the Quebec law on end-of-life care.

**Derryck Smith:** A psychiatrist from BC, Dr. Smith was an expert witness in the Carter case, and has appeared before parliamentary committees on MAiD. In addition to his work as an MAiD assessor, Dr. Smith has completed training to provide MAiD. He has also published and lectured extensively on this issue.

**Donna Stewart:** A university professor, member of the Order of Canada, senior scientist and member of the Centre for Bioethics at University of Toronto, Dr. Stewart has conducted approximately 200 MAiD assessments. She has done research, published scientific articles and lectured internationally on MAiD. Her research on stressors and protective factors in Canadian MAiD practice is in press in the Journal of Palliative Medicine.

**Michael Trew:** A former chair of the Alberta Health Services Expert Panel for Medical Assistance in Death for Non-Life Limiting Illness, Dr. Trew has presented to groups both public and professional on the current and possible rules involved. He is a member of the Canadian Association of MAiD Assessors and Providers, does capacity assessments for MAiD, and has supported the provincial MAiD Navigator group since 2016.

**Melanie Wong:** A psychiatry resident at Memorial University, Dr. Wong will be pursuing geriatric psychiatry subspecialty training following her general psychiatry training. Dr. Wong is interested in the medicolegal aspects of psychiatry as well as in medical education.

# BACKGROUND

The CPA most recently surveyed its members on the topic of MAiD in October, 2020. A survey containing the same questions was circulated to members of the provincial psychiatric associations as well as the subspecialty academies. In addition to the survey, the CPA obtained further input from its members by way of virtual member town halls held on Oct. 20 and Oct. 21, 2020 as well as a call for written comments.

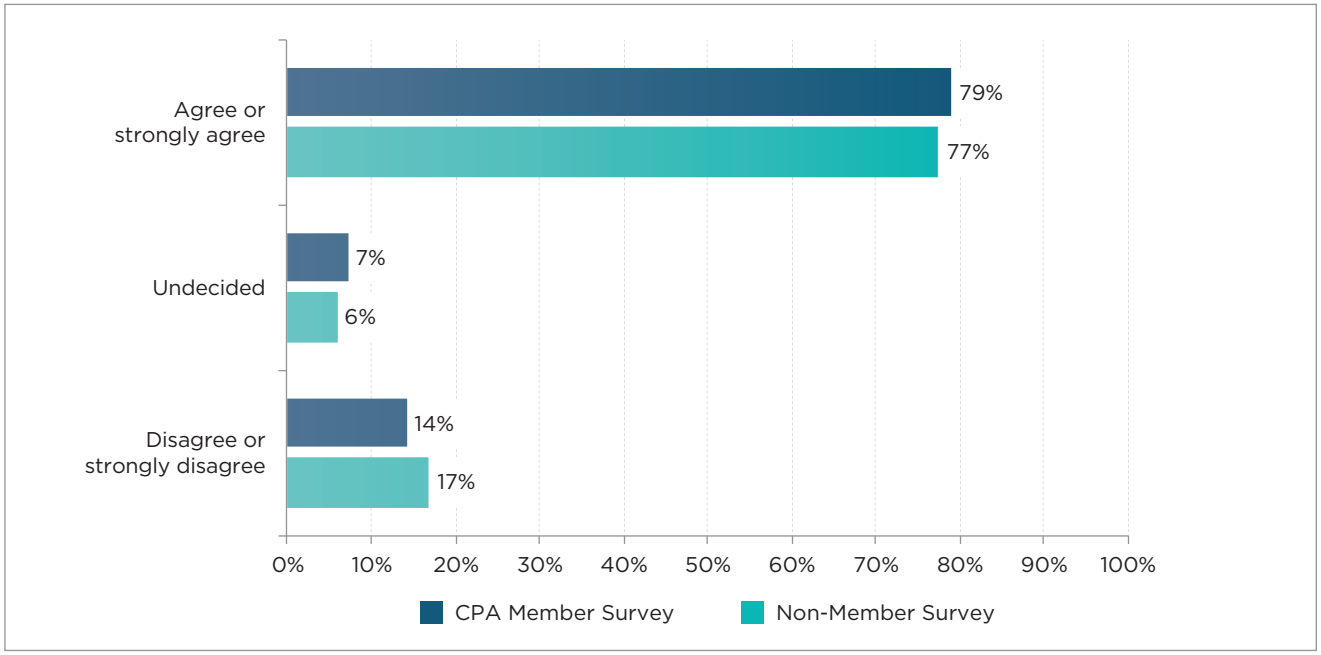
The current member consultation follows survey work the CPA previously undertook in 2016–2017 about MAiD. The previous survey results are available online at **https://www.cpa-apc.org/wp-content/uploads/CPA-MAIDTF-16Surv-Rep-FIN-EN.pdf**.

CPA fielded its member survey on Oct. 7, 2020 and closed data collection on Oct. 29, 2020. A total of 2,056 CPA members received the survey, and 474 responded (23%). The survey was available for completion in English or in French.

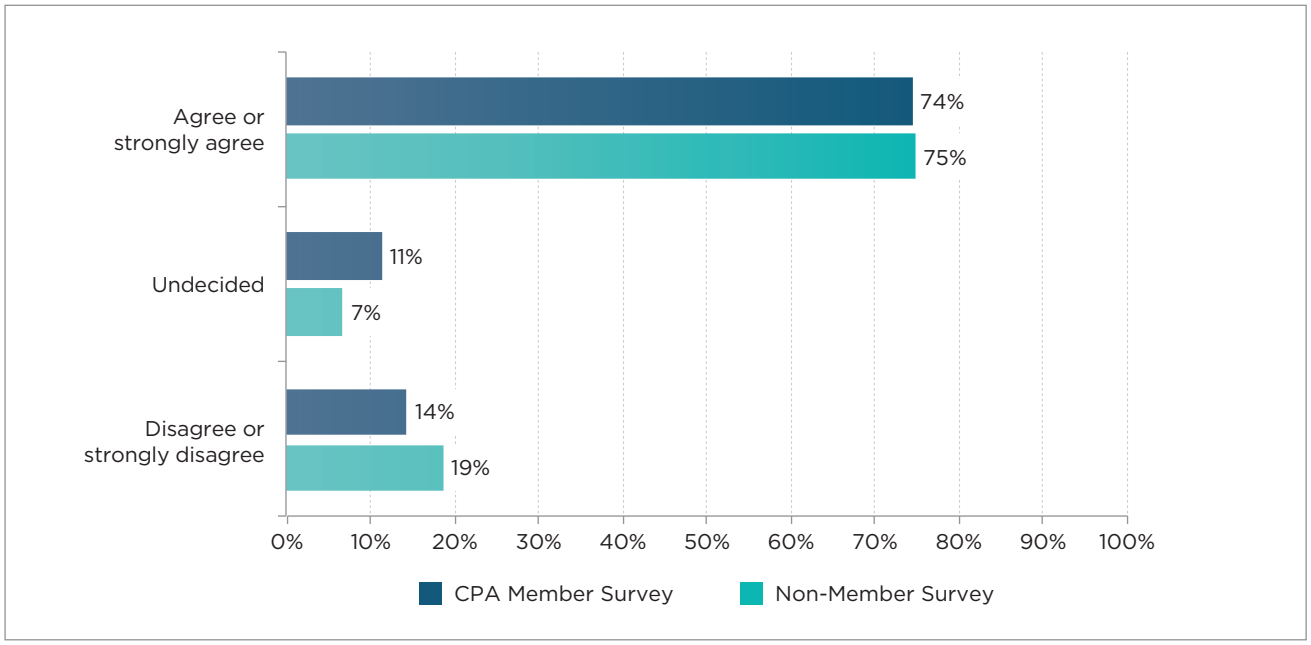
The provincial psychiatric associations in British Columbia, Saskatchewan, Manitoba, Ontario and Quebec distributed the same survey questions to their respective members, as did the child and adolescent, geriatric, forensic, and psychosomatic medicine academies. A total of 298 responses were received, and the estimated response rate to this non-member survey is 7%.

# SURVEY RESPONSES*

**1.** Medical assistance in dying (MAiD) is an option that should be available to persons deemed eligible under existing legislative requirements.

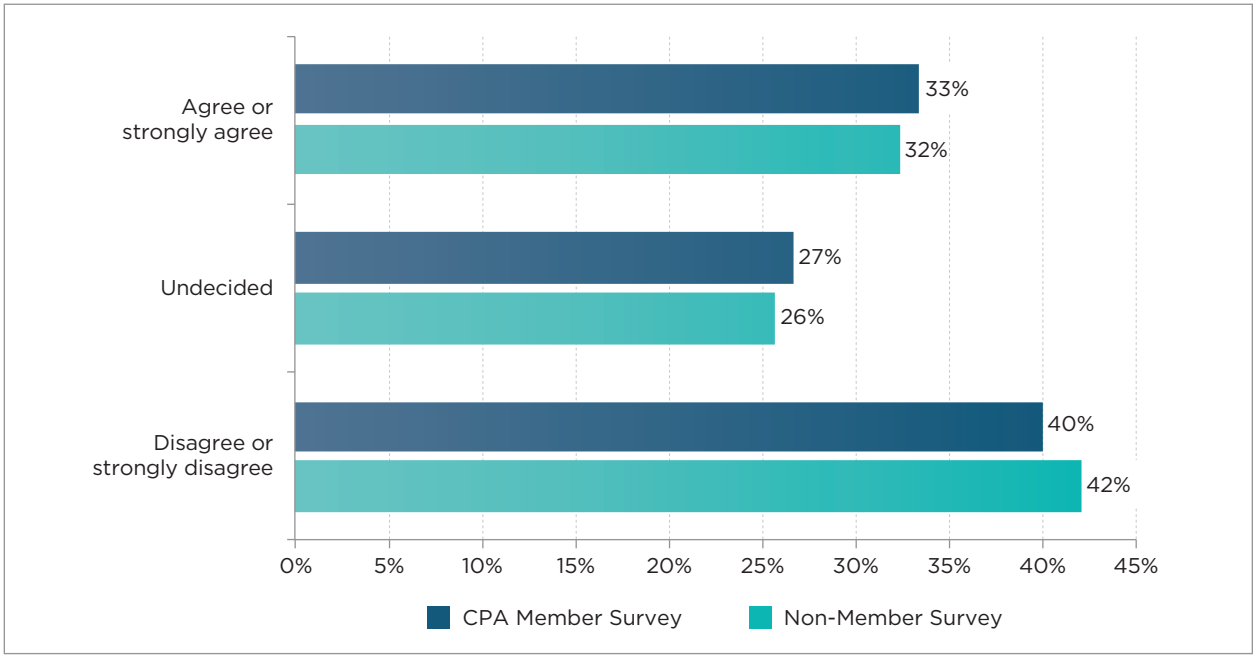



**2.** Persons who would otherwise be eligible should be able to provide advance consent to MAiD in anticipation of capacity being lost and with clear criteria for activation of the MAiD request.

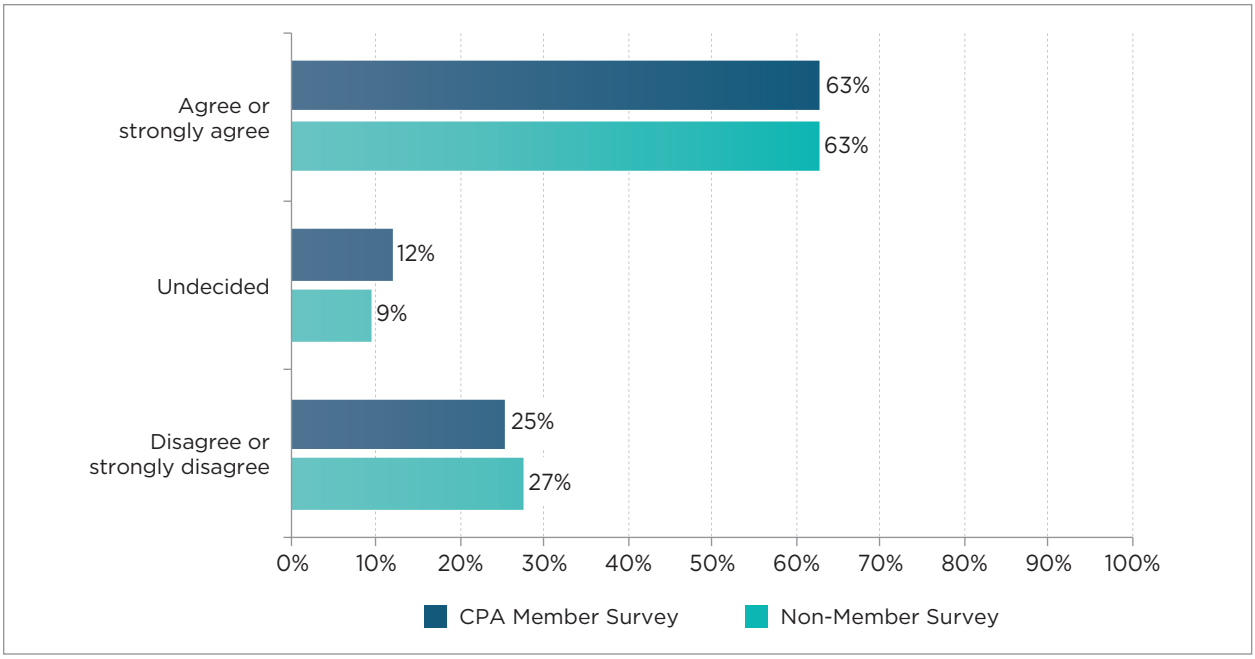



*Percentages may not add to 100 due to rounding

**3.** MAiD should be accessible to competent individuals under the age of 18 if they meet all other legislative requirements.




**4.** It is possible for a mental disorder to be considered grievous and irremediable.

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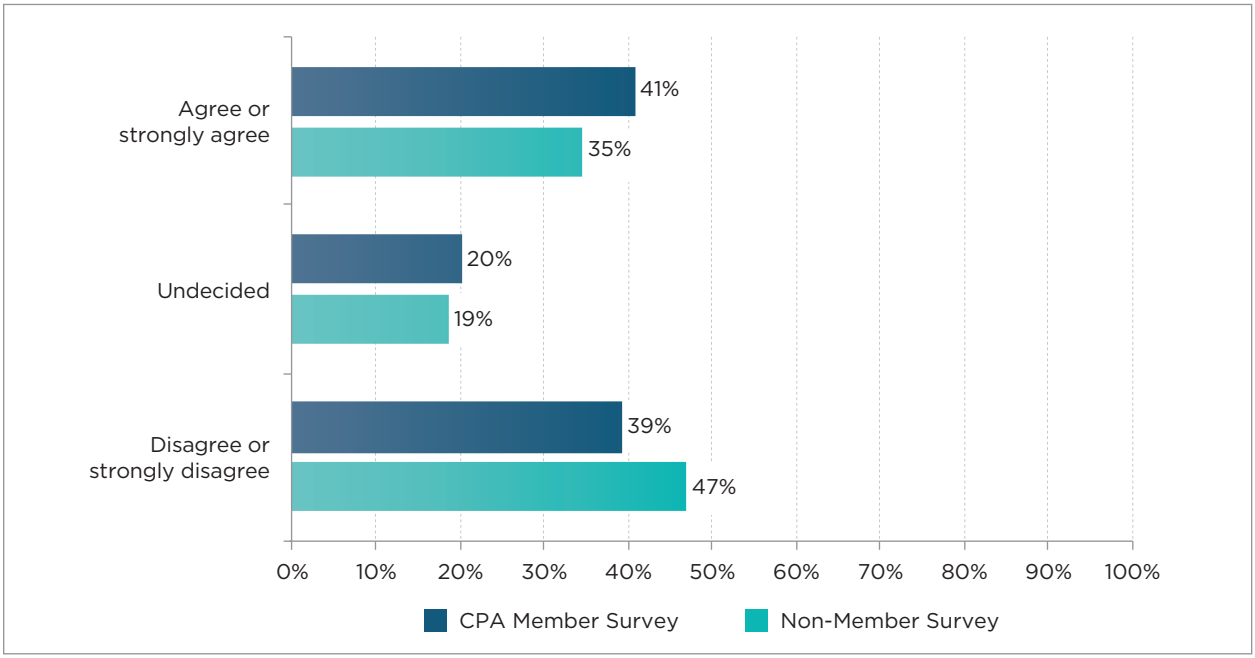
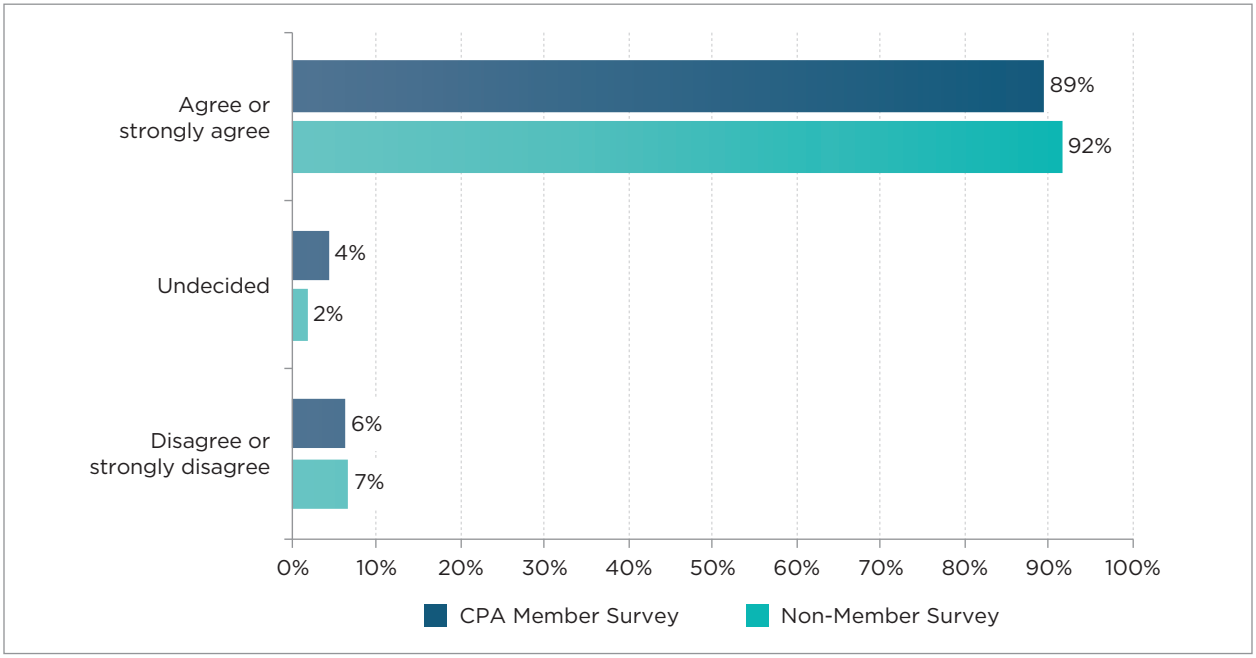
**5.** Persons whose sole underlying medical condition is a mental disorder should be considered for eligibility for MAiD.

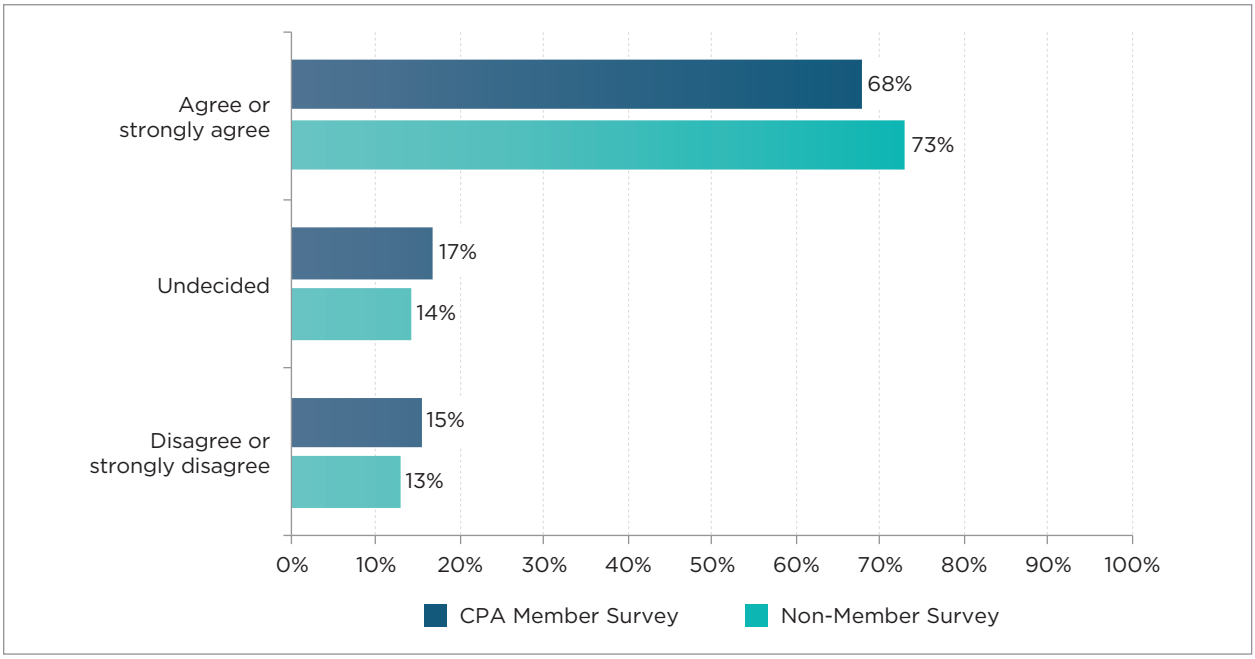



**6.** A psychiatric assessment should be required as part of the eligibility assessment process for MAiD for persons whose sole underlying condition is a mental disorder.

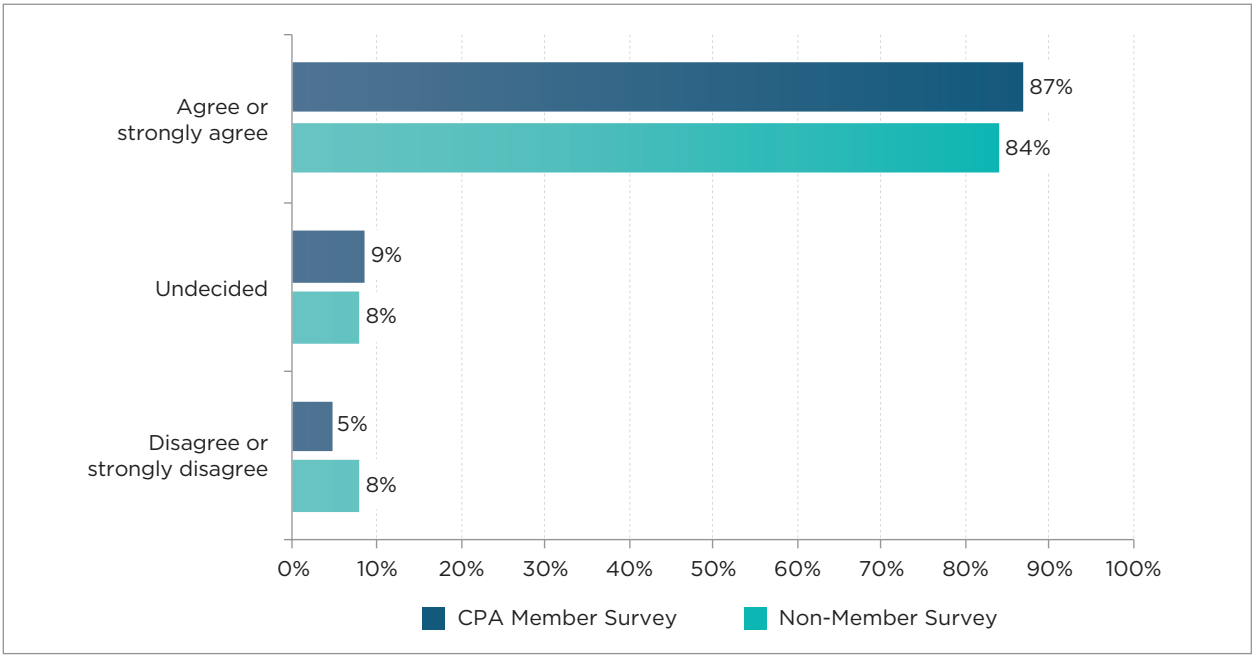



*Percentages may not add to 100 due to rounding

**7.** The reflection period should be longer for persons requesting MAiD whose sole underlying medical condition is a mental disorder.

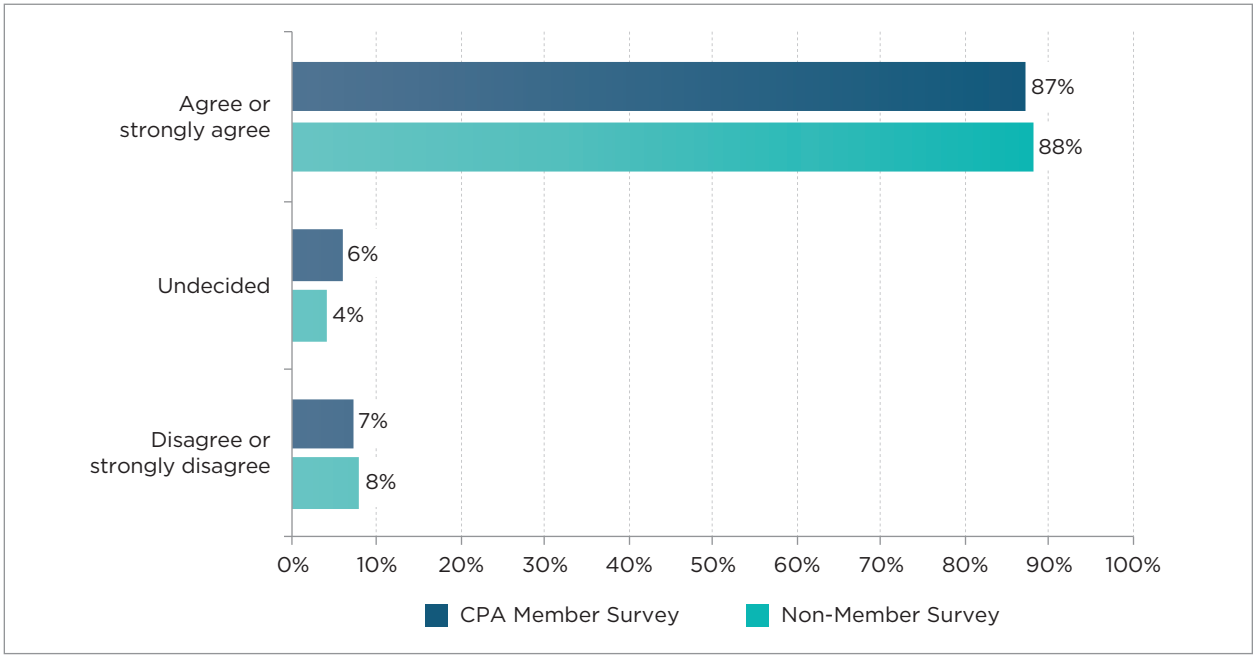



**8.** For persons requesting MAiD whose sole underlying medical condition is a mental disorder, collateral history should be obtained from others who know the patient.

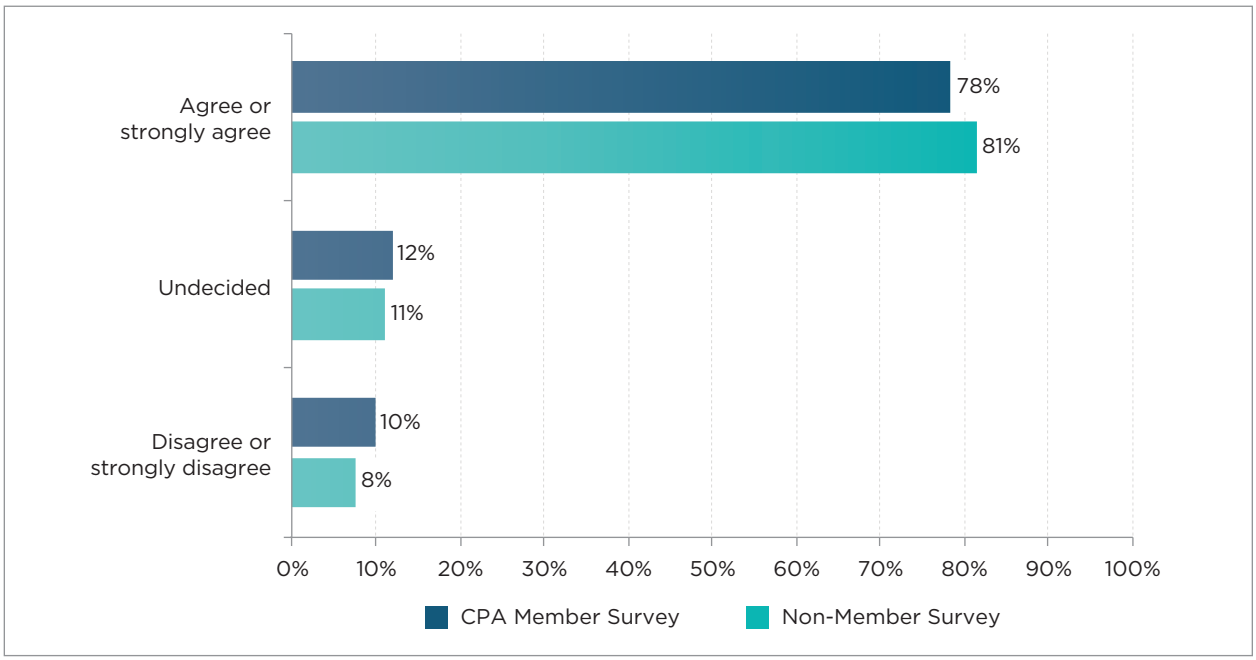



*Percentages may not add to 100 due to rounding

**9.** Training and education related to MAiD should be incorporated into residency and ongoing continuing education programs for psychiatry.




**10.** A formal oversight (review) process should be established for all patients requesting MAiD whose sole underlying medical condition is a mental disorder.

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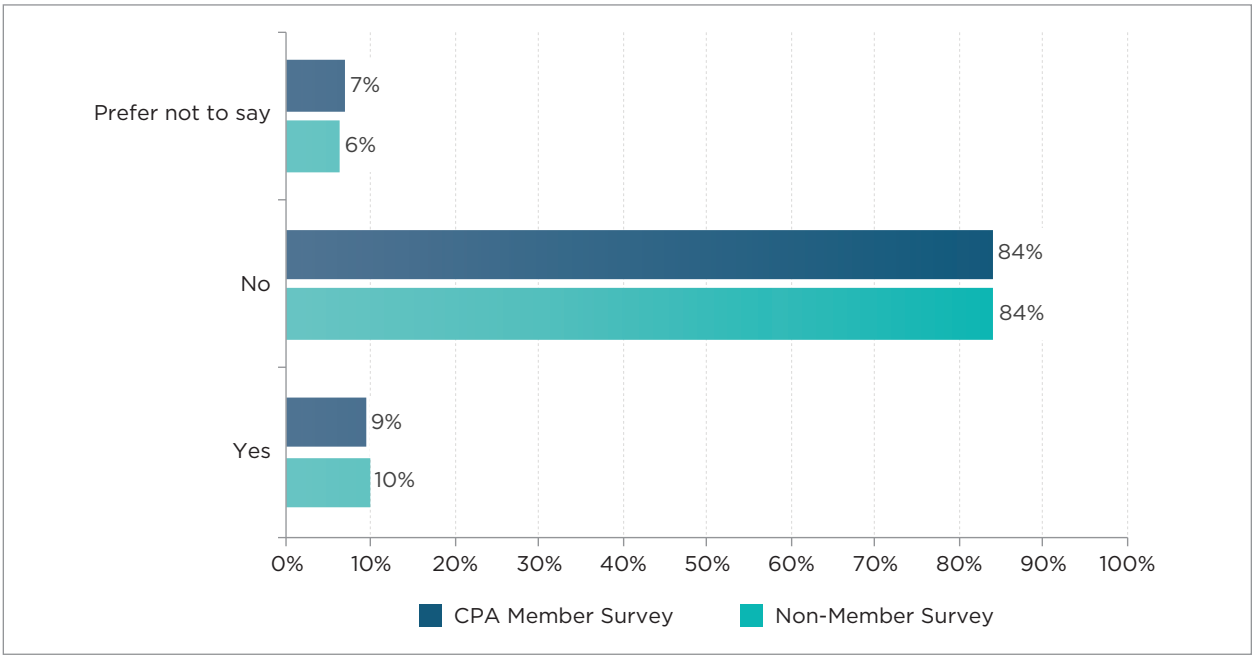
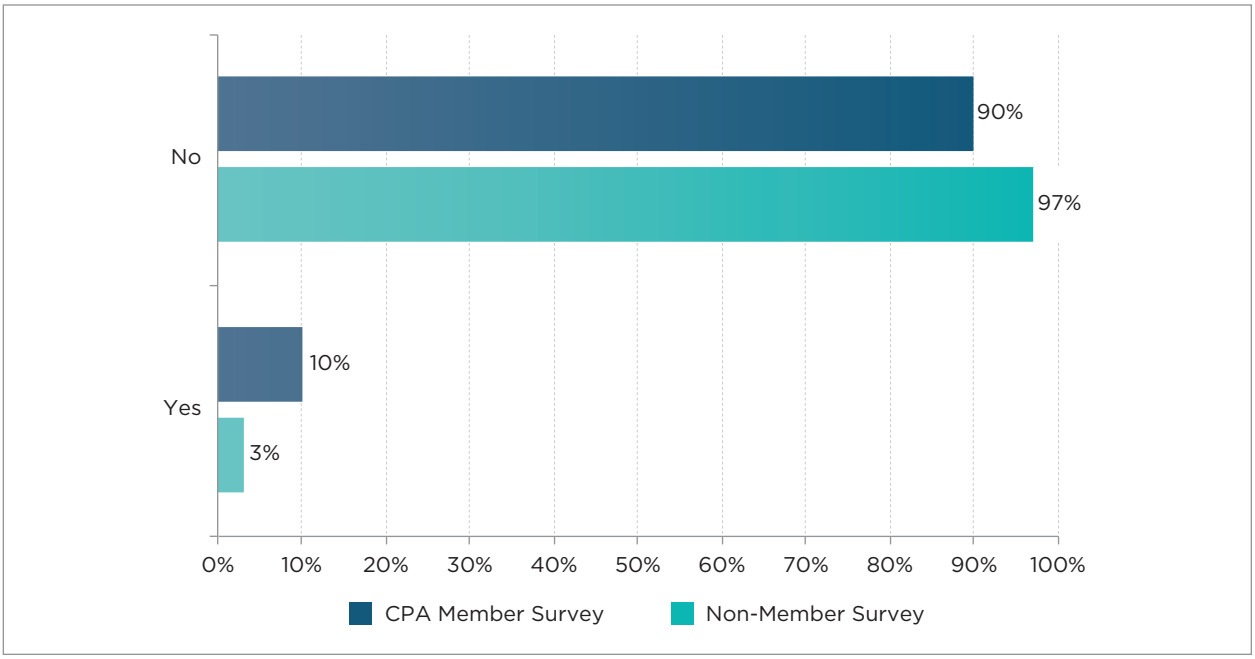
# RESPONDENT DEMOGRAPHICS*

**1.** Are you a conscientious objector to MAiD for all patients regardless of medical diagnosis?




**2.** Have you been involved in providing MAiD to a patient?

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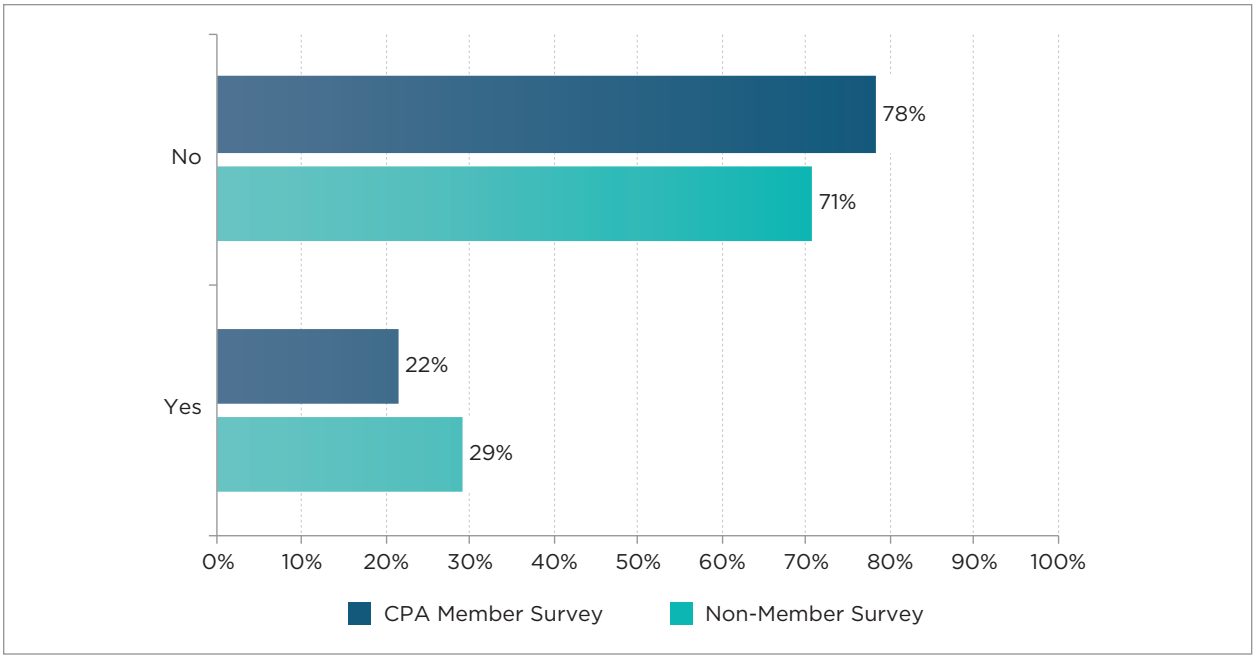
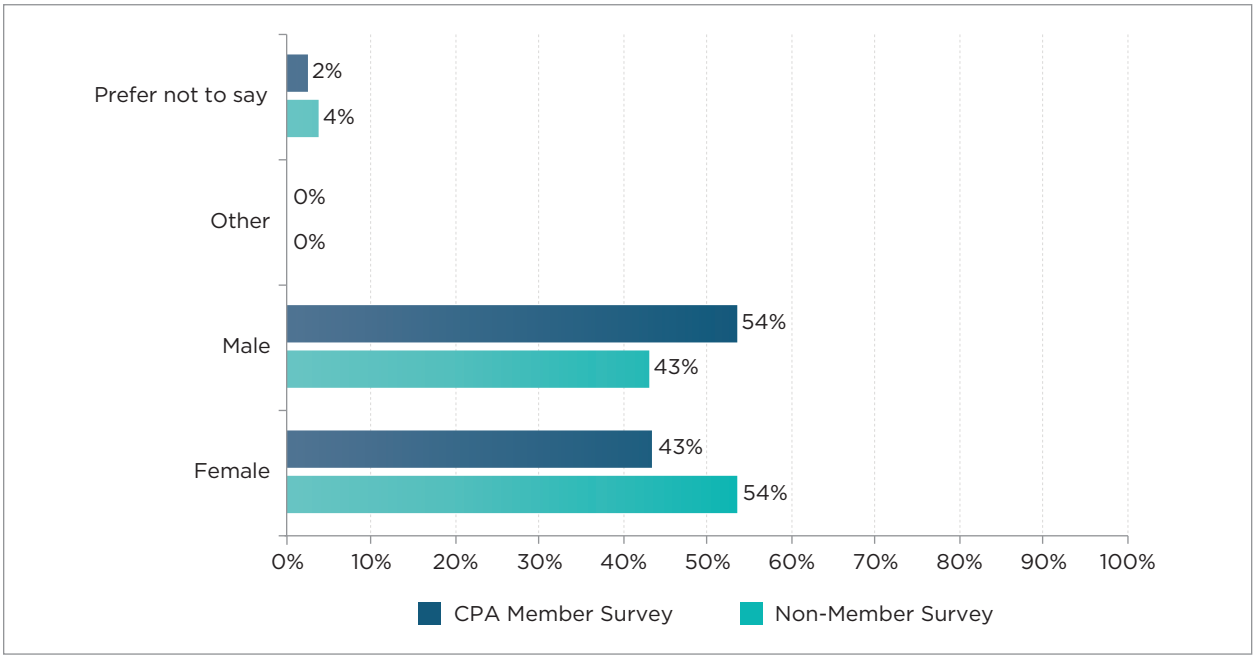
**3.** Have you been involved in assessing a patient for MAiD?




**4.** Do you identify as:

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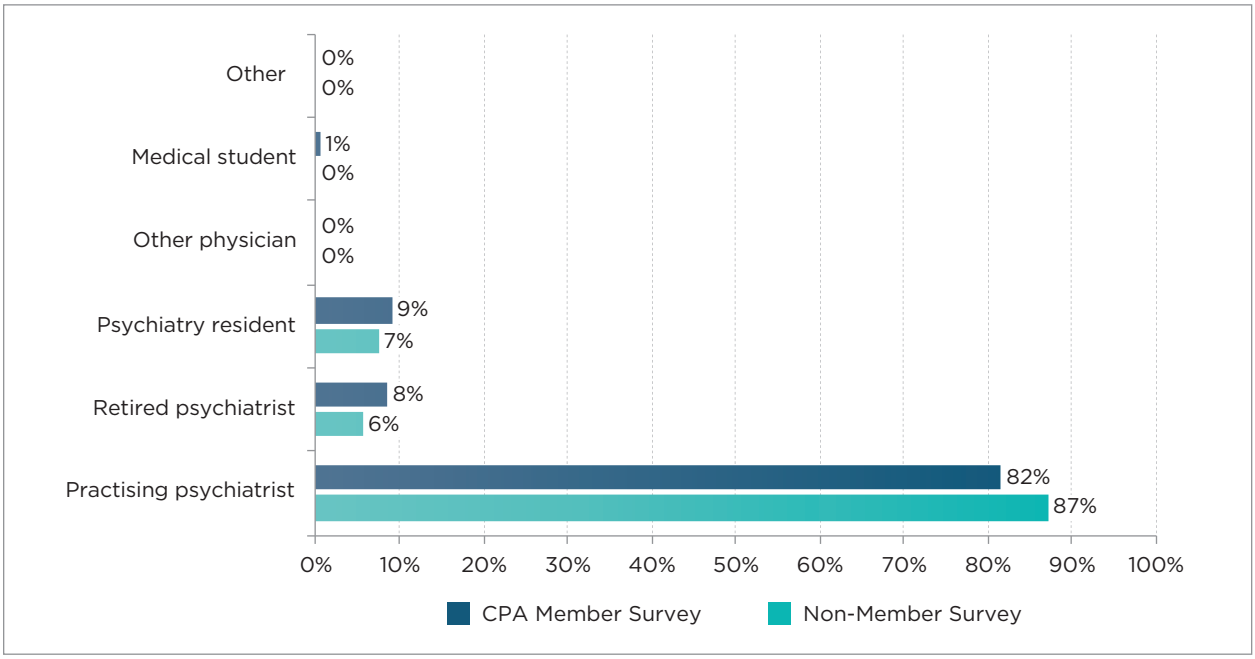
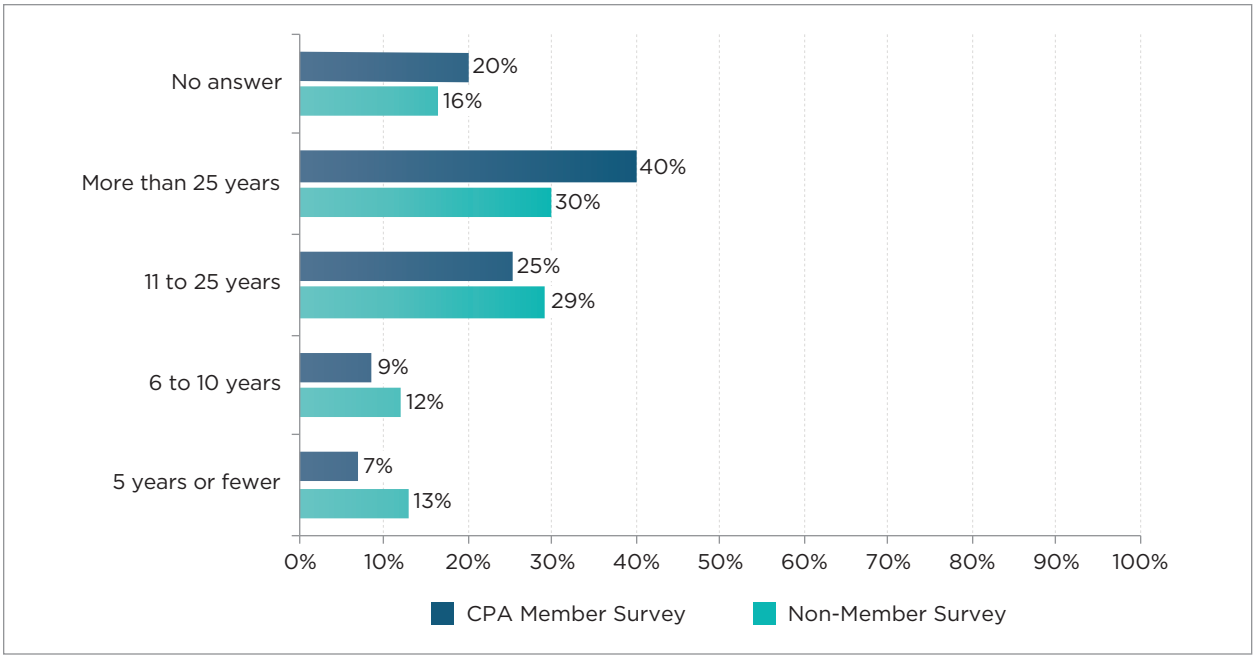
**5.** What is your profession?

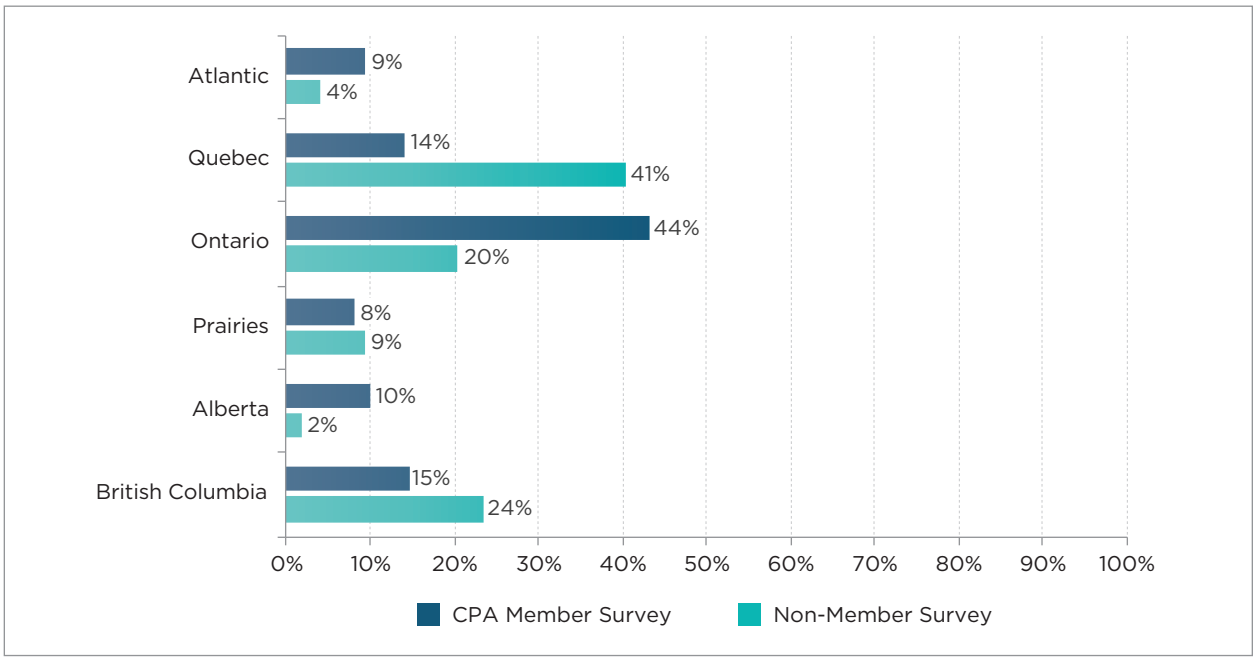



**6.** How many years have you been practising?




*Percentages may not add to 100 due to rounding

**7.** In what region do you live?

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# SURVEY COMMENTS

In total, there were 152 comments from respondents to the CPA member questionnaire, and 64 comments obtained from the non-member survey. Both surveys limited comments to 1,000 characters, but additional information was gathered from members at town halls on Oct. 20 and 21, 2020, as well as from a final call for written comments.

In general, survey respondents who provided written comments fell into one of three broad groups:

- Those who are morally opposed to MAiD in any form or are conscientious objectors.
- Those who are opposed to MAiD where a mental illness is the sole underlying condition (MD-SUMC).
- Those who believe it is discriminatory to not allow access to MAiD for MD-SUMC for capable patients because mental illnesses can be as grievous and irremediable as physical illnesses.

Among those who were opposed to MAiD for MD-SUMC, many commented that suicidality is a feature of many psychiatric conditions and is usually considered a symptom of illness. They felt their role as psychiatrists is to instill hope in patients and that provision of MAiD is incompatible with this and undermines therapeutic efficacy as well as psychiatrists' ability to work with patients. Some felt that providing the option for MAiD for MD-SUMC will further devalue and stigmatize people with mental illnesses by sending the implicit message that certain lives are not worth living and providing "suicide on demand." Concerns were cited about the difficulty and the subjectivity of determining when a mental illness is "irremediable." This lack of certainty and evidence led some respondents to say that it was on this basis that they were opposed to MAiD for MD-SUMC rather than for any inherent difference between mental disorders and other medical conditions. Others noted that until problems with access to appropriate services and supports are fixed it is hard to say that MAiD should be an alternative. Patients who are of low socio-economic status, immigrants, or members of minority communities often lack access to all reasonable treatments and may disproportionately request MAiD as a consequence. These respondents were not convinced that appropriate safeguards could be devised to protect people from coercion or abuse by substitute decision-makers, particularly in the case of those with intellectual disabilities.

There were common concerns noted by those who oppose MAiD for MD-SUMC and those who believe it is discriminatory to disallow consideration for MAiD solely on the basis of a mental disorder. The problem of defining and translating legal terms such as "mental disorder," "grievous," "suffering" and "irremediable" into objective psychiatric/medical language was often noted. Some felt that neurodegenerative disorders such as dementia and Huntington's with reasonably well-understood pathophysiology need separate consideration from other

mental illnesses. These respondents expressed concern about MAiD criteria that allow patients to refuse evidence-based treatments such as medications. Some suggested that all available treatments including ECT and even psychosurgery should have to be made available and be tried before MAiD could be contemplated. Others said that MAiD for MD-SUMC could be a viable option if there were evidence of treatment-resistance, consistent choice and a second psychiatric opinion. Personality disorders were cited as being particularly problematic. These two groups also expressed worries about the impact on medical practice (e.g., should there be independent clinical teams comprised of non-physicians who provide MAiD, will this result in radical shift to a stringent capacity-based practice, how will conflicts of interest be managed).

Among respondents who supported access to MAiD for MD-SUMC, many noted that there should be fair and equal access to MAiD as with any other service in health care, and that having a mental disorder should neither be equated with a lack of competence nor disqualify someone from consideration. Some respondents noted that while mental illnesses may be curable in future, people should not necessarily have to wait forever for a treatment that does not yet exist or alleviates their condition: in certain situations, suffering is grave and current treatments are ineffective. With respect to safeguards, some respondents did not believe that there should be any additional special or "bureaucratic hoops" for mental disorders over and above physical disorders. Others felt that a more rigorous assessment process would be needed should MAiD for MD-SUMC be permitted in legislation including a longer period of time between application and assessment, one or more psychiatric assessments, assessment by a psychiatrist with expertise in the diagnosis, consultation by MAiD assessors with the treating psychiatrist, increased oversight and review of MD-SUMC requests, or even a panel composed of people who have known the patient for a longer period, the family doctor, the treating psychiatrist and a psychiatric evaluator.

With respect to the survey format, some respondents commented that they disagree with MAiD for MD-SUMC and consequently felt some of the questions were difficult or impossible to answer. Others said that more context and/or background would have been helpful, particularly for those who are less familiar with current MAiD legislation.

A number of respondents commented that advance directives should be available in cases of dementia and neurodegenerative diseases. Others queried how physicians would deal with a patient who has an advance directive and changes their mind after losing capacity. Some respondents said they would personally want to be able to choose to have an advance directive under the right circumstances, and that it would be hypocritical to advocate for others to have less.

# MEMBER TOWN HALLS and CALL FOR FINAL COMMENTS

To further understand psychiatrists' perspectives on and the range of opinion about MAiD, the CPA hosted virtual member town halls to help explore and discuss some of the nuances of the 10 survey questions. The town halls were held in English and in French on Oct. 20 and Oct. 21, 2020, respectively. Advance registration was required to participate.

Based on preliminary survey results, the working group identified five topics for further exploration. Town hall participants were polled at the start of each session about which of the five topics was of greatest interest to them to help prioritize and allocate time.

Members of the working group were silent participants at each town hall so they could hear first-hand the range of opinion and consider this information in preparing a discussion paper[1] on behalf of CPA.

Participants at the town halls did not prioritize the five topics in the same order:

| TOPIC | PRIORITY RANKING | |
|---|---|---|
| | ENGLISH | FRENCH |
| Persons who would otherwise be eligible should be able to provide advance consent to MAiD in anticipation of capacity being lost and with clear criteria for activation of the MAiD request. | 2 | 4 |
| MAiD should be accessible to competent individuals under the age of 18 if they meet all other legislative requirements. | 5 | 2 |
| It is possible for a mental disorder to be considered grievous and irremediable. | 3 | 3 |
| Persons whose sole underlying medical condition is a mental disorder should be considered for eligibility for MAiD. | 1 | 1 |
| A psychiatric assessment should be required as part of the eligibility assessment process for MAiD for persons whose sole underlying condition is a mental disorder. | 4 | 5 |

[1] CPA discussion papers facilitate discussion and consultation, and offer background information, ideas and options without necessarily reaching focused recommendations or conclusions.

A summary of discussion by topic area follows.

### Persons who would otherwise be eligible should be able to provide advance consent to MAiD in anticipation of capacity being lost and with clear criteria for activation of the MAiD request.

In general, participants supported the possibility of advance directives for MAiD, though there was recognition that it may be more difficult to operationalize depending on the nature of the illness. The example was given of a patient who gives an advance directive, then does not wish to proceed with the directive when the criteria established in the directive are met and administration should occur. Other participants questioned whether there is a "right" to die, or whether one has a right to conscript others into this endeavour and "transform suicide into murder."

### MAiD should be accessible to competent individuals under the age of 18 if they meet all other legislative requirements.

Some participants did not feel that this was a matter that CPA should weigh-in on unless it pertains to access to MAiD by those under 18 on the sole basis of a mental disorder. In cases where mental disorder is not involved, there was some concern about the potential for assessments to not be shared with parents.

### It is possible for a mental disorder to be considered grievous and irremediable.

Participants generally agreed that while some mental disorders could be both irremediable and grievous, not all of them are (though there is suffering), and the "devil is in the details." The legal terminology used in the legislation was also noted as a challenge as it does not translate to medicine.

### Persons whose sole underlying medical condition is a mental disorder should be considered for eligibility for MAiD.

Some town hall participants expressed concerns about how any mental disorder could objectively be deemed "irremediable" when lack of access to treatment is an issue, and patients are not required to try all evidence-based treatments. Others pointed out that whether Canadians should have access to MAiD is not up to physicians: it is a decision of Canadian society. Doctors should take a non-paternalistic approach and allow capable patients to decide on their own course of action. The difficulty of determining what illnesses should be considered a "mental disorder" was raised, as was the issue of how excluding access to MAiD for MD-SUMC is stigmatizing and discriminatory.

### A psychiatric assessment should be required as part of the eligibility assessment process for MAiD for persons whose sole underlying condition is a mental disorder.

Participants had a variety of perspectives on this issue. Some thought a psychiatric assessment should be part of any MAiD request, regardless of the basis for the request. Other attendees felt it was important for psychiatrists to be involved in screening and assessing for decisional capacity. Many participants agreed that it would be prudent to require an independent psychiatric assessment if MAiD for MD-SUMC were permitted, and some felt that this assessment should be done by a specialist in the disorder that is the basis for the MAiD request. If a panel were required to assess MAiD requests, concern was noted about the potential for some doctors to be come known as the "go-to" physicians, either for or against MAiD, thereby biasing the process. Some participants said that psychiatrists need to ensure that their patients are not discriminated against because of their mental disorder.

### Other Town Hall Comments

**Reflection period:** The length of the reflection period is unimportant if the patient has the capacity to make a decision: why should there be a longer period if a patient is deemed capable?

**Training:** Participants broadly agreed that training would be important. The particular issue of regulations and support for trainees was flagged as being of particular importance, as well as how these interact with conscientious objection. It was suggested that there is a larger education piece here about the importance of dignity, suffering and dying.

**Oversight and review:** All assessments should be reviewed by specialists in the type of illness that is the basis for the request.

**General:** Some participants said that CPA should take a strong stance against MAiD for MD-SUMC. Other participants felt it was important to stand against discrimination against people with mental disorders. Some town hall participants reiterated concerns about the CPA's survey questions, specifically how some were difficult to answer or the answer could be misinterpreted depending on whether a respondent agrees or disagrees with MAiD for MD-SUMC.

## Call for Member Comment

Since not everyone was able to attend the town halls who may have wanted to, CPA invited members to provide any further comments they wanted to share with the MAiD working group.

Many of the comments echoed those enumerated above that were provided either in response to the survey, or at one of the town halls. Some members commented that there seems to be a rush to sort out a complex issue when we do not have all of the information and we should instead rely on the practice of methodical exploration. Others asked if CPA were reinventing the wheel in the sense of hashing out an issue that many medical and psychiatric bodies around the world have already examined closely and would it be worth considering their reasoning. A number spoke movingly and at length about their reasons for choosing psychiatry as their vocation and how patients and treatment providers should demand better than the current mental health system that is “haphazard, poorly funded [and] inadequately valued.”