



Canadian Psychiatric Association
Association des psychiatres du Canada

Task Force on Medical Assistance in Dying

2016

MEMBER SURVEY RESULTS

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

SUGGESTED CITATION

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ABOUT THE TASK FORCE

The Canadian Psychiatric Association (CPA) Board of Directors formed the Task Force on Medical Assistance in Dying (MAID) in 2016 to assist the CPA in developing policy and influencing legislation regarding MAID, and to develop guidance for Canadian psychiatrists on how to apply and use any MAID framework.

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BACKGROUND

The Canadian Psychiatric Association's Task Force on Medical Assistance in Dying (MAID) asked CPA members for feedback on some key concepts related to MAID to help inform the interim guidance it is preparing on behalf of the profession.

The survey was fielded Dec. 12, 2016 and data collection closed Jan. 20, 2017. A total of 2,536 members received the survey, and 332 responded (13%). The survey was available for completion in English or French.

The data from the online survey that follow are compared to the top-line results from an earlier survey that had been fielded Sept. 23, 2016 during the CPA Annual Conference (n=30). In situations where the online member survey question was slightly rephrased compared to the annual conference survey, the original (annual conference) phrasing has been noted. The annual conference survey did not include a "maybe" response option, but since it was a paper-based questionnaire, some respondents wrote in this answer, so counts and percentages have taken this into account.

EXECUTIVE SUMMARY

| QUESTION | | Yes | | No | | Unsure | |
|----------|---|-----|-----|-----|-----|--------|-----|
| | | # | %* | # | %* | # | %* |
| 1. | In principle do you support the availability of medical assistance in dying (MAID)? | 239 | 73% | 50 | 15% | 35 | 11% |
| 2. | Do you support the current exclusion of mental illness as a sole indication for MAID, consistent with federal legislation Bill C-14? | 173 | 54% | 88 | 27% | 60 | 19% |
| 3. | Do you support MAID for mental illness if 1) clarity were established for the interpretation of “irremediability,” 2) psychosocial issues were identified and addressed, 3) access to appropriate treatments were ensured, and 4) capacity and consent issues were fully assessed? | 151 | 47% | 104 | 33% | 65 | 20% |
| 4. | Do you feel that a psychiatric assessment should be required as part of every MAID assessment, even in the absence of known or suspected mental illness? | 114 | 36% | 169 | 53% | 37 | 12% |
| 5. | Should a psychiatric assessment be required when a mental illness is either known or suspected to be comorbid with the primary illness in MAID applications? | 249 | 78% | 30 | 9% | 41 | 13% |
| 6. | Is a chart review and discussion with individuals other than the patient sufficient to inform an adequate psychiatric assessment (either clinical or capacity assessment) for MAID (i.e., no direct face-to-face or telemedicine interaction with the patient)? | 16 | 5% | 273 | 85% | 31 | 10% |
| 7. | If the most responsible practitioner treating the patient for their primary illness declines to be involved in a MAID application, should there be a requirement to contact the most responsible practitioner for the purposes of enhancing the understanding of the patient’s current clinical situation and relevant background health issues? (The rationale for this is to address concerns arising internationally where itinerant or travelling physicians are doing MAID assessments without long term knowledge of patients.) | 237 | 75% | 29 | 9% | 52 | 16% |
| 8. | Should a close family member(s) be contacted to provide input for all MAID assessments, unless a patient specifically objects to such contact? (If the principle of “patient autonomy” is applied in a narrowly interpreted manner then input from family should not be required, but family input may provide valuable information, enhanced confidence regarding MAID decisions, and appropriate respect for the role of family.) | 234 | 74% | 33 | 10% | 50 | 16% |
| 9. | In addition to legislatively required assessments by physicians, or nurse practitioners, should a multidisciplinary “team” of health care workers be required to provide a formal assessment for all MAID applications? | 96 | 31% | 144 | 46% | 73 | 23% |
| 10. | Should capacity assessments be guided by generally accepted principles for assessing capacity contextually applied to MAID with flexibility for assessors to choose from a variety of appropriate assessment tools or formats (as opposed to a prescribed tool)? | 232 | 74% | 25 | 8% | 56 | 18% |
| 11. | Do you support allowing mature minors to qualify for MAID? | 100 | 32% | 145 | 46% | 68 | 22% |
| 12. | Do you support advanced directives for MAID in anticipation of capacity being lost and with clear criteria for activation of the MAID request? | 203 | 65% | 70 | 22% | 40 | 13% |
| 13. | Do you support a tracking process for MAID applications so that, in the event of multiple and diverging opinions as to the nature of the illness or decisional capacity, all opinions are considered? | 266 | 85% | 21 | 7% | 26 | 8% |

* Percentages may not add to 100 due to rounding

RESPONDENT DEMOGRAPHICS

The demographic information below applies only to the online member survey. Corresponding data from the annual conference presentation survey are not available.

| SEX | COUNT | PERCENT |
|---------|-------|---------|
| Male | 167 | 50% |
| Female | 159 | 48% |
| Unknown | 5 | 2% |

| AGE | COUNT | PERCENT* |
|---------------|-------|----------|
| 21 – 30 | 20 | 6% |
| 31 – 40 | 47 | 14% |
| 41 – 50 | 45 | 14% |
| 51 – 60 | 67 | 20% |
| 61 – 70 | 77 | 23% |
| 71 – 80 | 43 | 13% |
| 81 – 90 | 24 | 7% |
| Not available | 8 | 2% |

| PROFESSION | COUNT | PERCENT* |
|-----------------|-------|----------|
| Psychiatrist | 282 | 85% |
| Other physician | 8 | 2% |
| Resident | 33 | 10% |
| Medical Student | 8 | 2% |

| MEMBER TYPE | COUNT | PERCENT* |
|-----------------------------|-------|----------|
| Active | 207 | 63% |
| Life | 55 | 17% |
| Associate | 8 | 2% |
| Honorary | 1 | 0% |
| International | 5 | 2% |
| Member-in-Training | 33 | 10% |
| Early career psychiatrist 1 | 4 | 1% |
| Early career psychiatrist 2 | 5 | 2% |
| Early career psychiatrist 3 | 5 | 2% |
| Medical Student | 8 | 2% |

| REGIONAL DISTRIBUTION | COUNT | PERCENT* |
|-----------------------|-------|----------|
| British Columbia | 37 | 11% |
| Alberta | 30 | 9% |
| Prairies | 31 | 9% |
| Ontario | 149 | 45% |
| Quebec | 44 | 13% |
| Atlantic | 34 | 10% |
| Foreign | 6 | 2% |

* Percentages may not add to 100 due to rounding

MEMBER SURVEY RESULTS

1. In principle do you support the availability of medical assistance in dying (MAID)?

COMMENTS FROM YES RESPONDENTS:

- Mais je crains qu'un accès croissant et plus facile contribue à faire passer au second plan la priorité à accorder aux soins palliatifs.
- I think it is humane to help a terminally dying patient to die a painless death.
- Choosing to go on living no longer is not, ipso facto, a sign of a major psychiatric illness. It should be an option for those who can make a choice about the future quality of their lives, and whether they wish to continue on. In saying this, we have to be aware that misery—from a variety of triggers—may be an emotional state, but is not a psychiatric illness.
- Within the current legislated criteria.
- I do support the program.
- I think there needs to be very clear criteria, however, with a lot of checks and balances.
- Only as a total last resort.
- Who else but a physician can determine if a person needs to die and needs help to do it.
- I have been involved in two MAID assessments so far.
- But only for the terminally ill who are incapable of killing themselves.
- Terminal illness when death is near.
- Medically and ethically necessary.
- Seulement pour les malades en fin de vie et souffrant.
- I'd like to see substitute decision making in the future for patients with dementias who when competent wanted MAID after a certain symptom load.
- Yes! I would want it for myself and loved ones and feel others deserve this right if they wish. People with contrary views also have the right to refuse it for themselves but not others.
- Independent medical opinion should be sought.
- I think it should be a right for appropriate cases.
- under the condition it is part of a continuum of care and an alleviation of suffering as belonging to the spectrum of medical care.
- Yes, but hesitant to provide assessment for this given limited guidelines, or involvement of a committee.
- Mourir dans la dignité est un droit.
- Am opposed to leaving a patient with intolerable suffering with no hope of improvement.
- Under very restricted circumstances.
- C'est un droit strict en autant que la personne est apte à la demander.
- There is a philosophical and ethical problem with the concept of providing means for someone to end their life that goes back to Hippocrates and is reinforced by all our philosophical, ethical and religious beliefs in the Western world. Yet profound changes in the practice of medicine in the last century have created new ethical dilemmas for all of us. In everyday life we have always faced these challenges and physicians have responded in a variety of ways short of actually administering the lethal dose. I recognize this but I want to be sure that everything has been tried to reduce suffering and effect a cure before I would consider this. This is particularly difficult in psychiatry where depression is a treatable

| |
|--------------------|
| YES = 239 (73%) |
| NO = 50 (15%) |
| UNSURE = 35 (11%) |
| NO ANSWER = 2 (1%) |

| ANNUAL CONFERENCE SURVEY |
|--------------------------|
| YES = 26 (87%) |
| NO = 4 (13%) |

disease and the impulsive actions of borderline patients should not be supported. Also in cases of progressive dementia, the suffering is more often by the family than by the patient. Access to MAID in psychiatry must be very restricted.

- It helps clarify a murky area of patient care and legitimizes and guides what good doctors have been indirectly doing for decades.
- For certain illnesses whose treatments' are well funded in our system.
- In circumstances of terminal illness, persisting pain, when life is no longer wanted.
- A dear friend developed ALS and after a year of growing paralysis wanted to die. She lives in California now and when I visited her last fall I was left in dismay that nothing could be done for her then fortunately MAID became legal and her GP was able to assist her dying in November. I was left with appreciation for MAID and support it, and appreciate it is now legal in Canada/BC.
- There are many potential problems and pitfalls of assisting someone in dying, however, in cases where someone is suffering and also of clear mind, and has had time to come to a decision consistent with their values, it seems unethical not to provide them with assistance to end their life.
- For terminally ill patients.
- As a doctor who was trained sixty years ago, I long supported the traditional view that assisting someone to die was unethical. But in recent years the experience of having two brothers, who died after long and painful struggles with metastatic cancer, has changed my view. I now support medically assisted death in appropriate cases.
- I think it is a good idea for a very select population.
- Not for mental health.
- I think good palliative care can do a lot but there are human situations that assistance in dying is an important option for a person meeting the guidelines. I think the guidelines being restrictive at first was a good idea to get a complete grasp of easier decisions and move into more difficult and controversial.
- It can be cruel not to assist in certain circumstances.

COMMENTS FROM NO RESPONDENTS:

- I am not opposed to choice of dying, rather the burden of carrying out the action of killing to the medical profession.
- I believe it is wrong in principle, and especially wrong for the medical profession to be involved. It is against our basic medical, Hippocratic ideals.
- I don't want to be keeping people alive unnecessarily but I don't want to be helping people die who are suffering from mental illness or are otherwise fairly healthy and well.
- I think that there should be a specific separate group that provide assistance and that it should not have the term medical attached.
- The role of a doctor does not involve taking of life.
- For longstanding medical ethics and for religious reasons.
- I feel the government has moved forward with this too quickly. In psychiatry, we try to prevent suicide, not assist it. There is a need for better palliative care, and better treatment availability for depression, and that should be worked on before allowing euthanasia.
- Incompatible avec la profession de médecin.
- I believe in providing good medical care and a maximum of comfort, but my role is not to kill, euphemistically called "assistance in dying."
- Doctors are trained to learn about illnesses and the treatment thereof (including alleviation of suffering but not of killing as a method of alleviation of suffering). If politicians and lawyers decide that suffering can be terminated by ending life then they should do it or mandate that from now onwards, part of medical training will include ending people's lives. This is not continuing medical education; it is a clear change in treatment modality that should not fall to physicians. The politicians, legal experts and other citizens (including physicians) who think it appropriate should find a way of dealing with it and leave physicians out of it. You do not need to be a physician to know how to end life. The Internet provides information on that.

- As an Orthodox Jew, my religion forbids me to support it and as a human being, I wonder what kind of moral society we are heading towards on this slippery slope.
- I prefer wide availability of good quality palliative care.
- I support medical assistance in providing optimal comfort and support until natural death.
- It is a major decision to take a life.
- I feel this option can be very open to abuse no matter what the rules. I entered medicine to try to treat and alleviate people's suffering and health conditions, not to take their lives.
- I have profound problems with a policy that might allow distressed patients, possibly inadequately treated for depression to potentially be assisted to die when they might readily respond to appropriate psychiatric care and intervention. I am also extremely concerned about the potential "slippery slope" which might in the future see patients deemed to be burdensome such as the intellectually delayed or the chronically mentally ill assisted to die.
- Do no harm. Intentionally taking a life is wrong. Physicians are privileged to help and heal. Suffering does not make a life less valuable.
- It is unethical in a world where we do not have enough support for good palliative care. People who have access to it will be led to chose MAID to avoid burden. It also gives a hierarchy between physical debilitating diseases and psychological chronic refractory psychiatric disease.
- Doctors assist people in living. I'm appalled that doctors would, and would sanction, the intentional termination of life. Equally applied that the representative doctors' organizations would become complicit in socially sanctioned killings. Spineless.

COMMENTS FROM UNSURE RESPONDENTS:

- I believe good palliative care can replace the need for MAID.
- It depends so much on the circumstances.
- Initially I thought slightly more favourably of the topic, however when I think back over my career I am not so sure about it. When I started practice I worked treating patients with HIV/AIDS who had psychiatric symptoms (many suicidal/depressed). Within the time frame of about six months, a disease that was tantamount to a death sentence became and has remained a treatable/manageable disease. Initially those patients may have met criteria for MAID, but would not have four to six months later. How many other medical conditions out there may have a cure or better outcome in the foreseeable future?
- I believe that the option of assisted dying should be present; however it conflicts with our mandate as physicians to promote death in an active way. Perhaps someone who is not a physician could be trained to do it. Physicians are often asked to determine capacity. However, the administration of death does not seem compatible with the physician's mandate.
- Perhaps in very limited, carefully prescribed circumstances.
- There is much room for it to be misused.
- En principe, nous devons suivre les recommandations du collège quelque soit notre opinion personnelle. En pratique, nous attendons la loi concernant l'aide médicale à mourir (AMAM) appliquée aux maladies mentales, et en théorie, je suis à l'aise avec la disponibilité de l'AMAM au niveau des idées en général.
- Depends upon the circumstances. For progressive terminal illness, I have no issue with it. For the rest (chronic conditions, but non-terminal), I am much more ambivalent, as I think it becomes a slippery slope, it is a very grey area, and at what point are we interfering with nature or trying to play God?
- I will never be sure if my choice or support for assistance in dying was right.
- Though I can imagine scenarios in which it would be the most humane option, I expect excellent palliative care/spiritual support could make most requests unnecessary. I find it ridiculous that our hospital has developed a rapid response to MAID responses, I gather to avoid having the patient die before they can be killed?!?! (that is a bit Monty Python-esque, non)
- Palliative care needs to be available to everyone before I can fully endorse MAID. I worry that people choose MAID because they are afraid of suffering, when palliative care would have relieved that suffering.

- Dying itself is very hard to define, and ending someone’s life at their request is an action fraught with potentials for abuse.
- Of course, all possible assistance should be afforded to anyone who is dying, including palliative care. Including measures to shorten life or hasten death among permissible actions will sooner or later expose the health-care system and its members to conflicts of interest (mostly over cost) which will become very difficult to resolve.
- I staunchly believe in provision of skilled palliative care for patients in the end stage of their life.
- Probably yes, but under very specific and limited circumstances of irremediable suffering, and not at the expense of investing all we can in good palliative care.
- The whole impetus for MAID stems from a failure to adequately support people who have a terminal illness, psychologically, and in terms of adequate symptom relief. I believe people have the right to decide about their dying, but the co-opting of physicians into this process is again a failure to respect our fundamental role as healers. Also there are political and financial motivators that our leaders are not honest about, advanced directives and open discussion about death and its inevitability is a further societal failure.



2. Do you support the current exclusion of mental illness as a sole indication for MAID, consistent with federal legislation Bill C-14?

| |
|-------------------|
| YES = 173 (54%) |
| NO = 88 (27%) |
| UNSURE = 60 (19%) |

COMMENTS FROM YES RESPONDENTS:

- I think psychiatrist and psychologist be involved in the assessment of a mentally-ill patient before his wish be met.
- As intractable as some conditions are, remissions do occur.
- As a psychiatrist, I see many people who see no other option than suicide when they are ill, yet who see things very differently when they recover. Most people I have seen who survive a suicide attempt are ultimately grateful that they did not succeed.
- I worry that it will be incredibly difficult to determine whether we should be preventing suicide or helping with the patient's suicide if mental illness is no longer excluded.
- This opens a big can of worms!
- The Supreme Court was clear. If you are able to kill yourself, that is your option. We respect it but neither encourage nor condone it. Suicide is understandable, but never the best answer to life’s problems. Outside of terminal illness, all life is a struggle. One should never ask another person to kill you. It is neither a doctor’s duty, nor a patient’s option.
- Wish for death can be short term or long term and can be still helped with pharmacotherapy and psychotherapy and changes in personal circumstances. Even in cases that I thought this would never resolve it has.
- In general, I believe that the current limits protect from the “slippery slope” concerns. Inclusion of mental illness invites a real “slippery slope,” and invites the question for the practitioner faced with a suicidal patient: “do I certify and admit, or do I assist you to die.” I do not believe that we are ready to deal with such complex dilemmas.
- I have seen many patients who seemed to have a hopeless prognosis get better to advocate for assisted dying for mental disorders.
- What we can’t cure today may be curable in future.
- Yes and no. I think there should be demonstrated evidence of physical harm from the psychiatric illness as well and then I’d agree fully.
- With the improvement in outcomes in psychiatry I think it’s a slippery slope to include mental illness as an indication for MAID.
- The wish to die can be a symptom of psychiatric illness, and needs to be treated, not assisted.

| ANNUAL CONFERENCE SURVEY |
|--------------------------|
| YES = 25 (83%) |
| NO = 5 (17%) |

- Les soins en santé mentale ne sont pas prodigués au maximum de ce qui pourrait être fait, souvent pour des questions de logistiques, de disponibilités, de finances, de professionnels, etc. Alors pour le moment je suis pour cette exclusion tant que tout n'a pas été fait dans le cadre de propositions de soins aux patients. Après, on pourra raisonnablement discuté d'exclure cette exclusion.
- Mental illness should be excluded as a sole indication for MAID.
- Many psychiatric conditions are amenable to adequate therapy and expert care. An adequate psychiatric consultation and assessment is always necessary in these circumstances before MAID is considered.
- The definitions used were not precise enough to guide decisions with regard to mental illness and hence too subject to individual interpretation. They did not distinguish between illness secondary to its being refractory and that secondary to lack of access to adequate treatment.
- I don't think we should be part of transforming suicide into MAID.
- I think that MAID is suicide, but physician-assisted and societally acceptable suicide. The context may be different (illness, suffering, intolerable symptoms, etc), but it is still suicide. I am concerned that people have access to MAID, but not to caring and competent psychiatric care. We need to advocate for good psychiatric care for those with mental illness alone seeking MAID.
- MAID goes against our work preventing suicides.
- Our whole practice of psychiatry is predicated on the relief of psychic suffering, the provision of hope, and saving people from committing suicide. How can we then turn around from certifying someone under the MHA as a danger to themselves, and then agree they can have MAID?
- "Mental illness" in the present day, with the rapid development of treatment, can never be said to be irreversible or "irremediable."
- Yes, especially when people are incapable (e.g., demented, intellectually disabled), and potential for undue influence is high.
- Many people with psychological pain often seek an out through suicide, but once their illness is treated they usually have a change of heart. A mental illness changes the way a person looks at the issue of death.
- I believe treatment for mental illness is grossly underfunded and until we have a medical system that is better funded I do not think this is a worthwhile path to go.
- Definitely.
- Suicidality is part of some mental illnesses and patients' views may change over time with adequate treatment of major mental illness and personality pathology.
- As a psychiatrist, suicide prevention is a goal. Many patients suffer with intractable symptoms as well as stigma from society-at-large. Perhaps some investment in social programs, building less competitively driven work programs can help people living with chronic severe mental illness live with dignity and a sense of being respected by their community.
- MAID becomes very murky and complex when illness effects cognitive capacity, emotional reactivity and impulsiveness, psychological outlook and judgment so the bar for this must be customized, and more rigorous for safety.
- This is an area that is very complex and requires a lot of review and consultation and in my mind should be the last option to be considered.
- I was very relieved that the exclusion was made while we examine the question further. We have not yet worked out all the ramifications of this legislation if applied to mental illness, as I wrote in a LinkedIn post introducing Dr. Sonu Gaind's article on the topic: [Excerpt:] [re MAID]: "Typically we think of cases like that of Sue Rodriguez, in which a person of sound mind with an irreversibly deteriorating condition seeks to exercise control over the timing and manner of his or her inevitable death, and requests help in doing so. These would appear to be the types of situations most readily addressed by last year's Supreme Court ruling which struck down the prohibition against physician-assisted dying. However, that ruling does not adequately address the special complexities inherent in situations where the illness causing the suffering is a psychiatric one. Suffering caused by mental illness is real, can be extreme, and at times can appear intractable. But is it different from ALS or terminal cancer, for example, when it comes to the development of legislation around assisted suicide? Certainly there are mental illnesses such as dementia, in which a person has a progressive neurodegenerative disease which—much like other degenerative conditions—gradually depletes the person's capacity to exercise control, and ultimately will be terminal if no other illness intervenes. This is perhaps a different scenario than a chronic mental

illness which does not end in death, but in which a sense of hopelessness and the wish for death may in fact be symptoms of the illness itself. How do we approach the person with severe chronic depression which has been resistant to current treatments, who suffers greatly, and who asks for help in dying? When are cognitive distortions (which may be features of the disease) impacting on the person's free choice? How and when could family members or those involved in the person's care switch their focus from doing everything in their power to prevent suicide, to actively assisting? And is it even necessary to involve others in the decision, and in carrying it out, if the person remains capable of ending his or her own life? These and many other complex questions underscore the need for particular care and consideration—even if it means further extension of the time frame for legislation around cases involving psychiatric illness. In his recent article for the *Globe & Mail*, Canadian Psychiatric Association president Dr. Sonu Gaiind explores this issue and makes the case for proceeding with caution—not as a form of discrimination against those with mental illnesses, but in fact as an expression of special concern that they be treated justly—and with safeguards against risk of harm in situations where they may be particularly vulnerable.” (Dr. K. Sonu Gaiind, *Globe & Mail*, May 30, 2016)

- Hopelessness, lack of insight and chronic characterological traits impact the ability to make an informed decision about such a final act. Suicide exacts a huge toll on families and is a tragedy, but becoming party to euthanasia undermines our role as physicians.

COMMENTS FROM NO RESPONDENTS:

- Truly suicidal people do not tell us their plans. It is usually a surprise. If a depressed and suicidal person knows they may obtain MAID, maybe they will request it, and we will have a better understanding of the depth of their hopelessness, and a more useful dialogue will result.
- Unless mental disorders are not considered medical conditions it does not make sense to exclude them arbitrarily from MAID.
- This area needs more study, and strict criteria.
- I have patients who suffer from recurrent illnesses who, during the period of quiescence, and knowing their future with current medical options, can make a conscious decision that they do not wish the future as they see it. They should be as entitled as anyone else to make such a decision.
- I believe that where mentally-ill people are competent they deserve some choice.
- Mental illness must not be excluded as a reason for MAID.
- It is discriminatory against people with mental illness. If we want parity with physical health we have to go all in, you cannot cherry pick.
- Psychiatrically ill are not necessarily unable to form the intent to die and still should be eligible to medical assistance.
- I think people suffering from dementia should be allowed to decide to end their lives while able to do so with capacity.
- It is as difficult to endure suffering from severe mental illness as it is from any other severe illness.
- If the person is capable of making treatment decisions then they should not be excluded, but this whole exercise should not be Medical Assistance In Dying (MAID); it should/could be “National” or “Conscientious” or “Legal” Assistance In Dying (NAID or CAID or LAID).
- I think that long-term mental illness, resistant to accepted methods of treatment and causing unbearable suffering should be an indication for MAID provided the person is competent to make such a choice.
- Too broad. Many who are mentally ill and able or are competent to make important decisions should be included.
- Subject to competent decision-making.
- NO—it's discriminatory at present. Each case needs individual consideration.
- Dementia should be given consideration.
- Je ne vois pas en quoi ces exclusions sont justifiées.
- Although it would be rare, I can foresee situations where everything has been tried or where comorbid chronic medical illness makes the possibility of recovering from mental illness impossible. There would need to be proof that all possibilities have been exhausted and that the patient is competent to make the decision about their treatment.
- C'est de la discrimination; par ailleurs, l'aptitude doit être établie ainsi qu'une stabilité du choix.

- I would like to see consideration for serious and persistent mental illness as an indication, with appropriate safeguards for vulnerable patients.
- For most mental illnesses, I support the exclusion. The presence of mental illness can directly impact a person's ability to make judgments. However, an early diagnosis of a dementia would be something that I think could be an indication for MAID.
- Intolerable suffering can arise from mental illness in addition to physical illness. Wanting to die does not by definition make someone mentally ill, although in our current culture of practice the two seem to be often conflated, often to the detriment of patients who are hospitalized involuntarily. Excluding patients with mental illness from MAID is quite arguably discrimination and takes a position of reducing the rights of a disenfranchised population.
- In recent years there have been definite advances in the treatment of depression, although I recognize that treatment resistant depression remains a serious problem. My concern is that, suicidal ideas being common symptoms of depression, allowing assisted suicide in such cases, might result in its being used too frequently.
- But a psychiatric assessment would be mandatory before this could be considered.
- A blanket exclusion would seem extreme, though currently defining which mental health conditions and under what circumstances is difficult and requires research. Perhaps a temporary no would be appropriate until consensus emerges regarding the mental-health-related situations that can be supported.

COMMENTS FROM UNSURE RESPONDENTS:

- I don't think that depression should be a sufficient sole indication, but I do think that dementia with a pre-written advance directive should be accepted as a sole indication.
- Given that mental illness is an illness why should it be treated differently? On the other hand, I also recognize the impact that mental illness can have upon decision-making.
- This is tricky. The availability of competent psychiatric care in all regions of Canada is a concern. If this could be assured, I would be more comfortable with MAID for some psychiatric conditions.
- Again, it depends on circumstances.
- Generally, yes I do. There is a part of me that feels that doctors should only be involved in suicide if the patient is physically incapable of carrying it out (i.e., advanced ALS). I'm not sure how I feel about having to do it for a patient if that patient is able to do this themselves (i.e., why do I need to be involved?). It may sound petulant, but I think that's a question that's important to explore with patients, and the public—why do doctors need to be involved in an action that the layperson can do themselves?
- There is also a big part of me that is very, very worried that many people who are looking for MAID with a mental illness may not have had access to the best treatments, because of underfunding in both research and service provision, and that other causes that we as a society need to address may also be at play (i.e., social isolation, a big factor for many of the patients involved in Belgium with mental illness and MAID). I also work with Indigenous people, with a high level of suffering and suicide—I don't think the answer is MAID. It's reversing the trauma of colonization. I would feel highly ethically compromised to offer this to my Indigenous patients, and I feel like this treatment option, which is quite cheap compared to others, may detract from doing the harder work of getting to the root of people's distress. The situations I can see being a good fit for MAID are more things like severe, refractory symptoms in illnesses like schizophrenia or OCD.
- Perhaps long-term illness with poor response to treatment should not be excluded.
- Unsure of its meaning.
- I am concerned that in time the availability of MAID for relatively treatment-resistant depression would encourage its use even before treatments have been fully explored.
- The presence of psychiatric disorder does not equal impaired judgement. When psychiatric disorder is the sole indication, evaluation procedure might need to be adjusted, e.g., by adding a test of capacity.
- There are many people who would not want to stay alive if they suffered from severe dementia.
- Needs to be circumscribed and well-articulated. Risks of overuse appear greater than with physical terminal illness.
- Not sure of question.
- Il faudrait définir des critères pour les types de conditions mentales acceptables pour donner accès au programme.

- I agree there is something daunting about including mental illness, but I can't see how we could allow it to be excluded after psychiatry as an institution has pushed so much for distressing psychological experiences to be construed as being caused by biological malfunctions, and against stigma surrounding such mental illnesses.
- As a psychiatrist I'm not sure about assessing capacity for those with mental illness. I have done a second opinion assessment on one person and was able to confirm she did not have a mental illness, which led to her getting MAID.
- I think it is wise for now to exclude it until parameters are clear. I worry about a slippery slope and would have a hard time myself with it if one of my patients wanted it. I would always very much worry about capacity, and future available breakthroughs.
- I don't think psychiatric patients should be stigmatized through exclusion, but obviously need closer evaluation than those without psychiatric diagnoses.
- Not sure how to answer this—for the following reasons that anyone, least of all a doctor, would contemplate intentionally terminating the life of someone suffering a mental disorder, strains credulity. Hopefully the CPA will refuse to participate at any level in this shameful process, on the principled grounds that doctors don't intentionally kill patients, and psychiatrists too don't intentionally kill patients.



3. Do you support MAID for mental illness if 1) clarity were established for the interpretation of “irremediability,” 2) psychosocial issues were identified and addressed, 3) access to appropriate treatments were ensured, and 4) capacity and consent issues were fully assessed?

| |
|-------------------|
| YES = 151 (47%) |
| NO = 104 (33%) |
| UNSURE = 65 (20%) |

| ANNUAL CONFERENCE SURVEY* |
|---------------------------|
| YES = 16 (62%) |
| NO = 9 (35%) |
| MAYBE = 1 (4%) |

COMMENTS FROM YES RESPONDENTS:

- Irremediability would need to be assured for the illness at hand.
- Good luck with assuring that all of these conditions are met! Will cost \$\$\$\$\$.
- Given MAID (which I disagree with)—yes, if the above are established, no reason not to.
- I agree.
- IF all these were possible. But they are not.
- However I do not believe that these conditions can be met given that they are not currently available to most suffering from mental illness. Provide these to everyone and go from there.
- Pain and unnecessary suffering justify MAID, there are several mental illnesses that fulfill the criteria.
- The bar for it would have to be high.
- I believe these four components should inform every MAID assessment and not just mental illness.
- These are sufficient safeguards.
- Patients with brain illnesses—whether “psychiatric” or other neurological—should not be stigmatized if safeguards and consistency are in place.
- ALL four.
- See my answer on previous page!
- For dementia certainly.
- Tout à fait légitime la maladie mentale est très souffrante.

* Percentages may not add to 100 due to rounding

- As above.
- But very difficult to do.
- Extreme psychiatric expertise will be necessary if MAID is to be considered, since most severe psychiatric conditions are amenable to adequate therapy, unless terminal organicity is a factor.
- Mental anguish is as painful as physical pain and often is a significant factor in a request for MAID for physical illness, which is covered.
- At very least those issues need to be addressed.
- There should, in particular, be an option for advance request for MAID in the event of irreversible dementia. Safeguards would, of course, be needed.
- Must be sure that the above are done by qualified persons in appropriate specialty areas.
- These conditional criteria address my uncertainty and I would support this.
- Capacity and consent issues are the most important for us as physicians. The rest is up to the patients themselves to determine what they want to address or leave unaddressed: what is “irremediable” or “appropriate treatment” to them.
- We know access to treatments are a concern. Strategically this might be a CPA leverage for better resources and access to mental health treatment.
- Chronic treatment resistant serious mental illnesses/severe cognitive impairment.

COMMENTS FROM NO RESPONDENTS:

- Therapeutic nihilism is never good and many “hopeless,” “refractory” patients have been helped by appropriate treatment.
- To be completely blunt, and probably massively politically incorrect, if people are physically capable of ending their lives (i.e., not bedridden, etc) then if they want to make this choice, they can do so without needing to involve the medical system. It is a huge responsibility and ethical burden which patients are placing on us, and one which I willingly shoulder, but not if the patient is able to take that responsibility on for themselves and simply unwilling to do so. There are medical conditions which, were I to be diagnosed with them, would cause me to want to end my life. However, if I were physically able to do it myself, I wouldn’t dream of asking someone else to help me.
- I wonder how access to appropriate treatments were ensured. At this time, the majority of people in Canada cannot access one of the most proven treatments for depression, CBT, in a timely manner.
- Même si le critère d’irremédiabilité était clairement défini dans la loi, il resterait très difficile à définir cliniquement lors de l’évaluation du patient atteint d’un trouble mental.
- Slippery slope problems will arise if above implemented.
- In no circumstances should psychiatric disorders be grounds for MAID because psychiatric conditions are subjective opinions and not based on pathophysiological evidence like cancer, severe heart disease or severe degenerative neurological illnesses.
- Leave physicians out of it.
- This is very tricky. Must a patient have tried and exhausted all available appropriate treatments—it seems that access should not be sufficient.
- Given some cases that I have already read/heard about, I doubt there would be a consensus as to what constitutes “irremediability” and “access to appropriate treatments.” I am struck that some doctors have been willing to sign-off on cases that clearly have not exhausted all treatment options.
- Too difficult to clarify and address all those issues, also impossible to predict outcomes.
- This is a judgement call. Sometimes the compassionate actions of individual physicians are hard to fit into a structured position statement. There is a limit to how many complex rules or guidelines you can have before the “black swan” effect sets in.
- I would like to see the actual wording before I could give it wholehearted support.
- I am concerned that patients would worry a psychiatrist wouldn’t help them through a difficult time and want them to choose MAID. I am concerned that access to MAID for mental illness would undermine the doctor-patient relationship, even if the psychiatrist did not support MAID.

- This is far too subjective an issue and the deliberate ending of the life of another person is an action that should either not be undertaken or only if the person is within days of dying. If there is a chance for the person to recover and live, so if the illness would not necessarily lead to death, then we should never deliberately kill the person.
- I do not support under any conditions.
- There are very few circumstances in which it would be justified. Suicide is prevented by reducing access to the means. Why on earth would we even offer a method!?
- Not at this time.
- Capacity to consent would by definition fall to the treating psychiatrist to assess. In my current clinical group there is now psychiatrist amongst us willing to do such a capacity assessment were it to lead to the eventual termination of a patient's life by medically assisted dying.
- Even with these safeguards, I have rarely seen a case where I have felt everything possible has been done and the patient is justified in ending his life
- Under no circumstances. If society, rather than seven judges, thought assisted suicide was a good idea, I would fiercely oppose the medical profession having any role in it—let society farm out mercy killing to others, killing is not what doctors do.
- My response to these laudable hurdles is to say we are not capable of addressing such subtle and complex concerns in our humanity.
- Ces questions sont trop complexes pour être codifiées. Il s'en suivrait des confrontations constants avec des patients à savoir s'ils rencontrent (ou non) les critères, cette question pourrait se transformer en une lutte de pouvoir qui risquerait de drainer beaucoup d'énergie qui devrait être investée dans un plan thérapeutique.
- These are not terminal illnesses.

COMMENTS FROM UNSURE RESPONDENTS:

- I wonder if accepting implies untreatable, intractable, hopeless surrender vs optimism.
- Difficile de combattre le suicide et de prôner l'AMAM pour des raisons psychiatriques en même temps.
- I work in the field of patients with affective disorders and feel very uncomfortable if a patient who has expressed suicidal thoughts requests MAID. I think that item #4 (capacity and consent) has to be specifically clarified due to the irreversibility of this decision.
- What would we do with people whose decisions were impacted by low SES, poor housing, difficulty with employment? Is the government going to ensure that all of this type of care is going to be provided?
- I suspect that it would be difficult to define #1 and #4 in particular.
- Not sure that the above criteria can be met.
- Perhaps.
- The risk of well-motivated cleansing appears at stake and eroding the role and perception of medicine as an encompassing discipline involved in the caring of human beings. The notion of irremediability is evolving for a number of pathologies through time.
- Understanding of mental illness is far from clear. Consensus among psychiatrists on diagnosis or treatment is poor.
- In my ten years of treatment, I don't think I've ever encountered this situation. We have poor access to treatments and there are always some sort of psychosocial stressors. So I think the question is unrealistic.
- I suppose it would depend on what the interpretation of "irremediability" was clarified as being.
- Too many unresolved questions to allow a provisional decision to be put forth.
- Yes would be comfortable with it so long as the criteria phrased as above were met, but I do not think that psychiatry as a scientific discourse and a clinical praxis has the conceptual capacity to do so. Embedded in the criteria you designed are issues of trust, dependency, social justice, sacredness, loss and mourning that are not amenable to a technocratic response by the medical institution. I am also afraid that society at large may not realize this, may blindly trust in our scientific capacity to make determinations about the value of lives, and that this may somehow backfire against us down the road.

- Perhaps, but we until we have addressed these issues then I can not say for sure. Ask me again once these issues have been adequately addressed.
- I am not sure that these issues can be fully addressed. And since suicidality is a symptom of chronic mental illness, how can this symptom be separated from the other issues mentioned. I am particularly concerned with the definition of “irremediability” and “chronic” as it pertains to people in their 20s who may fit such definitions but are still in active brain developmental stages.
- These are certainly critical areas and I would be more open to consideration if these all were met. I’m still thinking although these are important, I say unsure that area should be approached with great caution.
- As per my previous comment, we may want to look separately at brain diseases like dementia (progressive and irreversible) vs. illnesses like chronic depression, where irremediability may be difficult to determine, as it is not progressive or necessarily terminal, and new treatments could be on the horizon. I believe we cannot approach in the same manner the situation of 1) hastening death in a manner that relieves otherwise intractable suffering in a person who is—with certainty—dying, and 2) “putting someone out of their suffering” who would not otherwise be terminal.



4. Do you feel that a psychiatric assessment should be required as part of every MAID assessment, even in the absence of known or suspected mental illness?

| |
|-------------------|
| YES = 114 (36%)* |
| NO = 169 (53%) |
| UNSURE = 37 (12%) |

COMMENTS FROM YES RESPONDENTS:

- As with certain other medical conditions—suitability for transplants, suitability for organ donation, etc.
- Risk of depression or psychosis needs to be evaluated to see if the person really has the capacity to make the choice.
- As in the case of every major medical procedure, capacity needs to be assessed and MAID is no different.
- I think it is important to rule out a treatable depression before assuming that suffering from a terminal illness is “natural.”
- However, this should be done AFTER an assessment by the treating physician for the illness they are suffering from has providing information about the prognosis of the illness, treatment efforts, etc. For example, I don’t want to be in the position of judging whether a patient is correct in believing they won’t ever get better from their cancer. That information would have to be provided to me, and I would want the input of the team that actually knows the patient well.
- La corrélation entre désir de mourir et trouble psychiatrique est trop grande.
- If someone is that desperate then that itself is reason to pause and carefully consider.
- Yes if MAID becomes a reality. I oppose this reality.
- To make sure that treatable emotional illnesses are excluded.
- Even though the primary question is a moral and not medical question.
- It’s important to ensure a patient is competent to give permission and comprehends all options.
- Most important in order to document mental status and possibly decreasing suffering. In order for psychiatrists to acquire some knowledge relative to different mental status as someone is facing/is in the process of no-return decision-making.
- To ensure that there is not comorbid mental illness affecting the patient’s ability to tolerate the “physical” suffering.
- Preferable to rule out hasty decisions.
- Often psychiatrist issues are kept secret.

| ANNUAL CONFERENCE SURVEY |
|--------------------------|
| YES = 13 (43%) |
| NO = 17 (57%) |

* Percentages may not add to 100 due to rounding

- As physicians get more experience providing MAID, confidence will rise, and if there are not safeguards put into place that are predictable, standardized, and designed to increase patient safety, then more people will be assisted to die than otherwise.
- At least the absence of mental illness should be documented.
- The person should be assessed ideally by more than one person on separate occasions to get a sense of whether the person appears to be making a values-informed decision, that they are capable of making this decision, that they have given consideration to the effects on other people, and that they have fully considered all of the implications about ending their life.
- The presence of a remediable depressive disorder, for example, needs to be ruled out.
- Though I fundamentally disagree with this entire initiative, an assessment would at least identify the individuals with untreated psychiatric illness and could potentially lead to treatment rather than inevitable death.
- Formal capacity assessment and rule out undue influence from others. Most of the literature indicates that capacity has not been addressed.

COMMENTS FROM NO RESPONDENTS:

- This makes the unwarranted assumption that our colleagues cannot screen for mental illness, and refer if necessary.
- Give our colleagues some credit, please.
- Psychiatric assessment only required when suspected or when screened positive by another physician like for any other “treatment” decision. Even if the “treatment” is death.
- Family doctors should be able to assess routine capacity issues in patients with medical illness.
- I do believe that the medical doctor evaluating the physical condition is good enough.
- The workload would be excessive for psychiatrists as well who will pay for this?! If there are mental or addiction issues, that is different.
- The physician who has the most experience treating the irremediable condition is in the best position to decide if a patient’s assessment of their circumstances is in keeping with the typical progress and outcome of the condition. If that physician feels the patient’s assessment appears driven by inexplicable hopelessness or nihilism or amplification of negatives, then involving a psychiatrist might make sense.
- Although screening should occur.
- Only in cases where a potentially treatable psychotic motivation probably underlies the patient’s request for assistance in dying.
- Only if there is concern that psychiatric illness may be impacting decision-making.
- This could overburden the demand for consults, and be a disservice and potential delay for those with more clear-cut MAID cases.
- Des médecins autre que psychiatres peuvent évaluer la capacité à consentir au traitement. Une évaluation psychiatrique est nécessaire seulement s’il y a une suspicion d’une maladie mentale.
- I refuse to be a rubber stamp for a person of sound mind who has made his/her decision. Insulting and obstructive to their free will, and a waste of time for me.
- Not if those providing the service are carefully screening for complicating factors of influence. I fear some advocates for MAID may be too hasty in their assessment.
- It shouldn’t be required if no one is requesting it, but it should be required if any interested party requests it.
- Not needed in certain cases, e.g., ALS diagnosed by a specialist in the area and managed by them.
- Only if there are grounds for concern for mental illness, ambivalence or coercion.
- Les psychiatres sont formés pour diagnostiquer des maladies mentales pas pour certifier la normalité et entre absence de maladie mentale et normalité, il y a une zone grise.
- Je ne pense que c’est nécessaire pour les cas de maladie physique.

- A psychiatric assessment is not required de facto for withdrawal of care, surgeries with low risk of success, refusal of lifesaving treatment, etc, so I see no reason why a different standard should be applied here. Of course if there is suspected mental illness, a psychiatric assessment is appropriate.
- We have to trust the judgements of other physicians.
- But may be a part of the full assessment in many cases, especially those where the treating doctor does not have a long-term relationship with the patient. A good family doctor or palliative care specialist should not need an opinion from a psychiatrist.
- We don't have enough psychiatrists to see patients who want to recover and lead productive lives. I would consider this a waste of resources in cases where there is no known or suspected mental illness.
- Some cases are clearly medical such as cancer or ALS and there are no psychiatric issues.
- For us to make such a broad recommendation to society implies that we, from the strict evidence-based, scientific and medical ethos that we have adopted for ourselves over the last few decades, are somehow intellectually skilled to make some core determination about any sick person's view on the finality of their lives, which I think, to put it bluntly, would be a fraud. It would be more acceptable to me if the purpose of our intervention was clearly specified as something like: "ruling out a clinical syndrome impairing the patient's cognitive faculties and her or his ability to make that decision."
- All physicians who work with people who are dying and eligible for MAID should be able to do a MAID assessment. Dying is a universal issue! Why create extra work for psychiatrists and plug up the mental health system.
- I do not support MAID.
- From what I have heard of the New Zealand experience, this process was resented by patients and became largely meaningless. I see the potential for many inappropriate requests for MAID from psychiatric patients and don't want to be involved in the process in any capacity.
- I think most family doctors are competent to assess for the presence or absence of a severe psychiatric contributor to a MAID request for another medical condition.
- This would be a huge challenge for psychiatry and other physicians can make these decisions using their skill set and using the guidelines.
- In selected cases, yes.
- Psychiatry should not participate in the process in any way.
- The system will be overloaded and the wait times will become even longer.

COMMENTS FROM UNSURE RESPONDENTS:

- An assessment by either one of the following specialties should be required though: psychiatry, palliative care, geriatrics.
- We must presume capability; however I think given this is such a final outcome, it may be worthwhile as a protective measure. However capability assessments are not always reliable.
- The desire for hastened death is incompatible with our current understanding of mental health.
- I think a psychiatric assessment is probably important for every MAID assessment, but I am not convinced that it needs to be a separate assessment completed only by a psychiatrist. I think general practitioners should be able to include a psychiatric assessment as part of their MAID assessment.
- If concerns raised by attending physician, then yes. I also feel people have the right to refuse psychiatric assessment. The difficulty is that people may decline psychiatric involvement for various reasons (e.g., concern it could influence access to MAID, demoralization, depression, etc).
- There are grey zones in mental illness e.g., personality disorders, early dementia, which cloud the issues.
- I think a thorough mental assessment needs to be done on every patient, but this could potentially be done by another professional with appropriate training, e.g., family physician, psychologist, etc.
- In principle, but in reality, this may be an additional workload burden.
- On the one hand this might help in ruling out depression or other mental factors which might be unduly influencing the person's decision to die, and in establishing capacity in cases where that is questionable; however, it may also unnecessarily delay matters if psychiatrist opinion is not readily available and the situation is more clear-cut. As well, not all psychiatrists will be comfortable performing this function. Perhaps there should be a number of physicians

(psychiatrists and palliative care physicians among them) trained thoroughly in the ethical, medical, mental health and capacity considerations around MAID who could be called upon to participate in each MAID assessment, aiming for broad availability of willing physicians with specialized knowledge and training.



5. Should a psychiatric assessment be required when a mental illness is either known or suspected to be comorbid with the primary illness in MAID applications?

| |
|-------------------|
| YES = 249 (78%) |
| NO = 30 (9%) |
| UNSURE = 41 (13%) |

COMMENTS FROM YES RESPONDENTS:

- Again, capacity must be determined. However, having a psychiatric illness as a comorbid condition should not preclude someone from qualifying for MAID, it should (like all other illnesses) be treated as fully as possible before someone chooses MAID.
- Definitely.
- Untreated mental illness and its interference with the capacity to make decisions is clearly relevant.
- The comorbid mental illness if treatable could alter the patient's request for assistance.
- Or at least a second opinion, as in some cases it may not be a relevant contributor.
- But should not exclude eligibility if the person is capable of making treatment decisions.
- I believe this would be prudent and in the patient's best interest.
- Though this may require some clarifications where it may not be required.
- Competency.
- Il est important de connaître l'impact de toute maladie dans la demande de soins et de fins de soins, voire de fin de vie tout court.
- Only if it is considered to be an ACTIVE contributing issue. If the patient has a remote history of mental illness (e.g., depression) that is not felt to be concurrent, then I do not think such a patient should be treated any differently, or require any extra hoops to jump through.
- Nécessaire dans le cas de maladie mentale.
- Preferable in most cases.
- It's part of an appropriately comprehensive assessment.
- Although I feel very concerned that psychiatrists would then become the gatekeeper of MAID. Our role should be to comment on competence and the presence of major mental illness.
- ABSOLUTELY! By appropriate specialty e.g., geriatric psychiatry, child psychiatry, forensics, etc as the case may be.
- As a practising youth forensic psychiatrist I routinely encounter mental illness that affects capacity to stand trial, and see that many docs are uncertain about assessing mental illness.
- Independent assessment (probably psychiatric) should be made in all cases to assess capacity and also as part of a counselling/preparation process for the patient, whether there is a mental illness suspected or not.
- Unquestionably.
- Speaks for itself, especially given my earlier comments.

| ANNUAL CONFERENCE SURVEY |
|--------------------------|
| YES = 26 (87%) |
| NO = 4 (13%) |

COMMENTS FROM NO RESPONDENTS:

- This may cause undue delay. Psychiatric assessment should be requested if it is currently affecting decision to request MAID.
- People can make decisions without armies of doctors etc to interact with them.

- Sauf dans le cas d'une maladie mentale sévère et persistante.
- Many physicians are capable of assessing patients who live with mental illness. There are certain circumstances in which a psych consult may be helpful or even very important to have, but that should be at the discretion/need of the assessing physicians.
- I do not support under any conditions.
- Psychiatry should not participate and the CPA should represent the interests of psychiatrists by refusing to participate. By the way, the acronym MAID lends a jovial air to a very serious issue and trivializes intentional killing, another bad thing, just as co-opting the medical profession into participating lends the disgraceful practice an air of respectability. Would society approve of this practice if the medical profession condemned it and refused to participate?

COMMENTS FROM UNSURE RESPONDENTS:

- Proposée certainement, mais obligatoire??
- There is some nuance in this statement that I feel is not captured in such a brief statement. On the whole, I probably do support this, but with some limitations—otherwise we will get more referrals for assessment when there is no real basis for it.
- This should depend on the presumably mandatory content of such an assessment and should address the issue of assessing a patient who is presumably not psychotic but is seeking to persuade the psychiatrist that they are a suitable candidate for MAID. I don't think that we, as psychiatrists, have experience with this type of assessment, but the politicians and bureaucrats will no doubt happily pass the buck to psychiatrists. It would also be important to know what legal liability attaches to doing such an assessment.
- Likely would be helpful. However resources are a significant issue.
- I am reluctant to suggest a requirement that removes the treating physician's ability to exercise their expert judgement and also to require something that may prove to be a significant barrier to the patient access (given psych access issues).
- Not required, but assessors should be able to get access to a psychiatrist for this type of assessment if requested/needed.
- I would recommend this only if in the opinion of the primary assessor, there is a question. So, I would not necessarily require psychiatric assessment for someone with a history of GAD and remote substance abuse.
- Depends on how bad the mental illness is, and how hopeless the medical condition is, e.g., depressed person refusing treatment for a good prognosis cancer should be assessed.
- It would depend on how the comorbid psychiatric illness will impact the decision. For instance, if someone has end-stage cancer, I think it may not matter that they also have a comorbid psychiatric illness.
- I think that it could be recommended. In general I think that we need to be cautious in building in such broad generalizations. Physicians are always making decisions that may include decisions about those with a mental disorders which are common. What if the person has long-standing addictions or anxiety problems? If someone has a dementia is that considered a comorbid mental disorder? The presence of clinical practice guidelines would be better than a blanket legal requirement.
- You should have a category of "refuse to answer" or "non-pertinent." I am fearful that any answer I give you will be misconstrued given that I disagree with the MAID program itself.
- Case by case.
- I think it depends on the mental illness. If it is mild, and or is unlikely to affect functioning for example, I don't think a psychiatric assessment always needs to be done.
- Yes in case of psychosis, no in case of anxiety disorder.
- There may be times when such an assessment may be needed, but it should not be mandated in all cases.
- I think that each case should be evaluated case by case—if there is some type of guidelines, etc, this generally makes it more difficult to assess the situation case by case.
- Ça dépend du pronostic de la maladie physique.
- The word "required" is my problem here. I think it should be done, but am unsure whether it should be made mandatory.
- Il faudrait élaborer des critères de sévérité.

- I don't know. I think the need for the assessment should be at the discretion of the doctor who does the assessment for MAID. Presumably that doctor will do frequent assessments of patients for MAID, and develop expertise in recognizing when a patient has mental illness that may affect their judgement, and when they do not.
- Again, the purpose of such a mandatory assessment should be specified.
- If the mental illness is suspected to be contributing to the person's desire to die.
- It would make sense for some cases but I'm not convinced it should be a requirement for each case.

* * * * *

6. Is a chart review and discussion with individuals other than the patient sufficient to inform an adequate psychiatric assessment (either clinical or capacity assessment) for MAID (i.e., no direct face-to-face or telemedicine interaction with the patient)?

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|-------------------|
| YES = 16 (5%) |
| NO = 273 (85%) |
| UNSURE = 31 (10%) |

COMMENTS FROM YES RESPONDENTS:

- When patients can no longer communicate their immediate request and they had already stated in the past they would find the condition being reviewed as intolerable.
- If an appropriate assessment has been done, e.g., by a GP, then it is cruel to make a patient repeat this.
- I think so, with the caveat that an experienced psychiatrist can be available to do the assessment.

| ANNUAL CONFERENCE SURVEY* |
|---------------------------|
| YES = 1 (3%) |
| NO = 28 (93%) |
| MAYBE = 1 (3%) |

COMMENTS FROM NO RESPONDENTS:

- Ce n'est pas suffisant mais çela demeure très important pour ceuillir toutes les données pertinentes pour une décision éclairée.
- Cannot be assured of competent and lack of coercion without face-to-face.
- There should be a face-to-face assessment.
- I think you must ask the questions face-to-face and offer followup questions to really establish the person's decision-making capacity.
- The assessment has to be done directly, that is face-to-face. Worse case scenario: via telemedicine.
- Absolutely not. I wouldn't even prescribe an SSRI for a patient without seeing them, much less MAID.
- The opinion of the person that will chose the program is indispensable.
- There may be no need for a full interview in a patient who has preexisting wishes and a psychiatric condition that renders them incapable such as dementia, but the patient would still need to be assessed, at least for functional status, capacity, symptoms.
- Absolutely not.
- I think this is far too grave of a decision to make without consulting the patient themselves.
- Compte tenu de la gravité des conséquences résultant de l'AMAM, l'évaluation de la compétence doit être la plus complète possible : elle doit inclure l'évaluation direct du patient lui-même et la collecte d'information collatérale des proches et du dossier.
- We would not accept that for any other psych consult so why in this circumstance?

* Percentages may not add to 100 due to rounding

- In my opinion what is suggested above could only constitute a first impression. To regard this is adequate for giving an expert opinion and assessment would be akin to giving psychiatric diagnoses on public figures based on their publicly available statements and information. I thought this had been declared unethical.
- Assessment of the person is always necessary.
- Assessments should be done in person or via telemedicine with the patient.
- The graver the decision, the higher the standard of care it deserves—otherwise administrative euthanasia may devolve.
- Évaluer le patient incluant un évaluation de l'état mental est essentiel.
- If you are requiring a psychiatric assessment, then an appropriate assessment should be conducted either face-to-face or telehealth.
- There is never any excuse for making conclusions without examination.
- A proper assessment should include a face-to-face assessment. The lawyers will interpret the law to suit themselves and blame psychiatrists for inadequate assessments.
- Definitely not.
- Absolutely not.
- One should be required to see the patient, face-to-face as well as doing the chart review and discussing with relatives and other individuals.
- Tout doit être fait avec le patient car il est au centre de la démarche et le premier concerné par l'AMAM, donc toute intervention sert à l'éclairer, à le confirmer ou l'infirmier dans sa demande, tout comme son dossier et l'évaluation psychiatrique devrait être mise à sa disposition. La transparence doit être totale car l'enjeu est majeur.
- Patient always needs to be consulted. If family or representatives need to be involved the patient should be present as long as it doesn't intensify their suffering.
- I am unsure that this is ever sufficient to inform an adequate psychiatric assessment.
- La consultation du dossier et la discussion peuvent établir la pertinence ou non d'une évaluation, mais ne sauraient la remplacer.
- A psychiatric assessment cannot be done without appropriate interaction with the patient.
- Unless there is terminal dementia, psychiatric consultation would be preferable.
- I can't see that a chart review or case conference would be acceptable as a mental health assessment. Notes are often inaccurate/inadequate. Clinicians can present a case any way they want (as I recall from my days as a resident reviewing cases on-call with my attending).
- Assessment needs to be face-to-face.
- And never has been sufficient to make a psychiatric diagnosis. Our special skills require direct interviewing
- NEVER. Must be face-to-face for psychiatric assessment.
- If I understand the question properly, my answer is no. There should always be face-to-face interaction and assessment of the patient by the MAID provider personally.
- I do not support MAID under any conditions.
- There must be some amount of "gut feel" that is important in meeting the person—whether they appear to be of calm and lucid mind, for example—that cannot be obtained from third parties. Furthermore there should be some counselling provided.
- Not sufficient if assessment is for purpose of diagnosis and possible treatment of a psychiatric illness.
- That's a ridiculous proposal.
- The psychiatrist should assess the patient as well.
- What an absurd notion, taking the ridiculous to extraordinary heights.
- I don't believe that provides enough of a safeguard. At least a telemedicine interaction would seem to be a minimal standard for assessment.
- Le psychiatre a un methode pour elicer l'information qui est differente de la plupart des autres intervenants et pourrait donc obtenir de l'information differente.

COMMENTS FROM UNSURE RESPONDENTS:

- Depends on the situation and information provided. Who will pay for the OHIP funded physician for indirect care?
- This would depend on the guideline. In many clinical situations, this kind of indirect consultation is sufficient and there is no reason this could not be an adequate level of involvement in some situations unless a law or guideline declared it to be inadequate.
- Face-to-face preferable when possible but not mandatory.
- If this involves a discussion with another knowledgeable physician (e.g., palliative care, GP) who has had detailed discussions with the patient regarding MAID and their mental health this may be possible.
- This is challenging. The content of charting varies. Without seeing the patient, a psychiatric assessment is limited to more broad statements, e.g., “I would screen for this..,” or “I would consider offering a trial of antidepressant treatment if concerns persist.” Making definitive statements about capacity, in particular in MAID, without meeting a patient would be difficult. I also feel the burden of the medical assessment would need to be distributed given the importance of the decision. For example having review panels (similar to mental health act), case discussions, etc.
- I could imagine the possibility of such a review being sufficient, but basically I think some direct observation should be part of the psychiatric assessment.
- Chart review and collateral MAY be enough or may require face-to-face assessment.
- Depends on patient’s capability.
- I don’t understand the question. If a chart review and collateral indicates that the patient may have a mental illness, then I think the person should have a psychiatric assessment and/or MAID should be put on hold. The risk of harm is substantial, and the decision is irreversible.



7. If the most responsible practitioner treating the patient for their primary illness declines to be involved in a MAID application, should there be a requirement to contact the most responsible practitioner for the purposes of enhancing the understanding of the patient’s current clinical situation and relevant background health issues? (The rationale for this is to address concerns arising internationally where itinerant or travelling physicians are doing MAID assessments without long term knowledge of patients.)

| |
|-------------------|
| YES = 237 (75%) |
| NO = 29 (9%) |
| UNSURE = 52 (16%) |

| ANNUAL CONFERENCE SURVEY |
|--------------------------|
| YES = 20 (83%) |
| NO = 4 (17%) |

COMMENTS FROM YES RESPONDENTS:

- Provincial bodies would need to fund both participants for this clinical activity.
- As my former mentor used to tell us, “you can never have too much information about a patient.” To make a decision of this magnitude without collateral from the MRP is malpractice, in my opinion.
- At very least an attempt should be made to contact the most responsible physician to try and ensure all relevant information has been obtained.
- It will be a miscarriage of justice not providing the person who somebody that the primary practitioner declines doing it.
- Yes. The reason for the refusal is important to assess.
- Involvement in the decision does not mean absenting from the care, and there may be a number of significant contribution that the attending physician could contribute, even if absenting themselves from the decision or other involvement.
- Any decision in such complex circumstances should be subject to judicial review.

- For thoroughness.
- I think that relevant longitudinal history is essential to safely providing this service.
- And he should be free to state his objection to MAID.
- Toute démarche concernant la santé du patient rend les médecins obligés de communiquer entre eux pour la meilleure approche possible et répondre aux besoins du patient, y compris son besoin de mettre un terme à sa santé physique et mentale par la demande de mort.
- In the the practice/application of MAID it is essential for medicine and any physician to respect the Hippocratic oath and not be part or become an executioner or part of an execution plan that is real or perceived or possibly perceived. The medial therapeutic relation is based on trust and the development of trust.
- Yes, I do think it is important to connect with the attending physician. Another challenge is that this adds to the assessment process, and compensation/billing codes would need to be in place.
- Absolutely or there will be physicians abusing the system.
- C'est réglé est en accord avec la bonne pratique medicale.
- If this happened there would need to be enough contact to develop a therapeutic alliance and to ensure that the clinician involved is able to know enough to understand the patient's life and environment context and the patient's lived experience.
- The normal rules of professional conduct should apply. If the MRP does not wish to be involved on ethical or religious grounds that have nothing to do with the medical indications for MAID, and the patient is requesting MAID then the physician should step aside and the patient should decide who to consult. They will need assistance for this and obviously the MRP must be consulted.
- The MRP still has knowledge about the history and treatments attempted which may be hard to tease out from separate charts and may be only in that person's chart for the patient. Some GPs still use paper records (and often have good reason for doing so!)
- I don't know how irremediability of a condition can be determined without information from the treating physician.
- The MRP and the physician doing the assessment should be REQUIRED by law to communicate about this.
- And conversely there should be an obligation put on the MRP to provide such information, despite their moral objections to euthanasia.
- If the most responsible doctor has historical experience with the dying patient this information would be valuable, even critical, in assessing a patient for MAID. The feelings and wishes of spouses and relatives are very important and knowledge of them could help avoid disputes and litigation!
- Since MAID is now available in Canada, there should be less need for patients to go abroad for such services.
- The idea of a patient terminator physician for hire is highly unpalatable; the potential contact with the primary physician would at least lend some professional accountability to the situation. Just because a policy has become law does not make it ethical and does not remove from the fact that I and most of my colleagues took the Hippocratic Oath.
- Seems reasonable and sensible, as long as some thought is given as to what to do if the MRP is either unavailable or unwilling to participate in providing information for this purpose.
- Regardless of our moral beliefs we have a duty to our patient and should not abandon them. I accept that some psychiatric illnesses are malignant and terminal, and psychiatrists need support in dealing with such cases.

COMMENTS FROM NO RESPONDENTS:

- Must respect responsible physicians choice to not be involved in MAID.
- The most responsible should continue to be the responsible physician, and not be pulled into a process that he does not accept and historically has not been accepted by the medical profession (see Hippocrates).
- If the relevant information is available in the patient's chart, contacting is likely not necessary.
- Definitely not.
- Si le médecin refuse pour des raisons de valeurs personnelles.
- There shouldn't be a requirement, as it may not always be necessary, but it would be advisable to attempt to contact the MRP for enhanced understanding of a patient's history, etc in some, even many, circumstances. Again, this should be

at the discretion of the MAID provider or assessor. Making it a requirement would carry the risk of impeding or delaying MAID assessments and/or MAID procedures if the MRP stalled, delayed, or refused to speak with the provider/assessor. This would not serve the patients well.

- I do not support MAID under any conditions.
- Absolutely not.
- Je ne pense pas que ça devrait être une obligation car le médecin le plus responsable qui est contre l'AMAM pourrait ne pas vouloir collaborer avec le processus. Cependant, il est impérative que le médecin qui fait l'évaluation pour l'AMAM soit tenu de pouvoir démontrer après du Collège des médecins qu'il a fait une évaluation approfondie de la condition du patient, sous peine de sanction disciplinaire (et légale??)

COMMENTS FROM UNSURE RESPONDENTS:

- The “most responsible” practitioner, if unwilling to do it, must appoint someone in their stead.
- Too complex of a question to answer in this format of questionnaire design.
- This should probably occur but there could be justifiable circumstances where one might not contact the MRP (not sure what those are though).
- I don't understand the question.
- I think it should be a good practice expectation but not a requirement. We need to chart why the MRP was not consulted.
- The question is somewhat unclear, since the first sentence refers to presumably two different “most responsible practitioners.” The situation outlined in the second sentence should be banned.
- There will always be situations where this is not necessary (when a clinical assessment will make it evident that the patient is eligible and supporting information can be obtained from reliable others like family). In completing a consultation and forming an opinion we are expected to obtain relevant collateral. This would typically involve contacting other providers or obtaining their records.
- I think an appropriate assessment is required, and this would seem to ordinarily include getting adequate understanding of the case, which would seem to ordinarily include talking to the care provider who best knows the patient. I am leery about making this a requirement, and even more leery about having it appear in legislation. While the issue of MAID is complex and does seem to require specific legislation (it is a social policy question), I want to keep professional judgment as part of the work of doctors and am hesitant to require this level of detail (i.e., you must contact a specific person for collateral) in guidelines.
- I seriously don't understand this question.
- This likely would require a case-by-case analysis. For example, if the treating doctor is simply ethically opposed to participating, then no contact should be required. There should be a mandate on the treating physician to participate to the extent of clarifying (e.g., on the form) why not participating (e.g., clinical issue of patient, moral objection, other).
- Preferable, but I know from experience that some MRPs refuse to reply to any calls about MAID patients if they oppose it.
- I am unclear about the intent of this question.
- This should ideally be done anyway, but may lead to problems with conscientious objectors.
- I hope Canada does not come to have itinerant/travelling physicians doing MAID assessments. But I also see problems with insisting on contacting the primary MRP—if a doc is going to approve MAID regardless of what the MRP says, it seems a waste to insist on contact.
- The idea of travelling physicians with this niche market is disturbing, but if the most responsibly involved physician refuses to be involved, who exactly is the person who, knowing this, still asks that physician to be involved?
- This may be a best practice responsibility in some cases but not all.
- How can one enforce a Canadian law on an international basis? It doesn't make sense to include this as a requirement if the patient travels outside the country for the suicide. If the assessment is being done in Canada; however, yes the assessing physician should be obligated to contact the MRP for further information.



8. Should a close family member(s) be contacted to provide input for all MAID assessments, unless a patient specifically objects to such contact? (If the principle of “patient autonomy” is applied in a narrowly interpreted manner then input from family should not be required, but family input may provide valuable information, enhanced confidence regarding MAID decisions, and appropriate respect for the role of family.)

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|-------------------|
| YES = 234 (74%) |
| NO = 33 (10%) |
| UNSURE = 50 (16%) |

| ANNUAL CONFERENCE SURVEY |
|--------------------------|
| YES = 25 (89%) |
| NO = 2 (7%) |
| MAYBE = 1 (4%) |

COMMENTS FROM YES RESPONDENTS:

- Family input is almost always important when making similar decisions.
- It should not be mandatory, just encouraged. Patient should be given option to say no and to specify which family member would be appropriate to contact.
- In case of necessity only, but should be permitted if could help the physician to make the best decision possible.
- Is necessary.
- Family need to be involved in the process wherever possible as MAID will have ongoing ramifications after the person has died.
- Autonomy and selfishness are different matters. Obtaining information from a close relative is not undermining a patient’s autonomy. In the end the patient and the physicians involved make the decision, not the close relative. But to cut out the close relative could be very selfish in the sense that the aftermath, the consequences of a death from an illness, a suicide or MAID on the surviving family members can be profound and the patient for his or her own reasons or lack thereof may not be able to appreciate this outcome. Even a specific objection by a patient should be closely examined as to its validity, i.e., what is the reason, what is the harm, what is the benefit.
- But family should only be contacted with patient permission.
- I would argue that collateral information from someone who knows the patient well should be a requirement, in order to have a complete assessment.
- Il faudrait impliquer les familles autant que faire se peut, avec l’accord préalable du patient bien entendu.
- While I think it is useful to involve a family member (or even more than one), there can arise a situation where family member(s) and patient disagree, which can be based on legitimate family member observations of the patient’s mental state. This may provide confusion for the assessor but seems legitimate to me.
- Family must live with the consequences of the decision, and will be the people who know the person best. We are all at our most healthy when are decisions are collaborative.
- Noting that in some contexts, close friends may be more informative than the closest biological relatives.
- Yes, so long as family members understand they do not have “veto” power over a patient’s decision to proceed with MAID.
- I have read of some cases in Belgium where family found out AFTER the person died. This was particularly troubling because the “reason” for the assisted death was 1. bipolar 2. depression.
- Not necessarily a family member, I prefer “a significant other.”
- Yes this would be considered a good practice in psychiatric assessment.
- Will full permission. Not assent, but consent for contact.
- This is not an individual decision and should involve the whole family.
- As in all our work as psychiatrists, relevant collateral is invaluable to a comprehensive, safe and more accurate assessment.
- Of course!
- Contact should be made only with the patient’s consent, assuming they are capable of consenting to or refusing this contact.

- I have seen family input much opposed to a patient's stated wish to die in the case of a depression, and they were instrumental in having him receive needed ongoing care in hospital when he wanted to give up and seek medically assisted suicide as an outpatient.
- On ne peut conclure l'évaluation tant qu'on n'a pas l'ensemble du portrait, cela sera donc de la responsabilité du patient de donner son accord ou non mais il devra savoir que sans conclusion d'évaluation, il ne pourra y avoir d'accès à l'ANAM, le dossier restera en suspens. Ceci permet de respecter l'autonomie du patient mais de faire une évaluation scientifique, sociale, affective, etc la plus exhaustive afin de prendre une "bonne décision," car il n'y aura aucun retour possible s'il y a un accord d'ANAM ou un refus (ce qui inciterait les médecins dans le cas d'une nouvelle demande à beaucoup de prudence).
- If the patient and family disagree, it can be distressing for all involved, including the health-care team. I think these are the cases that lead to emotional burnout. I think having family involved is important, but only with the patient's consent. If the patient does not consent to have them involved, then I think this needs to be explicit, that the family is aware that a physician does not have consent to speak with them.
- Generally would not obtain history or information if patient requests so. But for MAID assessments I would consider it mandatory.
- Tout à fait légitime mais pas obligatoire.
- As the family will be affected by the decision there needs to be discussion between patient and family to explore relational factors, options etc/for love to be expressed as they are able/for beliefs and morals to be shared and expressed. This might require very skilled and empathic facilitation.
- Of course, if the patient does not consent to the involvement of family, that should be respected.
- Family should be involved unless the patient formally objects. Then the usual rules under consent and capacity will apply.
- It is hoped that the patient will not be alone in making such a critical decision.
- But only with knowledge of the patient.
- The family are about to lose someone to death earlier than anticipated. They need to feel as if they are heard, but should not be allowed to block a request though.
- I like the points included in the brackets for this question. My question is, what is being done now? One of the differences between suicide and MAID that I've read about, is that family usually support and are present at a planned MAID death, whereas a person dies by suicide alone and impulsively. So I hope that family are involved in the assessment!
- Collateral has always been a vital part of our information gathering diagnostic and treatment process.
- Humans are social creatures and our identity is partially shaped by our family interactions (positively or negatively). The choice to die with medical assistance is one of the most important decision a person can face and impacts society at a greater level—mostly at the level of the family. I would hope that, for the most part, the inclusion of the family could also serve a therapeutic value in helping family face issues surrounding death before the person actually dies. This could also help detect issues, like untreated mental illness, that a person may be hiding.
- Input should be sought unless the patient specifically objects; having a sense of family context could also enhance the counselling that could be provided to the patient.
- Autonomy is preserved if the patient refuses to provide this consent and this is honoured.
- I would require such contact before proceeding, even if the patient does object (analogous to an airline passenger having the right to refuse security clearance but then not being allowed to fly).
- Involving family, where possible, appears indicated. It has been shown to be associated with better patient outcomes. In this kind of situation it is very likely that in most situations involving the family will be associated with better outcomes for those left behind.
- It helps assess the seriousness of the demand and see if it was consistent throughout time.
- I do agree, and if there is a specific objection, that should be examined to see if it points to some overlooked issue which impacts on the decision. When I trained in consult-liaison psychiatry and when I worked in community outreach geropsychiatry, I was repeatedly humbled to find that the collateral history from a close family member often greatly deepened and sometimes changed my impression as to what was going on with the patient. In such an important assessment this would appear to be a wise move. It also might reduce the risk of family feeling excluded and later coming back with complaints against the physician if they disagree with the patient's choice.

- There are long-term consequences for the family of a person choosing MAID and while a blanket recommendation is not always possible, in principle they should be involved.

COMMENTS FROM NO RESPONDENTS:

- It would be ideal, but if a patient is capable, then the family's wishes really have no bearing.
- Not all assessments but collateral may be indicated in some cases.
- I think that families CAN be involved but ought NOT be involved unless a patient specifically REQUESTS it.
- If patient wants it, yes, but if not, no.
- This may be appropriate in certain situations and it may be helpful to have a family member attend part of the assessment, but I do not feel it is necessary in all situations.
- Not in all cases.
- I would put it instead that it be universally recommended to all patients requesting euthanasia that they allow the assessing physician to solicit input from loved ones of their choosing, and that patients be provided with the reasons why this is a recommended part of the assessment. It would seem odd to judge that a given patient is capable of choosing to end their own life, but that they must be "tricked" or "led" when deciding whether to allow their doctor to speak to their spouse.
- Again, this is something that is certainly desirable, but should not be required. It should be up to the patient and his/her assessor/provider to determine what is needed in order to provide that patient with good medical care and treatment, just as with any other important procedure.
- I do not support MAID under any conditions.
- While standard of practice should involve attempts to get the patient's consent for family member input, it should not be a requirement for competent adults.
- If the patient has the right to refuse this then it should not be a criterion, but instead a recommended part of any good quality assessment where we gather input with permission as part of patient and family-centred care. It is in the physician's interest to try and get this input regardless of criteria.
- As before, no medical profession participation is the optimum.
- Pas une obligation. Dans certains cas, un tel contact sera essentiel à l'évaluation de l'aptitude chez un patient qui n'est pas connu, dans quel cas le psychiatre devra expliquer au patient (et, au besoin, aux instances administratives) pourquoi ce contact est essentiel.

COMMENTS FROM UNSURE RESPONDENTS:

- As for any procedure, if there is doubt about the patient's competence to make the decision, the person with power of attorney or the closest kin needs to be approached.
- Probably? I have a difficult time when we set terms like "all MAID assessments" rather than saying that one should, as far as possible, contact a close family member.
- It would depend on every particular case.
- I would favour family involvement as they often know a lot about the psychosocial elements that may be impacting the patient's request and may also be completely unaware of the plan by the loved one. Although autonomy is a key principle, given the finality of this process and potential anger and legal repercussions I think family should be contacted.
- Again good practice expectation but not a requirement. Should chart why family not contacted.
- Not in all cases. In one of my MAID assessments the family attended. Ultimately if this remains an OHIP-funded assessment, who will pay for time spent contacting family?
- Obtaining information from others is always valuable. A patient has the right to limit the release of their information and to ask providers to limit the information released to the maximum extent. It is important to delineate asking for information about a person and their function or symptoms ("I've been asked to assess your brother's condition, can you tell me about...") from informing someone else about the nature of your assessment ("I am assessing your brother for medically assisted death...").

- Ensuring there is clarity in recommendations about obtaining relevant information from others is essential or this portion of a guideline could prove to be very obstructive or unduly limiting to a patient who wants their MAID assessment to be private; however are open to having others contacted to give relevant information about their disease and function.
- Usually. There may be special situations.
- Should differs from must.
- Should be encouraged and even likely be seen as standard of care, but I don't support making this required in regulation.
- Should not be mandatory, but recommended.
- Again, these are complex issues. Some patients may be disenfranchised from family in which case contact would be not needed or may be harmful.
- Individual consideration as situations vary.
- Suggest you ask the applicant if such contact is desired.
- Involving family should always be attempted, but only after consulting the patient.
- When close family members are supportive it makes the decision clear and easy. When there is disagreement, conflict and potential litigation may be a risk. The law about patient autonomy should be very clearly defined.



9. In addition to legislatively required assessments by physicians, or nurse practitioners, should a multidisciplinary “team” of health care workers be required to provide a formal assessment for all MAID applications?

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|----------------------|
| YES = 96 (31%)* |
| NO = 144 (46%) |
| UNSURE = 73 (23%) |
| NO ANSWER = 1 (0.5%) |

COMMENTS FROM YES RESPONDENTS:

- I think that this should be extensive to psychologists, social work, and other members of the team. We live, after all, in an era of clinical democracy, where hierarchies need to be flattened.
- There are many facets to MAID and all should be explored to the extent possible using the expertise of a multidisciplinary team approach when possible.
- It seems reasonable to me that the assessment opinions should be considered by a “team.” I do not think that it will be necessary for every member of the multidisciplinary team to have individually assessed the patient. The terms of reference for such a team obviously should be made clear. This is a mechanism that would spread the responsibility and also the liability.
- Mais il faudrait que ça se fasse rapidement.
- Including consent and capacity boards that psychiatrists who agree to be involved in assessments can ask for reviews from.
- I think this would be helpful in complicated presentations as allied health care professionals often have valuable observations and collateral (especially with respect to undue influence from others, for example).
- Because it's not just a “medical” issue.
- I feel that her social worker should likely be involved.
- I think a social worker should be involved, at the very least to ensure the patient has been able to access other necessary professionals to make suitable arrangements for death and burial (e.g., spiritual counsel, legal counsel, financial counsel, etc).

| ANNUAL CONFERENCE SURVEY* |
|---------------------------|
| YES = 15 (56%) |
| NO = 11 (41%) |
| MAYBE = 1 (4%) |

* Percentages may not add to 100 due to rounding

- Une équipe multidisciplinaire est nécessaire mais pas limitée à des travailleurs de la santé parce qu'il ne s'agit pas de santé uniquement. Des philosophes, éthiciens, sociologues, anthropologues, etc seraient les bienvenus pour une meilleure compréhension individuelle et systémique.
- Timeliness is also essential.
- Comme dans les autres modèles légaux cette approche est acceptable.
- As it is available. I can imagine remote situations where this might not be possible. All multidisciplinary work should be person-centred and occur with the patient's full knowledge and input.
- I think education should also be an important part of the assessment process and this could be done by other clinicians.
- Ideally there should be more than one person assessing the patient in order to arrive at consensus.
- At least one second opinion by a person with experience in this area should occur.

COMMENTS FROM NO RESPONDENTS:

- That would be unnecessary bureaucratization.
- Treating physician and psychiatrist/psychologist is enough.
- Do not turn MAID into another health care industry by-product.
- Impractical. Where would this team come from and who would fund them?
- Not sure what they would add to the process. What would they assess?
- Although I'm sure a multidisciplinary team would be helpful, I don't know that this needs to be mandated
- I am reminded of the days when women had to go before a panel of physicians and "prove" she needed an abortion, or the days when a woman needed her husband's consent to have a tubal ligation. If a patient is so ill that they are asking us to help them end their life, then we should make the process as minimally intrusive and invasive as is consistent with good care. And frankly, the understanding of capacity assessments in our institution by non-psychiatrists is in many cases completely wrong, substandard, and inconsistent with current legislation. I'd rather do it myself and know it was done fully, rather than have someone who is not trained in assessing capacity making a mess of things (as happens—I recall one patient staying in hospital for over a year after being declared incapable because the person in charge of arranging placement said the patient had to "agree" to the placement, which of course the patient wouldn't do, as she functions at the level of a five-year-old and wanted to go home).
- It is restricted as it is, going for a multidisciplinary team could make it unnecessarily complicated.
- I think this would be of benefit, but would limit access to some patients. This is an ideal, not a baseline requirement.
- Would make the process too cumbersome and add little or nothing.
- Not required, but highly desirable.
- Multidisciplinary involvement is likely beneficial, but should not be required.
- I believe making this mandatory is not required in all cases. In some cases, a multidisciplinary team involvement would provide the best assessment and care.
- Une évaluation multidisciplinaire serait préférable mais non nécessaire.
- For God's sake, there is a time element here. Pain and suffering will only be prolonged if we add a bureaucracy.
- I don't think that practice should be so closely legislated. There are plenty of situations in which such a team would not be required. Good clinical practice guidelines and the general laws of providing the best care possible should apply.
- If practical, yes, if not, then no.
- Sometimes an OT assessment might help—not always—it should depend on patient needs just as with treatment of other illnesses.
- A big problem when we have tried it.
- Would only render the process overly complicated, to no advantage for the patient.
- Not in all cases. I feel that there are cases where it is relatively straightforward, and that making it more complicated for all is a waste of resources and time.
- Not in every case, but only in complex cases where the course of action or path is not clear one way or the other.
- I do not support MAID under any conditions.

- Too cumbersome.
- No, as before.
- This would be ideal in principle, but given health care resource limitations, I would not see it as feasible.

COMMENTS FROM UNSURE RESPONDENTS:

- Je crois que cela peut s'appliquer dans certains cas selon la personne, son entourage ou non, son isolement. Cela permettra une évaluation plus complète de la situation.
- Ça semble complexe et lourd.
- Might be nice, similar principle to capacity assessments, but might not be practical.
- There is the risk of a dominant group member influencing the whole group for termination of life.
- Where I practice in NW Ontario, it may not be possible.
- A decision by committee to kill is just as bad as that decision being made by one physician.
- Ideally yes, but the resources required for this would be inordinate, and it is hard to justify such cost when we are struggling to provide adequate and timely care in other domains, including palliative care and pain management.
- Ideally, yes, there should be a multidisciplinary team involved. Practically, I do not know if we have resources in place for smaller centres, or community hospices, etc. Having access to a consultation team for complex cases would be valuable.
- I suppose that depends on 1) who is on the "team" and 2) what role would they play, if they are not adjudicating the request. Certainly it would likely be helpful to the patient and family members to have support from a multidisciplinary team.
- This is usually done, but I am cautious about how structured this should be.
- Experience and practice of a team may make the process easier for the patient and physician/NP. Patients suffer when we struggle to find out how to do something in terms of delays and potential lack of confidence in their carers.
- Who would be on the team? How would that enhance assessments or decisions about allowing MAID? Won't that take even more resources which should go to people on wait lists for treatments to restore quality of life/health/functioning?
- They should not be doing MAID as it is murder plain and simple.
- I like the idea given that MAID is unlikely to be a common procedure for the vast majority of practitioners. A dedicated team can develop expertise that individuals can't.
- For what purpose exactly? And to bring what set of skills that would be of what value exactly in assessing a person's wish to end their life? Worded as is, it just sounds like some attempt at diffusing responsibility by drowning it between many expert professionals whose role in the issues at stake is not clarified.
- Palliative consultation should be required, unless refused by the patient.
- This is a highly disturbing potential clinical practice for which increased numbers of assessors and education cannot remove its innate questionable ethics.
- Depends on what the team can bring to the assessment process

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10. Should capacity assessments be guided by generally accepted principles for assessing capacity contextually applied to MAID with flexibility for assessors to choose from a variety of appropriate assessment tools or formats (as opposed to a prescribed tool)?

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| YES = 232 (74%) |
| NO = 25 (8%) |
| UNSURE = 56 (18%) |

| ANNUAL CONFERENCE SURVEY* |
|---------------------------|
| YES = 22 (85%) |
| NO = 3 (12%) |
| MAYBE = 1 (4%) |

COMMENTS FROM YES RESPONDENTS:

- One size rarely fits all.
- Okay.
- This question is so convoluted it is difficult to follow.
- You need to be able to choose from validated assessment tools combined with your own clinical assessment, but some guidance and training in these would be really helpful.
- Guided by good practice is better and more flexible. Avoids a tick box.
- I can't imagine any perfectly formulated "prescribed tool." A variety of appropriate assessment tools would improve the confidence in any such tool with time.
- We are currently working on a guide in Alberta. It will not be required, but is designed to be of assistance to the assessor for capacity, with questions about mental health and vulnerability.
- À ma connaissance, il n'y a pas d'instruments validés spécifiquement pour la capacité de l'AMAM. Je dirais que le MacArthur Capacity Assessment est probablement le meilleur outil à cet effet.
- This statement reflects several of my comments that in many situations MAID is part of normal clinical practice and should not be set apart from the usual practice of medicine.
- Should be guided by generally accepted principles.
- Prescribed "tools" have limited efficacy and accuracy.
- But, nothing is better than a good face-to-face exam. Filling out forms can become rote.
- Tools themselves are usually inadequate. The history and patient assessment are most helpful, but tools may be helpful for specific symptoms like depression or severity of cognitive impairment.
- Again flexibility is key.
- Absolutement.
- I am very nervous about "prescribed tools."
- Assessors should have familiarity with a broad range of evidence-based assessment tools among which they can choose.
- A patient could have the capacity to make the decision regarding MAID, but not have the capacity in other areas.
- Mandating a specific tool would undermine the highest level of judgement, namely that of the most well-trained most responsible health provider, the physician. Tools are just one of many technical factors and enablers that are transcended by expert judgement of the physician (reference Dreyfus model of expertise whereby experts are able to transcend and know when to go beyond simple technical tools). Mandating a tool would only lead to uninformed challenges and power disputes by technicians and bureaucrats who don't understand when the context and judgement goes beyond the limitations or even is different than suggested by a simple tool.
- Sounds reasonable, as long as the guidelines are clear.
- As long as the tools/instruments have been validated, are reliable, etc i.e., I do support that there should be a toolkit of options not one specific prescribed tool but yes a range of "prescribed" tools to choose from not just some random ones choose by whim. The decision must be informed by the best science of the day allowing for future advances.
- This is a diagnostic dilemma at times and a variety of tools and resources should be used. However guidelines would be helpful from those with the expertise in this area.

* Percentages may not add to 100 due to rounding

COMMENTS FROM NO RESPONDENTS:

- Should be standardized across the country.
- In my experience, capacity assessments are currently done very poorly, i.e., there is a wide range of opinions and beliefs by practitioners that are evident in these assessments if they are done at all, e.g., cognitively-disabled patients with dementia are treated on medical and surgical services with no capacity assessments or very slipshod ones. MAID is a nationally accepted procedure covered by federal legislation. It needs to have national standards and that should include only approved assessment tools for assessment of capacity. If capacity assessments are not done in great detail and recorded properly physicians and others involved in MAID will be open to being sued. Just look at the way in which wills are contested because of presumed lack of capacity.
- Le seuil pour l'aptitude devrait être plus élevé étant donné les conséquences sérieuses découlant d'une décision reliée à l'AMAM.
- Accepted principles, acceptable by whom? Very subjective.
- Un instrument prescrit et soumis à des réévaluations en fonctions des cas étudiés (style théorisation ancrée) m'apparait nécessaire pour une évaluation équitable pour tous.
- Consistency is important. Not all physicians are capable of assessing capacity, nor of grasping the concepts of capacity. Either there should be physicians with a specialty in such assessments, or there should be a standard tool which assessors get trained to use.
- Seems inordinately complex.
- We need some minimal standard.
- I do not support MAID under any conditions.
- Capacity to refuse treatment is appropriate, but capacity to have a doctor kill you is just bizarre.

COMMENTS FROM UNSURE RESPONDENTS:

- À mon sens, il n'existe pas d'instruments adaptés à l'AMAM car le risque demeure la mort et le bénéfice recherché est le même, soit la mort.
- A capacity tool specific to this purpose needs to be developed.
- I actually think it should be customized to be specific to MAID as the law specifies differences with the usual health care and consent laws, i.e., current law indicates that consent given at time A is not affected by subsequent incapability. However, the MAID guidelines indicate that if capacity is lost during the time frame between consent and implementation then MAID cannot occur.
- Since this is a new situation and circumstance I am unclear what the "generally accepted principles for assessing capacity" are, as applied to this situation. Nor am I sure what the unspecified "prescribed tool" would be. If this is merely a checklist to ensure completeness of the assessment that may be satisfactory, if it is somebody's specific tool for the assessment, then one needs to be assured of suitable psychometric properties prior to its introduction.
- I probably agree, there is no specific tool developed for this purpose, but neither should "any tool" or an idiosyncratic tool be acceptable. The McArthur CAT tool is probably the best format and should be encouraged.
- I again have no idea what you are talking about.
- I think there should be guidelines as to the necessary components of an assessment, with flexibility as to how the assessment is carried out and/or which specific tools are used. I suspect tools will be developed and altered as experience with MAID progresses.
- I would need more information about the "tools," I am not fully informed on this topic.
- I am unfamiliar with the tools recommended for MAID as I am not providing direct capacity assessments for this. I do think there should be several options, or bedside tests.
- A specific tool should be developed for exceptional circumstances.
- I don't know enough about the tools available. I've been comfortable doing capacity assessments without a prescribed tool. However, I don't know if it would be best to have the assessments be as structured as possible.

- What is more important here to me is to clarify and to make explicit to society at large what is it exactly that the assessor assesses and with what set of skills. It may be that as this is attempted, we will realize that what we can in fact assess as physicians or psychiatrists is in fact quite limited, compared with the unspoken assumption out there that we can confidently and scientifically determine who should be allowed to end their life, and that the use of a prescribed “instrument,” while initially sounding reductionistic, will end up the more honest approach.
- Not sure what this question is trying to ask.
- The question is too convoluted. I am not sure I understand what is being asked.



11. Do you support allowing mature minors to qualify for MAID?

| |
|-------------------|
| YES = 100 (32%) |
| NO = 145 (46%) |
| UNSURE = 68 (22%) |

COMMENTS FROM YES RESPONDENTS:

- If they are judged to be decisionally competent.
- Provided they meet all the other criteria.
- Kids with chronic/terminal illnesses often have a degree of understanding and maturity well beyond their years, I see no reason why they should not be allowed to make this choice within appropriate guidelines.
- Exception à la règle.
- Only for illnesses that are clearly terminal, with severe suffering. Should be used exceptionally.
- Should hinge on capacity to consent, not age alone, as with other medical decisions.
- Their maturity would have to be part of the assessment just like the mental capacity has to be assessed in any adult.
- I expect that the numbers would be very small, and would be very carefully assessed. This would clearly be in the context of respectful end-of-life care.
- I am a child and adolescent psychiatrist. Why should we condemn only minors to suffering?
- Yes, if MAID is considered a normal part of health care, then the general rules should apply.
- Needs more study and individual consideration.
- Mais ça porte à controverse et c’est beaucoup plus difficile.
- If it’s an irreversible fatal condition.
- In hopeless situations where the parents are capable and securely attached and able to help the child. Always what is in the best interest of the child should be central to the decision making.
- Avant 16 ans, l’avis des parents et leurs appui devraient être requis.
- Truly mature minors have for a long time been allowed to make decisions regarding termination of care, I feel they should be allowed the same rights for MAID.
- Why deny someone who has capacity the ability to make a decision? Age is no guide to capacity. Mature minors who are able to make the decision will have capacity, those who are too young will not.
- For physical illnesses only. It would be very difficult to attest that a mental illness in a minor has truly been demonstrated to be irremediable.
- We all know that minors can suffer from painful and fatal illnesses.

| ANNUAL CONFERENCE SURVEY |
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| YES = 5 (19%) |
| NO = 20 (74%) |
| MAYBE = 2 (7%) |

COMMENTS FROM NO RESPONDENTS:

- I am against MAID under all circumstances.
- Parents should be involved in the decision.

- If that were allowed, all sorts of new definitions of “mature minor” and assessments to determine maturity would have to be developed. “Mature minor” is more of a concept than a clear entity and so far is interpreted differently in different jurisdictions. It is by no means a solid legal term.
- When you get down to it they are not that mature, ebullient precociousness is often pseudo competence of the overwhelmed.
- I presume this question is relevant where the guardian of such a minor would be in disagreement with the “mature minor” over MAID. I have difficulty defining a “mature minor”—these so often appear to be children and immature youth when placed in contrast to mature adults, in my experience.
- Do not know how you determine that a minor is mature?
- The ethical difference between this and condoning suicide in minors is what?
- Absolutely not. How will we ever agree upon what defines a “mature minor?” As a child and adolescent psychiatrist, one way of identifying a minor as mature is when they can put their present experience into the broader context of their life overall, and take “the long view,” perceiving the future and hold a vision for themselves in it. The majority of minors do not have the capacity to see much beyond their present experience. Without the ability for full perspective taking, the suffering experienced in the present is not evaluated adequately, and often times results in suicidal fantasies or actual attempts as a means to alleviate what is most often temporary suffering.
- Because I would need a better definition “mature minors.” Regardless, these so-called mature minors are very rare breed.
- Not yet able to understand a lot of abstract issues. If, however, there was a substitute decision-maker or family support than yes, assent ok.
- Seuls les majeurs peuvent se qualifier pour l’ANAM, restent le consentement parental ou bien aux juges d’émanciper le mineur. Il est question ici d’une loi pour des situations d’exception dont les conséquences peuvent être irrémédiables et qui change l’essence même de notre humanité.
- We are talking about intolerable suffering and irremediable conditions with no end in sight. That is hard to imagine in most illnesses with minors. I think that the case would have to be made on a case-by-case basis. In psychiatry, I find it hard to imagine that we could ever make the case. Brain plasticity indicates that the brain is never fully mature, and certainly not before the age of 25 or 30. There is considerable suffering in many disorders but the disorders are remediable.
- Only as an extreme last resort.
- What is a mature minor? Sounds like another left-wing loopy concept.
- This is an irrevocable step, frontal lobes only develop in late teens, early 20s.
- Except in cases of irremediable pain associated with terminal illness.
- Not sure what a mature minor is!
- I do not support MAID under any conditions.
- Mature minors is a difficult concept to apply even in regular psychiatric practice as maturity to make decision vary, and in practice this will next to impossible to implement, and might pit those minors against parents/guardians. E.g., transgender interventions are a case in point, where irreversible interventions are usually reserved until they are of legal age.
- It will become too difficult to define and draw the line on the concept “mature.”
- Beyond bizarre.
- Again a dubious classification. This could be tragic, again the much feared slippery slope.

COMMENTS FROM UNSURE RESPONDENTS:

- Qu’est ce qu’un mineur mûr? Il faudrait définir cette personne avant de procéder.
- In principle, I do support this however I wonder about the value of life experience in assisting the quality of this decision-making process.
- There is no reliable/validated “test” for the maturity of minors.
- It is premature in a process that is as new as it is in Canada.
- I am not sure how you define mature.

- Nécessiterait l'appui de la famille (parents/tuteurs) dans cette situation.
- My gut feeling is no, but to give a yes/no answer, I would have to study this in depth.
- After a capacity assessment.
- I feel these cases need to involve a specialized judge, and medical experts. I would defer to my paediatric colleagues for their expertise in how they might manage this.
- I don't feel I have the knowledge to comment on this question. I'd hope that the government would ensure mature minors have full access to palliative care before considering whether they should be able to request MAID.
- Oui si un tuteur est au dossier.
- With the same reservations I have about it for adults, it is difficult to justify allowing it for adults but not for minors.
- The idea of assisting a mature minor in ending their life is unnerving; at the same time if a mature minor could be allowed to refuse life-saving treatment then it seems difficult to ethically justify not allowing MAID. If the parents strongly object then performing an action that ends a child's life rather than withholding an action that might save it might be experienced as more upsetting and therefore the potential psychological harm to the family may be higher, which might justify disallowing MAID for children if parents refuse to assent.
- If they clearly meet the other criteria and a parent or guardian is involved?
- Probably yes, again in those circumscribed cases of irremediable suffering in the context of anticipated inevitable death, and with family participation (so that a person with hopefully a fully formed frontal lobe is involved in the decision, but the minor has an ability to say yes or no if he/she appears to meet the criteria for capacity).
- Pas pour le moment. C'est peut être injuste envers eux.



12. Do you support advanced directives for MAID in anticipation of capacity being lost and with clear criteria for activation of the MAID request?*

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|-------------------|
| YES = 203 (65%) |
| NO = 70 (22%) |
| UNSURE = 40 (13%) |

COMMENTS FROM YES RESPONDENTS:

- Substitute decision-maker would have to agree with the directives as they represent the patient's wish.
- When I develop dementia—and for most of us, that is when, not if—I would like my advanced directives to be followed. They would be my decision made in anticipation, but with a clear mind.
- This is of critical importance for patients with a dementing illness. Without these provisions patients may chose to end their life sooner than they need to.
- This is particularly important for patients with early cognitive decline.
- It's what I would want for myself, so I definitely support this.
- Avec précautions d'avoir plus d'un avis.
- Absolutely.
- I might want this for myself, if I am diagnosed with a dementing illness, for example.
- Dementia offers the best example, it is common and predictable. Personally I would consider asking for MAID for dementia at the point that I no longer recognized my family members.
- Although I fundamentally disagree with MAID, it only makes sense to me that MAID would be supported by advanced wishes of patients. I believe that the majority of the Canadian public is under the impression, albeit false, that the present

| ANNUAL CONFERENCE SURVEY |
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| YES = 17 (65%) |
| NO = 8 (31%) |
| MAYBE = 1 (4%) |

* This question was rendered as "Do you support advanced directives for MAID" in the conference survey

legislation allows for MAID to be administered as an advanced directive. When Canadians' opinions were polled, this is the concept of MAID that the majority of our fellow citizens probably held in mind.

- Alzheimer is a perfect example of why this should be allowed.
- Definitely! Current situation is problematic for CNS disease and other situations.
- When meeting strict criteria re notarized signature, prognosis etc.
- But only if it includes a provision for ongoing reassessment for the advance directive.
- Yes, with limitations, and careful discussions about how perception of quality of life might change as capacity does.
- These should follow the same rules as any other advance directive under consent and capacity legislation.
- In line with a living will.
- I see many who lose the capacity to consent or request MAID even though they had clearly expressed this prior to the loss of capacity. The ability to make advance directives when competent should be extended to MAID.
- Otherwise those with, e.g., ALS or dementia may feel forced to die before they "need" to in order to avoid being denied the privilege later on when they reach a point at which they need MAID but no longer have capacity.
- As long as they are not allowed to override other safeguards which would apply.
- With the same reservations I have for capable adults requesting it. One issue that I would anticipate, given the wild and highly prevalent misconceptions about resuscitation and technological care at the end of life, would be the ability of people in our culture to correctly identify "clear criteria for activation."
- Absolutely. The nature of a slow decline condition that effects cognition such as dementia should not exclude one from the spirit of MAID as it currently does, provided that advance directives have some safeguards and clarity which are achievable.
- This is critical for individuals who lose competency through various serious cognitive disorders and yet have an opportunity to make this choice as an advanced care directive should they be suffering from these conditions in the future.
- I think this is reasonable in the case of an anticipated degenerative/progressive illness in which loss of capacity will quite possibly occur before the point of irremediable suffering. Consider specific criteria, as noted, but also the need for a substitute decision-maker in that situation to agree to authorize the assisted death, as per the person's prior capable wishes, after the person becomes incapable. That way someone is giving consent at the time, as with other non-emergency procedures, and using similar substitute consent rules.

COMMENTS FROM NO RESPONDENTS:

- How can anyone know in advance how they will feel under certain circumstances?
- There are better ways to deal with this.
- It should always be a competent decision in the present.
- La capacité fluctue dans le temps. Il est difficile de prévoir quel sera notre choix par rapport à l'AMAM lorsque nous devenons incapable.
- I do not support anything that makes a physician deliberately complicit in hastening a patient's death.
- Because the person's values and perspective may change between when they sign the advance directives and when the MAID request would be activated. Again, PEOPLE NEED ACCESS TO GOOD PALLIATIVE CARE!!!! They wouldn't need advance directives for palliative care if they were confident they would not be in pain and would be cared for.
- The person must be capable at the time of MAID request.
- I do not support MAID under any conditions.
- If a person provided an advanced directive for MAID but at the time of activation they do not want to die, the experience of MAID could be traumatizing for both the patient and the provider regardless of capacity or consent provided. It may also be traumatizing for the provider to perform this action if the patient does not object but does not understand what is happening to them.
- Absolutely not.
- Dans la pratique, ce n'est jamais si clair que ça. C'est comme les directives anticipées. Le patient refuse l'intubation en théorie, puis il apprend que c'est pour quelques jours pour une condition réversible et alors il accepte.

COMMENTS FROM UNSURE RESPONDENTS:

- Tricky situation—“maybe” is my answer.
- Seems people can live with situations they imagine they could not. How would it be determined that capacity is lost permanently?
- In theory this seems reasonable and something to be honest that I would like to have available for my own care in future. However it also opens a much greater risk of abuse and error in the application of MAID. I have recently been involved in a case where daughter was trying to move toward strict comfort care only, including stopping insulin in keeping with her father’s previously clearly expressed wishes (he had previous history of depression, had been vehemently against long-term care, etc) but the patient himself, now dementing and facing long-term care, was indicating that he was now quite accepting of his quality of life and had no wish to hasten death.
- Depends on circumstances. Let’s get the basics correct first.
- I think this will be challenging. If the directive is specific to a particular kind of illness such as Alzheimer dementia in someone knowing that this is a high-probability outcome, it would seem to be a stronger argument. On the other hand, some generic advanced directive seems to me very challenging for everyone to know “when to pull the trigger.” I think it might be an invitation for all kinds of moral distress.
- I would support it for myself: not sure I want to extend it beyond that! Afraid of abuses.
- I’m opposed to MAID on principle, but if it became a legal option then anticipatory requests would make sense.
- Would need examples to make a judgement.
- Je n’ai pas lu les directives préalables.
- I would struggle with this as a routine procedure, I would support it being limited to very specific conditions (e.g., ALS, dementias, neurodegenerative disorders). I think resuscitation codes/levels of care may be more relevant.
- In limited circumstances. People are allowed to change their mind and unless their wish was MAID was confirmed fairly close to loss of capacity, how could one be sure they still wished that for themselves? (Patients can find surprising strength in the midst of difficulties that if they had been asked in advance of developing said difficulties, they might have thought it would be unbearable/life not worth living if...).
- It is so very difficult to anticipate the future. I have mixed feelings about this.
- There is a vital importance for advanced directives to be followed even in the case of dementia. However there needs to be a well-established protocol for the establishment of how these directives are obtained. This is where physicians should have a role as well as other health-care providers to ensure there is no coercion or abuse occurring. There is a need for clarity around end of life management, what constitutes heroic measures to keep people alive and a rational approach to the distribution of health care resources. This is very complex and my concern is that MAID has been introducing rather than engaging in a fulsome dialogue.



13. Do you support a tracking process for MAID applications so that, in the event of multiple and diverging opinions as to the nature of the illness or decisional capacity, all opinions are considered?

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|------------------|
| YES = 266 (85%) |
| NO = 21 (7%) |
| UNSURE = 26 (8%) |

COMMENTS FROM YES RESPONDENTS:

- With caveat that the person’s wishes carry most weight.
- In something irreversible, all the available information should be considered. You’d want all the path reports before amputating someone’s leg, so of course all of the opinions should be available.
- This will increase provider confidence in our assessments for requesting patients and may mitigate legal risk.

| ANNUAL CONFERENCE SURVEY |
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| YES = 29 (100%) |
| NO = 0 (0%) |

- Every application should be scrutinized and its like research—it should all be transparent, not just the recommendation you like.
- Protection against potential abuses of power is important.
- Absolutely.
- Restera la question des experts et des critères d’expertise qui posent, comme on le sait, bien des problèmes.
- Ça. À de soi.
- Yes, yes, yes.
- It will be important to perform quality measures to ensure that all jurisdictions are providing the same level of access and that decisions are consistent. This will protect everyone (physicians, care providers, families and patients).
- Who does the tracking and how are opinions weighted if differing from that of the patient?
- However, I am concerned about how cumbersome this might become. Someone has to be in a position to make the call.
- Evidence, data and transparency and reporting helps ensure good oversight and good science.

COMMENTS FROM NO RESPONDENTS:

- Seems to be too unwieldy/bureaucratic and may permit less than legitimate stakeholders to have input—herbalists and naturopaths claiming that the disease is in fact treatable with their particular potions.
- This is too cumbersome to be practical. Currently legislation does not call for this type of process. What we do need is an annual federal report on MAID in Canada (model—state of Oregon).
- Abstention dans ces cas et revision plus tard 2 à 6 mois.
- I believe this would change the nature of capacity (which can fluctuate and is contextual) and the way we address this in health care overall. This kind of oversight or tracking should not be MAID specific if the group recommends it is utilized. There are broad reaching implications in creating this kind of system.
- Only an advanced directive or a direct request by patient should be considered.
- I don’t support MAID, let alone a tracking process. Your questions remind me of the question that required only a yes or no answer: “HAVE YOU STOPPED BEATING YOUR WIFE?”
- No, the normal medical decision-making rules need to apply.
- Too complicating again.
- I do not support MAID under any conditions.
- Going from worse to worse.

COMMENTS FROM UNSURE RESPONDENTS:

- Not sure what the question means.
- It is complicating the process even further.
- How would this affect patient autonomy?
- I don’t know.
- Probably, but I’m not sure.
- This might be too complex.
- My concern is that physicians would become targets for family/advocate discontent. I do think accountability of the process is important as well. If multiple opinions, then I could see it triggering a larger review panel process.
- This sounds good and useful in theory, but I have grave concerns about how it would work in practice.
- Not quite sure what you mean by this?
- Je ne suis pas trop certaine ce que la question veut dire. Si les opinions sont divergentes, je pense que l’AMAM ne devrait pas avoir lieu jusqu’a ce que la situation soit clarifiée.



14. Please provide further comments you feel are relevant.

- My answers reflect my view that physicians should have no role in assisting dying.
- Question très nouvelle et qui nécessite beaucoup d'expérience humaine et professionnelle, du jugement clinique et un grand respect...doit être traitée avec grande finesse et délicatesse.
- I think that MAID is essentially a good thing to have available—the difficult part is to figure out how to prevent it from being abused. I am particularly concerned about the “wealth transfer” that is taking place in Canada with our elderly demographic—the baby boomers, or their offspring might get greedy and not want to see what they perceive as their rightful inheritance being used up by the costs of nursing care.
- Je trouve très dangereux que l'AMAM puisse être considérée pour les mineurs, les patients avec démence et simplement pour souffrance psychologique; les patients psychiatriques sont vulnérables, et plus sujets à coercition par des proches/ autres mal intentionnés à leur suggérer l'AMAM. L'AMAM n'est pas le traitement de pathologies psychiatriques difficiles à traiter.
- None that I can think of now.
- I hope the CPA will take a position against MAID or at least communicate the serious potential risks of any process that enables MAID. These risks include clinical errors (in assessment and implementation), “slippery slope,” changing the role of physicians and serious “boundary violation” issues, etc. One of the risks rarely (if ever) addressed is the potential increase in ALL suicides as a result of a culturally permissive attitude toward suicide as a method for relief of suffering.
- There needs to be a much better tracking system for MAID in Canada. Currently each province is doing its own thing. Knowledge is critical to make this process a better one.
- This is a very difficult area. If it is put in place, it should perhaps be done on a trial basis in a limited geographic area.
- It is clear that the Carter decision does include psychiatric patients as per the EF decision from the court of appeal in Alberta. To deny psychiatric patients access to MAID is an infringement on their Charter rights and increases stigma.
- I was dismayed by the exclusion of advanced directives and psychiatric patients from the legislation. I would like the CPA to develop guidelines and principles for MAID in psychiatric patients and patients with progressive dementias. It is usually older, well-educated professionals who choose MAID—most likely ourselves!
- The expense of this system will be considerable. Is it a good use of funds? Making this a medical procedure means it will likely be funded from that budget.
- God is the author of life and death. Remember the Hippocratic oath words “I will give no deadly poison though it be asked of me.”
- In general I do not support MAID for patients with the primary condition being mental illness (i.e., chronic depression). The wish for death colludes with the underlying illness itself. Potential for abuse including family members advocating for death can be a complex issue as well which would be very hard to disentangle.
- Il n'y a pas de place pour les états d'âme du docteur c'est le bien être du patient qui doit primer en tout temps.
- I have been very distressed by the number of cases of MAID being requested, and in a majority of these cases ultimately provided, in my elderly patients for what seems no other reason than “existential suffering” and the various insults of aging. Examples include: not wanting to go to long-term care so preferring death; having chronic pain that was demonstrably well controlled with medication and minimal side effects but patient just didn't want to have to take medications anymore and so was suffering pain—she was given MAID; a man with two violent suicide attempts but no evidence of depression who then wanted MAID and precipitant was clearly shaming and abusive behaviour as well as refusal to allow appropriate supports for his medical problems into the home by his wife. I was in principle supportive of MAID but have become extremely leery of being involved given these experiences.
- I am profoundly concerned that there will not be enough safeguards to protect the vulnerable, pressured to request it or worse, with the push to expand to substitute decision-makers and advance directives a lot of people will have their right to live their natural lives overshadowed by a few who have to live longer than they wish in agony. We abolished the death penalty in part because of the imperfections of the legal system no falsely convicted innocent person should have to die so why are we now seeing that again on the horizon.
- I have done two assessments over OTN. The Ontario fee code for psychiatrists has not paid me adequately. Time with patient is limited but I spend time speaking to primary physician, possibly family-based on this and reviewing/preparing documentation is time consuming.

- The ethical analysis of this question to date has been very narrow. It is crucial that the CPA take a clear stance against mental disorders being primary qualifying conditions and keep MAID to terminal illnesses alone.
- This survey has all questions “required” and I was not able to skip or refuse to answer a question. This is very irritating and will reduce the response rate, especially from those who have well formed opinions however cannot fit them into your questions or someone who does not want to answer one specific questions for a number of reasons. For a feedback process, this is disappointing and forces opinions into limited boxes.
- What about an accelerated application process for non-questionable terminal illness. For example metastasized brain cancer in young male patient now non-ambulatory and declining rapidly. This is an example of an actual patient that passed in the middle of applying where the application was delayed due to physician scheduling issues and whose wife I saw since diagnosis.
- Still uncertain about MAID.
- There should be a free choice if one wishes to opt out of MAID requests as per personal preference and values, and there should be no obligation or requirement to find an alternate physician as that goes against the original preference or value.
- Thank you for the opportunity to contribute.
- This is an important topic and needs to be approached with the treating physician, family and community involvement being in alignment.
- Complètement contre.
- I went into medicine to cure occasionally, to relieve discomfort, to comfort always, but not to kill, even those who were going through a phase of wanting to end it all.
- Thank you for the stimulating and important questions.
- I have worked with some of the most refractory depressed patients in our region quite by coincidence by being involved with surgical treatments for depression. I have never been able to predict which patients would improve and stay well with the interventions we provide (whether biological or environmental). I don't think psychiatry is currently in the position to prognosticate irremediability. When we understand and become more competent and treating the clinical conditions we help our patients face, hopefully we will become more expert at prognosticating. Until then medically assisted death for psychiatric patients is unethical (in my opinion).
- As a member of the British Columbia Psychiatric Association executive, we are also working on recommendations to help guide our colleagues in this complex area. We would be happy to continue and liaise with the national CPA.
- It's not a medical issue, it's a social and moral issue—why are doctors involved? Of the fifteen people who attended the Wannsee conference that decided on the extermination of European Jews as a Final Solution, eight held academic doctorates. Intelligence is no guarantee for good moral decision-making.
- This is a thorny problem and for those practitioners interested in being involved, I would recommend training accompanied by a certificate of competence to be renewed every two years.
- Some of these questions are very black and white and I hope do not reflect hidden agendas of those actively involved from the CPA. Some of the issues may come down to clear policy, while others should be guiding principles (e.g., contacting family would be desirable or even necessary in some situations and not others).
- We will mature over time as a society using this legislation. We should not be afraid to allow it to run its course and revise as needed.
- I am currently involved in MAID and find it challenging but very rewarding. Inclusion of patients with mental illness as the primary reason for MAID is controversial and would have to be extremely clear and well thought out before I would support it.
- Thanks for asking and your careful consideration. I have done several MAID assessments and am impressed by their diversity but also some similarities.
- Although (after 58 years in practice of psychiatry), I am generally not in favour of assisting medical death for individuals with psychiatric illness, I did have one patient with a schizophrenic illness, with painful hallucinations commanding him to kill himself, who, even after additional consultation with an esteemed colleague, killed himself.
- Je crois que l'offre d'une aide médicale à mourir pour des cas ayant uniquement une maladie mentale enverrait un message paradoxal et contradictoire quant au rôle du psychiatre et notamment quant à notre travail pour diminuer le suicide. Je suis tout à fait opposée à l'extension de l'aide médicale à mourir à des patients ayant uniquement une maladie

mentale, considérant de plus que la psychiatrie est encore une discipline complexe avec des pronostics très variés pour des mêmes diagnostics.

- As a psychiatrist at a community general hospital, I've been asked to represent "mental health" in MAID previewing and debriefing of cases. Our hospital has had five cases so far and I've attended three meetings in the last month. So far, my mental health expertise had not been required and staff involved in the provision of MAID have not required my services.
- Looking forward to further guidance.
- I feel that one should be able to use some means of assuring that in the event of dementia one's desire to end life should be allowed. In essence some form of "living will" type of direction.
- We have a duty to protect those who for reasons of mental illness cannot protect themselves. Given that suicidal ideation is a common symptom of a variety of mental disorders, the possibility of "rational suicide" in a person with a mental disorder would be an extremely rare occurrence if it happens at all. Having broad legislation to open the door for assisted suicide in the case of mental illness would bring about much more harm than good for our patients and for society in general. These patients need our compassion and efforts to help them live, not help them die.
- Data collection and annual external review of completed MAIDs should be part of the program.
- Je crains que l'on demande encore aux psychiatres de jouer un rôle sociétal pour lequel ils n'ont pas été formé (plan humain, juridico-légal, sociologique et ultimement philosophique—la raison d'être).
- In the community, I see physicians spending a great deal of their time counselling patients/families regarding MAID. It can be emotional and time-consuming. I would like to see more support for physicians/health care staff in addition to patients/families. I would support patients administering MAID, not physicians directly, to limit escalating rates of MAID. I would see MAID for severe mental illness as a rare exception, akin to "case law," that would need to be dealt with each case individually and not allow MAID for severe mental illness otherwise.
- I believe MAID should only be allowed when death is imminent in order to alleviate suffering associated with final moments of life.
- La loi fédérale est un peu trop large. La loi du Québec me semble plus susceptible d'éviter la pente glissante.
- This is a highly contentious and divisive issue and cannot be forced. I agree with the limited approach taken by the present legislation. In my view it should be very restrictive. Maybe after a couple of decades experience with this we would be able to take a balanced view towards further fine tuning or loosening of the criteria but not now.
- A MAID decision must always be in the service of the patient and his/her pressing need.
- Considering MAID is a mark of a civilized and compassionate country that is prepared to take on the responsibility of tackling challenging ethical decisions rather than relying on dogma to avoid the intellectual and emotional challenges involved. It will require clear guidelines with regard to eligibility and the assessment process if we are to do it in a safe and consistent way that protects both the patient and those involved in the decision.
- If we are able to mobilize resources so quickly to "solve" the problems posed by MAID/ensure rapid access to MAID, think what we could do if we applied such energy and resources to the original cause of the suffering instead? How about rapid access to pain treatment (as appropriate), depression, etc.
- Je crois que l'aide médicale à mourir est nécessaire.
- I must again lobby for the CPA to advocate strongly for palliative care (including palliative psychiatric care) for all Canadians. I think the CPA also needs to be more blunt that MAID is suicide. Planned, socially acceptable, an understandable choice, but suicide just the same.
- MAID is an immoral and illegal law and is against the natural law. The mentally ill will be victimized by this law as well as vulnerable others. The CPA should be defending our patients from the onslaught of their dignity and freedoms instead of trying to cooperate to apply this law. This is the time for the CPA to be courageous and take a stand for us psychiatrists who spend our life preventing self-destruction by "just saying no."
- I do not support MAID. Some of the questions I answered with "no" when it could mean "not applicable." However, I believe in relieving pain and suffering even if pain medication results in death. I do not support keeping patients alive by "artificial" means such as ventilators, feeding tubes, intravenous therapy when patients are suffering physically and or mentally. Thank you.
- Psychiatrists can play a valuable role but our time is limited and our involvement shouldn't become an unnecessary barrier to MAID.

- Very murky area. Need a proper registry of all MAID cases, scientific study, access to data in a transparent manner, knowledge transfer tools, conferences, and ethical/spiritual/legal guidance as we learn more. Canada MUST be a world leader in MAID knowledge, skills and attitudes. We can make it better every day.
- I am thankful that I don't expect to be involved in such proceedings.
- I appreciate efforts from committee members and the CPA at large, but I think there needs to be more critical thinking done around the role expected of psychiatrists, what constitutes our skills and expertise, and whether the latter two match the former. Admittedly, such critical reflection on our part may run counter to soft consensus in force since the SCC decision and the subsequent legislative process, but I would not equate critical reflection with opposition to euthanasia. The moral anguish about ending one's life in our culture was not extinguished by the recent judicial process, and the use of technical sounding but poorly defined words such as "irremediability" and "assessment" simply buries that anguish, for the general public I think, in the comfortable assumption that "experts" will sort it out. Somehow, I feel that this may lead to a misunderstanding between us and the public, and that this could backfire down the road.
- It is very important not to see a patient's choice of MAID as a failure of psychiatric care.
- I do not support MAID under any conditions. I took a oath to heal, not to harm or kill!
- I believe that intractable mental illness is as painful as terminal cancer. Patients should be able to say enough is enough.
- Excellent questions.
- We need better palliative care; it would diminish the demand for MAID. After 32 years of "fighting" hard to encourage very ill, suicidal patients to never give up, I doubt I will ever feel comfortable with any of my patients requesting assisted dying. I will never approve it but will consider transferring the patient to a colleague. At any rate, I am retiring in 18 months.
- Thank you for asking!
- Congrats to CPA for taking this on!
- What else is there to say?
- Thanks for your consideration of psychiatrist input on this important issue. I generally agree with Dr. Sonu Gaiind's previously expressed concerns. While I do not wish to impose undue suffering on people waiting for a decision on the use of MAID in mental illness, I believe it is very important that we get this right, as the stakes are high. It will also be important to closely track requests for MAID for mental illness, if it becomes authorized, in order to learn more about the situations that can arise and continue to refine the guidelines and legislation if needed.
- The court of last resort has spoken and we should respect that. However, the SCC has essentially created a medical procedure by their definitions. Physicians are under no obligation to be involved. Regulatory bodies obviously should have a process and tracking for MAID. I am concerned about the impact on physician well-being. This should be an opt-in not an opt-out. There should not be mandatory training in MAID for learners such as residents and medical students. This is a revolutionary change in medicine. I believe that we can have respectful disagreement. If there must be MAID then the process, including agents used, should come from a government body (since it is responsible to respond to the SCC). The agents should be produced by government so that no company or shareholder issues arise. A learned group of physicians should get together and ensure that the means cover all possibilities. Stores of the agents could be located around the country. The rights of institutions and sponsoring bodies to not participate as well as those of physicians, nurses, pharmacists, etc should be upheld. No regulatory body should insist that any physician must assist the patient to get to the MAID process. By definition the SCC said this is solely for competent patients. Such persons should be able to contact the MAID resources. Government could make available readily accessible information on the process. This should all be the task and responsibility of government, not the medical profession. Government makes the laws, in this case the one the SCC overturned. The medical profession has no obligation to be involved.
- Many thanks to the CPA for putting such important work into this issue.

