

Canadian Association of Psychosocial Oncology • Position Statement

Role of Psychosocial Oncology in Medical Assistance in Dying (MAID)

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1.0 Purpose of the Position Statement

Recent amendments to the Criminal Code of Canada established a federal framework for the lawful provision of Medical Assistance in Dying (MAID) [1]. While MAID provides an option for patients experiencing intolerable suffering at the end-of-life, psychosocial oncology clinicians will undoubtedly have concerns and questions about their role in MAID.

This **position statement** put forth by the Canadian Association of Psychosocial Oncology is intended to clarify the role of psychosocial oncology services and psychosocial oncology clinicians in responding to patient inquiries about MAID. This document is not a replacement for the judicious application of knowledge, skills and professional decision-making as described in specific standards from respective regulatory colleges that govern or regulate the practice of psychosocial oncology professionals. Nor does this document replace policy, guidelines or position statements regarding the role of psychosocial clinicians in MAID from discipline specific national and/or provincial professional associations. Rather, it presents a context and framework for the consideration of the psychosocial aspects of MAID.

Clinicians should be fully apprised of their organization standards and guidelines for MAID requests and the provision of MAID (e.g. pathways to follow when requests are made, documentation requirements, privacy issues, etc) and the psychosocial, supportive care, and palliative care resources available in their organization or the community.

2.0 Guiding Principles for Psychosocial and Supportive Care Services:

There are relevant guiding principles derived from the CAPO standards for psychosocial oncology and supportive care [2], including statements about ethical principles that are important for consideration in relation to MAID. These principles are as follows:

1. The provision of person/family centered care that appreciates the perspective, values, vulnerabilities, cultural background, preferences, needs, and dignity of all those involved.
2. Psychosocial services are delivered by a range of health care professionals and may include psychologists, psychiatrists, social workers, spiritual CAPO Professionals, counsellors and nurses.
3. Persons affected by cancer are informed of, and have access to, psychosocial oncology and supportive care services as required by the Accreditation Canada standards (www.accreditation-canada.ca).
4. Psychosocial services and clinicians are guided by ethical principles of autonomy, respect, beneficence, honesty and confidentiality and by the professionals' respective codes of ethics.
5. Persons affected by cancer receive psychosocial health services that are respectful of, and attend to, cultural and linguistic diversity, gender and sexual orientation, socioeconomic status, and other aspects of diversity that merit consideration.
6. Persons affected by cancer are entitled to have access to professionals who are knowledgeable and skilled in providing therapeutic psychosocial and supportive care interventions for identified needs appropriate to the level of care required.
7. Psychosocial oncology services are provided by health care professionals who collaborate effectively with each other on inter-professional teams.
8. Psychosocial and supportive care of persons affected by cancer is guided by evidence/best practice and informed by clinical judgement.
9. Persons affected by cancer are entitled to treatment by self-aware, reflective practitioners who recognize their own needs for support, and act to prevent and manage their own sources of personal distress.

3.0 Background to MAID Legislation in Canada

3.1. Legislation for Medical Assistance in Dying (MAID)

On June 17, 2016 Bill C-14: {An Act to amend the Criminal Code and to make related amendments to other Acts} became law, amending the provisions of the Criminal Code of Canada so that in certain cases, persons may access Medical Assistance in Dying (MAID) without the assisting physician and healthcare team being found guilty of a criminal offence [1].

MAID, as denoted by the federal legislation refers to:

- 1) Administering by a medical practitioner or nurse practitioner (NP) of a substance to a person, at their request, that causes their death; or
- 2) Prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance, and in doing so, cause their own death.

Health care professionals are protected from criminal prosecution for aiding in MAID under the exemption: “no person is a party to culpable homicide if they do anything for the purposes of aiding a medical practitioner or nurse practitioner” to provide a person with MAID in accordance with Bill C-14. For greater clarity, no social worker, psychologist, psychiatrist, medical practitioner, nurse practitioner (NP), or other health professional commits an offense if they provide information to a person on the option for lawful provision of MAID.

However, the legislation also clearly prohibits any activity that could be construed as counseling or aiding suicide, specifically: Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years, whether suicide ensues or not, if they 1) counsel a person to die by suicide or abet a person in dying by suicide; or 2) aid a person to die by suicide. For greater clarity, suicide in this context refers to the act of intentionally ending one’s life without medical assistance as laid out in Bill C-14. This does **not** refer to providing information pertaining to MAID for those who are considering this as an option towards their end of life.

3.2 Legalization of MAID in Quebec- Special Considerations in Quebec Law 2

Psychosocial clinicians in Quebec must also be aware of Law 2 legislation [3], which legalized MAID in Quebec. An Act concerning end of life care (RLRQ, c. S-32.0001) (hereafter referred to as Law 2), came into force in Québec on December 10, 2015, before the introduction of Bill C-14. Law 2 requires that patients have access to a full range of healthcare interventions at the end of life, which includes MAID.

Although both laws apply in Québec, there are some important differences. For instance, no specific waiting period exists under Law 2, but the Québec Ministry of Health and Social Services does require physicians to adopt the 10-day safeguard outlined in Bill C-14. Law 2 permits only euthanasia while C-14 allows both euthanasia and assisted suicide. Law 2 states that the person ‘experiences constant and unbearable physical or psychological suffering.’ Suffering must be reported not only by the patient, but also confirmed by two clinicians who attest to eligibility. While this does not invalidate a patient’s perspective, it does mean that under Law 2, a person who requests MAID can be refused if the physician(s) does not believe she fulfills the criterion relating to suffering. [personal correspondence, Dr. Mona Gupta, Research Director of the Groupe de recherche sur la souffrance psychique et l’AMM du CHUM]

3.3 Criteria for Medical Assistance in Dying (MAID)

Persons who request Medical Assistance in Dying (MAID) must meet the following eligibility criteria [1]:

- The person is at least 18 years of age and eligible for publically funded health care services in Canada
- The person is capable of making decisions with respect to his or her health
- The person suffers from a grievous and irremediable medical condition defined as:
 1. a serious and incurable illness, disease or disability;
 2. being in an advanced state of irreversible decline in capability;
 3. causing them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable; and
 4. causing a reasonably foreseeable natural death taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
- The person is making a voluntarily request for MAID, with no evidence of coercion and not due to external pressure
- The person has provided informed consent to receive MAID, after having been apprised of alternate care options available to alleviate their suffering, including palliative care

3.4 Conscientious Objection:

Psychosocial oncology professionals, like all clinicians, have the right to decline to participate in the provision of MAID. The legislation also honors the differing moral convictions as follows: Whereas, everyone has freedom of conscience and religion under section 2 of the Canadian Charter of Rights and Freedoms. Whereas, nothing in this Act affects the guarantee of freedom of conscience and religion; Nothing in the Act compels an individual to provide or assist in providing MAID.

Psychosocial oncology professionals, like all clinicians, are responsible for continuing to provide the usual standard of care (i.e. professional responsibilities separate from MAID) to patients expressing interest in or pursuing MAID.

4.0 Psychosocial Considerations in MAID

While CAPO recognizes that MAID provides an option for addressing intolerable suffering at the end-of-life, psychosocial oncology clinicians may require clarity about their role in the context of MAID. Psychosocial oncology services and psychosocial oncology clinicians may play an instrumental role in understanding and addressing psychosocial issues that contribute to a person's request for MAID. They may also ensure that the individual and their family receive support in the decision-making process, including access to supportive and palliative care services consistent with best practices. As noted by the National Cancer Institute of the U.S. National Institute of Health, requests for MAID may be considered as a sign of intolerable physical, psychosocial or spiritual suffering and possibly unmet needs [4].

Clinicians should be aware that most requests for MAID will have a psychosocial dimension. However, amongst the general public there is a widely-held belief that requests for MAID are most likely to occur in circumstances of unbearable and uncontrollable physical pain or suffering [5]. In reality, physical symptoms such as pain may be a contributing factor for some individuals, but requests for MAID most often occur in a clinical situation that has multiple facets.

Patients (and families) in advanced stages of illness and at the end-of-life may experience a myriad of biomedical, physical, psychosocial, and spiritual issues that can contribute to suffering [5-8]. For example, patients often experience multiple interacting physical symptoms such as pain, fatigue/exhaustion, delirium, and dyspnea. Emotional distress may include anxiety, depression, profound sadness, feelings of hopelessness, existential distress, demoralization, anger, fear or terror of dying, loss and grief, loss of dignity, and loss of a sense of control [9, 10]. Social distress including social isolation, feelings of being a burden, concurrent stressors (e.g. financial costs, work leave and unemployment) strained relationships, loss of valued roles, changes in sense of self, and self-stigma are also common [10].

More often the reasons for requests for MAID are existential and values-based concerns rather than rooted in suffering due to physical symptoms, e.g., a desire for autonomy and control, existential distress, and fear of being a burden on family [11]. Even when physical issues are at play, such as loss of bodily functions or pain, it is the associated hopelessness, loss of dignity, demoralization, loss of independence and depression that spur on desire for death [12, 13]. Data from Oregon show the most common reasons for MAID requests were loss of autonomy (92%), loss of dignity (75%), being less able to participate in enjoyable activities (73%), concern about being a burden on family/friends, caregivers (48%), losing control of bodily functions (36%), inadequate pain control (or concern about this) (29%), concern about financial circumstances (2.3%) [14]. Individuals also express a desire for hastened death over anticipatory suffering—experiences that they dread they will experience in the future [15]. However, some of these reasons can be transient, and if they are resolved (e.g., feelings of hopelessness, existential distress, reassurances about pain control) some patients may no longer wish to proceed with MAID.

Expressions of a desire for death are relatively common in palliative care, with various studies showing at least occasional, transient thoughts in 11-41% of patients, and a more persistent and serious desire in a further 3-20% [16,17]. This suggests that there can be ambivalence, uncertainty, and instability in the desire for death, which is acknowledged in the Bill-C14 recommendation for a 10-day waiting period prior to performing MAID. It is also clear, however, that once a patient has made a firm decision about MAID, it can be stable and consistent over time [17].

Whenever an individual expresses a wish to die, it should trigger an inquiry into the underlying reasons. For psychosocial clinicians, this inquiry may involve (a) exploring underlying issues; (b) identifying clinical problems that may be treatable, and; (3) discussing interpersonal issues that may be involved [18]. There is evidence that:

- (1) Some individuals may not desire MAID, but rather feel that they have a readiness, or even a willingness for death to come. This can be a manifestation of “letting go” [15].

- (2) Some individuals undergo acute crises with pain or other physical symptoms that trigger urgent requests for MAID. If these symptoms can be treated effectively, the desire for death can change [11].
- (3) Some individuals are depressed to a clinically significant degree, and can perhaps be helped with psychotherapeutic or psychopharmacological intervention [11,13].
- (4) Some individuals feel that they have become a burden to others, and that loved ones will be better off when they have died. This can sometimes be addressed with couple or family counseling or targeted psychosocial interventions or spiritual support [13].
- (5) Some individuals feel that their lives have become futile and that they are merely lingering while waiting to die. This suggests an existential demoralization, or a lack of purpose and meaning [11].
- (6) Some individuals may appear reasonably comfortable at the time of a MAID request. However, present psychological suffering about anticipated future dependence, loss of autonomy, and perceived loss of dignity can be the basis for a MAID request [18].
- (7) Some individuals may use the language of MAID as a way of communicating suffering and distress.
- (8) Some individuals may have a high degree of fear or death anxiety, exacerbated by a sense of being out of control. Having the option of MAID may paradoxically relieve death anxiety by providing a sense of control.

Each of these issues may call for different psychosocial approaches, and not all will inevitably end in MAID. It is important to recognize that although psychosocial oncology services should be offered, patients are not legally required to undertake these interventions to be eligible for MAID.

4.0 Position Statement(s) and Practice Points:

Position Statement 1:

Careful Exploration of End-of-Life Suffering and Optimization of Psychosocial and Supportive Care

Patients' who express a desire for MAID, and their family members, should have access to psychosocial oncology and palliative care services. These services should comprise clinicians who are skilled in communication and in the careful exploration and assessment of physical, psychosocial, spiritual or existential sources of suffering that may be contributing to the MAID request. Possible means of addressing these concerns through psychotherapeutic, psychosocial and/or spiritual support or other therapeutic interventions (e.g. legacy work, dignity therapy) and through optimization of pain and symptom control or alternative strategies where appropriate (i.e. terminal sedation) should be reviewed.

Psychosocial oncology considers the family as the unit of care and recognizes that family members may also require support when a loved one requests MAID. Psychosocial oncology services should remain involved with patients and families who are undergoing the MAID process, including throughout the steps of MAID assessment, the waiting period (anticipatory grief support), and in the time after MAID is provided. Bereavement services or grief counseling for family members should be offered.

Simply stated, the statement from patients that, "I want to die" is not always a literal request for a hastened death, but it is an expression of distress, discomfort, or despair in one or more domains of quality of life. As integral members of interdisciplinary care teams, psychosocial oncology clinicians have considerable expertise in understanding the psycho-social-spiritual concerns of patients with advanced disease; and possess communication skills that are essential for exploring patients' underlying reasons for seeking MAID. Psychosocial Oncology services offer care to persons with cancer who have unmet needs related to coping with their illness, emotional distress, changes in relationships and spiritual and existential concerns. These are often best provided by professionals trained in psycho-oncology (e.g., psychologists, social workers, spiritual care specialists, psychiatrists and psychiatric/mental health or oncology/palliative care advanced practice nurses [APNs] inclusive of nurse practitioners).

Position Statement 2:

Distinguishing Requests for MAID, Desire for Hastened Death, or Suicide

Healthcare providers should distinguish between patient requests for MAID, the desire for hastened death (DHD), and suicidal ideation. For example, some individuals may request MAID not because they desire death, but in order to have choice over the circumstances of death. Conversely, some individuals would never request MAID, even if they have a strong desire for death, because they are opposed on moral or religious grounds, or they are prepared to experience death when it comes naturally, without being hastened. Finally, neither the desire for death nor MAID requests necessarily equate with suicidal ideation. Psychosocial oncology practitioners can provide expert guidance in this distinction.

The desire for hastened death (DHD), also sometimes referred to as the wish to hasten death (WTHD) [15], has recently been defined by international consensus as "a reaction to suffering, in the context of a life-threatening condition, from which the patient can see no way out other than to accelerate his or her death" [19]. "It is thought to arise in response to one or more factors, including physical symptoms (either present or foreseen), psychological distress (e.g. depression, hopelessness, fears, etc.), existential suffering (e.g. loss of meaning in life), or social aspects (e.g. feeling that one is a burden)". It is a manifestation of despair, and is most often transient, triggered by stressful illness events, and responsive to increased psychosocial or supportive care [15]. As such, it is considered a target of psychosocial intervention, rather than an indication for MAID. DHD is explicitly a wish for an earlier death, whereas individuals who request MAID may not actually desire death. Rather these

individuals would prefer to live but have a desire to control the circumstances of their death. The consensus definition of DHD also stipulates that “it must be distinguished from the acceptance of impending death” or “letting go”, which is a capitulation to impending death, often occurring in the last month of life and associated with the decision to stop all life prolonging treatments [15], but not necessarily with a desire either to hasten death or for MAID.

Some research has found that suicidal ideation represents a desire for death most often based on co-morbid psychiatric illnesses such as depression, delirium or psychosis [20]. Whereas, other studies show that some patients with suicidal ideation are not depressed [13]. Psychiatric assessment would be warranted in such patients in the context of MAID requests, and capacity would need to be carefully evaluated. Most patients who request MAID are in fact not suicidal. Death by suicide among patients with cancer occurs about twice as frequently as in the general population [21], but it is still a rare event. In Canada, the overall suicide rate in 2009 was 11.5 per 100,000 population; i.e., about 0.01% of the population took their own lives [22]. This suggests that the suicide rate among patients with cancer would still represent a relatively small number of people. MAID deaths, on the other hand, are likely to occur much more frequently. In Belgium, about 10% of people who die with a diagnosis of cancer end their lives with MAID [23]. Apparently, very few of these individuals would have taken their own lives had MAID not been available.

Position Statement 3:

Knowledge/Skills of Clinicians Responding to Requests for MAID

All MAID eligibility assessments should include a psychosocial dimension. Psychosocial oncology clinicians should be considered for consultation or inclusion as members of MAID assessment teams. The National Cancer Institute of the U.S. National Institutes of Health recommends in-depth examination of four dimensions of suffering in response to requests for MAID: physical, psychological, social and spiritual suffering. It stresses the importance of attending to psychosocial and spiritual dimensions of suffering, particularly the fear of becoming a burden and losing independence and/or loss of dignity [4].

Special competencies and knowledge are required to respond appropriately to patients who make a specific request for MAID (e.g., facilitate end-of-life conversations, assess patients psychologically, be receptive to requests and understanding reasons behind them, etc.). The psycho-social-spiritual approach allows for appropriate understanding of the person making the request, their motivations, and the factors beyond the medical indicators including any psychosocial factors [24].

Position Statement 4:

Assessment of Adequate Decision-Making Capacity

While the physician or nurse practitioner qualified to provide MAID as per the legislation is responsible for determining capacity, in circumstances where psychiatric disorders are present, psychiatrists may be consulted to provide a capacity opinion. Psychiatrists may play a role in verifying that a patient who requests MAID has adequate decision-making capacity. This involves ensuring that the individual understands and appreciates (a) the nature of the medical problem, its course and prognosis; (b) the irreversibility of MAID; (c) alternatives to MAID if it is not selected; (d) the potential risks associated with MAID and its alternatives; (e) the right to withdraw the request at any time; (f) the procedural aspects of MAID (i.e., waiting periods, assessments, distinctions between clinician-administered and self-administered forms of drug delivery) [25].

Issues that can impact capacity include cognitive impairment and psychiatric conditions that compromise the ability to make rational, voluntary decisions [26]. However, capacity determinations involve more than merely diagnosing and documenting the presence of cognitive impairment or a mental disorder; many people with mild cognitive impairment or mild-moderate depression may retain the capacity to make well-informed decisions about their treatment. The presence of a mental disorder in and of itself therefore does not necessarily make the patient ineligible for MAID. Rather, it must be determined whether these clinical problems are significant or severe enough to impair the individual's understanding of their circumstances, with an appreciation for the reasonably foreseeable consequences of a decision either for or against MAID.

Position Statement 5:

Psychosocial Support for Practitioners Responding to Requests for MAID

Discussions with patients about a desire for hastened death can be emotionally distressing for clinicians. Moreover, the impact of MAID on the health care professional team can be significant and is often an emotional experience for the practitioner and members of the health care team. Primary physicians participating in euthanasia in other countries have described emotional distress and general discomfort in cases of life termination [27]. It is encouraged that the care team debrief after participating in each case of MAID [28].

Psychosocial health services may play a key role in the provision of debriefing sessions with individual clinicians or teams participating in MAID; and in ensuring that clinicians are aware that emotional and moral distress may be a common response. Psychosocial services can advocate for clinicians to have access to support services to promote their own well-being. There may be a need to ensure access to support for clinicians outside of organized health care institutions, who may be isolated in the provision of MAID. Interdisciplinary collaboration with ethics specialists and privacy officers may be helpful to support clinicians' practice with MAID requests.

Position Statement 6:

Self-Awareness of Values and Beliefs Regarding MAID

Reflection and self-awareness of personal values and beliefs (i.e. ethical perspectives) in relation to MAID is an important process for practitioners in order to determine where they are either able or not able to assist. This process of reflection may be facilitated through completion of a values-based self-assessment tool [28], but may still involve moral distress. MAID, regardless of how experienced the practitioner, will have personal meaning and significance.

Professionals may object to participating in MAID on a variety of grounds (e.g., professional identity, religious beliefs and practices, moral opposition, philosophical disagreements). There must be protections in place to safeguard health care professional's rights to object to MAID, while at the same time ensuring patients' access under Bill C-14. Health care professionals must ensure that they have carefully considered their moral commitment and respect for diverse values, both for those who participate and those who do not participate in MAID.

Position Statement 7:

Public Awareness

There is much confusion among Canadians about different end-of-life care options, and access to end-of-life care services varies widely according to diagnosis/prognosis, setting of care, and geographic location. For example, with very limited palliative care options in rural and remote communities [29], including First Nations communities [30], people with life-limiting or end-stage disease within these communities may be compelled to see MAID as their only option. While advance requests for MAID are not legally permitted, some patients may wish to discuss MAID within advance care planning conversations, as part of the process of exploring their values, wishes, and options for the end of life. It is imperative that the public is informed of all end-of-life care options and strategies that may be available to them as alternatives to MAID, including palliative and psychosocial care, palliative sedation, advance care planning and goals of care discussions. In particular, Canadians need more information about what is and is not possible with MAID requests, and how provinces differ in their interpretation and implementation of the MAID legislation.

Psychosocial oncology services may play an important role in ensuring that patients and families, other health-care professionals, and the public are aware of the options for addressing suffering, including the treatable nature of end of life distress. Psychosocial oncology is also well-equipped to dispel inaccurate public perceptions about MAID—especially what constitutes a legitimate reason for requesting it. This education is an investment in the well-being and knowledge base of current and future recipients of end-of-life care and MAID. Having informed, prepared patients and families *before* end-of-life decisions must be made may significantly minimize the stress, uncertainty, and conflict that can arise.

Position Statement 8: Research

The option of MAID is a new reality in the health care system and for practitioners. There is a need for psychosocial research in all aspects of MAID and specifically how MAID affects patients, their family members including bereavement and for health care professionals. Moreover, early identification of end of life suffering, understanding contributing factors underpinning MAID requests, and study of mental illness in MAID requests are important areas for further research.

Collection of a minimum common database of MAID process metrics at the local, provincial and national levels should be encouraged to support psychosocial research efforts. Psychosocial oncology practitioners should advocate with health care institutions, regulatory bodies and organizations such as the Canadian Institute for Health Information to ensure psychosocial care variables are included in required reporting templates.

Updates to Position Statement

This position statement will be reviewed by the CAPO Clinical Practice Committee a minimum of every 2 years or will be updated when changes to the legislation are made public. This statement should be reviewed in September 2019.

DISCLAIMER

This document is for consultation purposes only. It is not intended as legal advice and cannot be a substitute for legal advice. If you have legal questions or concerns, please seek legal counsel through your professional liability protection organization or union. Participation as a member of the position statement working group does not imply an endorsement.

Definitions

Medical Assistance in Dying: In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes a substance for an individual to self-administer to cause their own death [1].

Capacity: A person is capable of making a decision if the individual is both 1) able to understand the information that is relevant to making that decision [the cognitive element] and 2) able to appreciate the reasonably foreseeable consequences of that decision or lack of decision [the ability to exercise reasonable insight and judgment] [25].

Psychosocial Care: Psychosocial health services are psychological, social and spiritual care services and interventions that enable patients, their families, and health care providers to optimize biomedical health care and to manage the psychological, behavioural, social and spiritual aspects of illness and its consequences so as to promote better health [31].

Psychosocial oncology (PSO) is a specialty in cancer care concerned with understanding and treating the social, psychological, emotional, spiritual, quality-of-life and functional [practical] aspects of cancer, from prevention through bereavement. It is a whole-person approach to cancer care that addresses a range of very human needs. Psychosocial Oncology focuses on the emotional distress aspects of cancer care and is particularly concerned with the assessment and treatment of distress (as supported by its identification internationally as the 6th Vital Sign of cancer care) and the management of complex issues [2].

Supportive Care services address a range of needs, including informational and counselling needs related to the management of symptoms and specific practical or functional issues. A variety of disciplines may be involved in provision of supportive care, such as nursing, medicine, nutrition and rehabilitation services. Supportive Care services address unmet needs of persons with cancer who require information, education, support, financial advice, or other practical advice [2].

Palliative Care: is "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" [32]. The Palliative Approach is an approach to care that focuses on meeting a person's and family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person's autonomy and right to be actively involved in his or her own care. Whereas, End-of-Life Care is both a term used to describe the care provided during the final hours or days of a person's life, as well as the continuum of care available to those with a terminal illness or terminal disease condition that is progressive and incurable.

References

1. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (formerly Bill C-14), 1st Sess, 42nd Leg, Canada, 2016 (assented to June 17, 2016).
2. Standards of Psychosocial Health Services for Persons with Cancer and their Families. Canadian Association of Psychosocial Oncology, May 28, 2010.
3. Quebec legislature of Bill 52, An Act respecting end-of-life care, on 12 June 2013.
4. National Cancer Institute, *Education in Palliative and End-Of-Life Care for Oncology: Self-Study Module 14: Physician-Assisted Suicide* (Online: <http://www.cancer.gov/resources-for/hp/education/epeco/self-study/module-14/module-14.pdf>, p. 5).
5. Breitbart, W., & Rosenfeld, B. D. (1999). Physician-assisted suicide: the influence of psychosocial issues. *Cancer Control*, 6, 146-161.
6. Block, S.D. (2006). Psychological issues in end-of-life care. *Journal of Palliative Medicine*, 9, 751-772.
7. Werth, J.L., Jr., & Blevins, D. (2006). Psychosocial issues near the end of life. Washington, D.C.: American Psychological Association.
8. Kissane DW., Psycho-spiritual and existential distress: the challenge for palliative care. *Australian Family Physician*, 2000; 29 (11): 1022-1025.
9. Branigan M. Desire for hastened death: exploring the emotions and the ethics. 2015. *Curr Opin Support Palliat Care*. 9(1):64-71.
10. Emanuel, E.J., Fairclough, D.L., Daniels, E.R., & Claridge, B.R. (1996). Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public. *Lancet*, 347, 1805-1810.
11. Wilson, K.G., Chochinov, H.M., McPherson, C.J., Graham, M., Allard, P. Chary, S., Gagnon, P.R., Macmillan, K., DeLuca, M., O'Shea, F., Kuhl, D., Fainsinger, R.L., Karam, A.M., & Clinch, J.J. (2007). Desire for euthanasia or physician-assisted suicide in palliative cancer care. *Health Psychology*, 26, 314-323.
12. Chochinov, H.M., Wilson, K.G., Enns, M., Mowchun, N., Lander, S., Levitt, M., & Clinch, J.J. (1995). Desire for death in the terminally ill. *American Journal of Psychiatry*, 152, 1185-1191.
13. Wilson, K.G., Dalgleish, T.L., Chochinov, H.M., Chary, S., Macmillan, K., De Luca, M., O'Shea, F., Kuhl, D., & Fainsinger, R.L. (2016). Mental disorders and the desire for death in patients receiving palliative care for cancer. *BMJ Supportive and Palliative Care*, 6, 170-177.
14. Ganzini, L., Goy, E.R., & Dobscha, S.K. (2008). Why Oregon patients request assisted death: Family members' views. *Journal of General Internal Medicine*, 23, 154-157.
15. Nissim, R., Gagliese, L., & Rodin, G. (2009). The desire for hastened death in individuals with advanced cancer: a longitudinal qualitative study. *Social Science and Medicine*, 69, 165-171.
16. Juliao, M., Barbosa, A., Oliveira, F., & Nunes, B. (2013). Prevalence and factors associated with desire for death in patients with advanced disease: results from a Portuguese cross-sectional study. *Psychosomatics*, 54, 451-457.

17. Price, A., Lee, W., Goodwin, L., Rayner, L., Humphreys, R., Hansford, P., Sykes, N., Munro, B., Higginson, I., & Hotopf, M. (2011). Prevalence, course, and associations of desire for hastened death in a UK palliative care population: a cross-sectional study. *BMJ Supportive and Palliative Care*, 1, 140-148.
18. Hudson, P.L., Schofield, P., Kelly, B., Hudson, R., O'Connor, M., Kristjanson, L.J., Ashby, M., & Aranda, S. (2006). Responding to desire for death statements from patients with advanced disease: recommendations for health professional. *Palliative Medicine*, 20, 693-701.
19. Balaguer A, Monforte-Royo C, Porta-Sales J, Alonso-Babarro A, Altisent R, Aradilla-Herrero A, et al. (2016) An International Consensus Definition of the Wish to Hasten Death and Its Related Factors. *PLoS ONE* 11(1): e0146184. <https://doi.org/10.1371/journal.pone.0146184>
20. Hirschfeld, R., Russell, J. (1997). Assessment and treatment of suicidal patients. *N Engl J Med*. 337(13), 910-915.
21. Misono S, Weiss NS, Fann JR, Redman M, Yueh B. Incidence of suicide in persons with cancer. *J Clin Oncol* 2008;25:4731-4738.
22. Navaneelan T. Suicide rates: an overview. *Health at a Glance*. Statistics Canada Catalogue no. 82-624-x, 2017.
23. Dierickx S, Deliens L, Cohen J, Chambaere, K. (2015). Comparison of the expression and granting of requests for euthanasia in Belgium in 2007 vs 2013. *JAMA Intern Med* 2015;175:1703-1706.
24. Canadian Association for Spiritual Care (CASC/ACSS). Responding to Clients Considering or Requesting Medical Assistance in Dying (MAID), Dec 2016. <http://www.spiritualcare.ca/page.asp?ID=272>
25. Appelbaum, P.S. (2007). Assessment of patients' competence to consent to treatment. *New England Journal of Medicine*, 357, 1834-40.
26. Assessing Vulnerability in a system for physician assisted death in Canada. Issued by The Canadian Association for Community Living, April 2016.
27. van Marwijk H, Haverkate I, van Royen P, The, A-M. Impact of euthanasia on primary care physicians in the Netherlands. *Palliative Medicine* 2007, 21, 609-614.
28. Centre for Effective Practice. (November 2016). *Medical Assistance in Dying (MAID): Ontario*. Toronto: Centre for Effective Practice.
29. Collins, A., & Leier, B. (2017). Can medical assistance in dying harm rural and remote palliative care in Canada?. *Canadian Family Physician*, 63(3), 186-190.
30. Saint Elizabeth First Nations, Inuit, and Metis Program. (2012). *"Walk a Mile in My Moccasins," Foundations for Action in First Nations Cancer Control*. Winnipeg, MB: Saint Elizabeth Health Care.
31. Institute of Medicine. *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*. Washington: National Academies Press; 2008.
32. World Health Organization. (2016). *WHO Definition of Palliative Care*.

Other Sources

De Bal N, Dierckx de Casterle B, De Beer T et al. Involvement of nurses in caring for patients requesting euthanasia in Flanders (Belgium): a qualitative study. *Int J Nurs Stud* 2006; 43: 589-99.

Matzo ML and Schwarz JK. In their own words: oncology nurses respond to patient requests for assisted suicide and euthanasia. *Appl Nurs Res* 2001; 14: 64-71

Harvath TA, Miller LL, Smith KA, et al. Dilemmas encountered by hospice workers when patients wish to hasten death. *J Hosp Palliat Nurs* 2006; 8: 200-9.

Odell, J., Abhyankar, R., Malcolm, M. & Rua, A. (2014). Conscious objection in the healing professions: A reader's guide to the ethical and social issues. <http://hdl.handle.net/1805/3844>.

Block S.D. & Billings, J.A. (1994). Patient requests to hasten death: Evaluation and management in terminal care. *Archives of Internal Medicine*, 154, 2039-42

Policy Templates and Practice Guideline Documents for MAID

For more information on *Carter v. Canada (Attorney General)*, please see Martha Butler and Marlisa Tiedemann, *Carter v. Canada: The Supreme Court of Canada's Decision on Assisted Dying*, Library of Parliament, Background Paper No. 2015-47-E, October 2015. And *Carter v. Canada (Attorney General)*, 2015 SCC 5, para. 127.

For a simplified explanation of the legislation, please go to:

<http://healthycanadians.gc.ca/health-system-systeme-sante/services/palliative-palliatifs/medical-assistance-dying-aide-medicale-mourir-eng.php>

Relevant Professional Association Position Statements

College of Physicians and Surgeons of Ontario Policy Statement #4-16: Medical Assistance in Dying. 2016. [cited 2016 June]. Available from:

<http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/medical-assistance-in-dying.pdf?ext=.pdf>

College of Nurses of Ontario: Guidance on Nurses' Roles in Medical Assistance in Dying. 2016. [cited 2016 June 27]. Available from:

<http://www.cno.org/globalassets/4-learnaboutstandardsandguidelines/maid/maid-june-23-final.pdf>

Roy-Desruisseaux, Poulin P, Hassoun, J. Discussion paper: Clinical and Ethical Challenges Facing End-of-Life Care. By the ad hoc Committee on end-of-life care. Association Des Mediciens Psychiatres du Quebec. April 2016.

Ontario College of Pharmacists: Medical Assistance in Dying - Guidance to Pharmacists and Pharmacy Technicians. 2016. [cited 2016 July 5]. Available from:

<http://www.ocpinfoc.com/library/practice-related/download/PhysicianAssistedDeath.pdf>

Canadian Medical Association. (2014). *Euthanasia and Assisted Death*.

Canadian Public Health Association. Canadian Public Health Association Position Statement: Medical Assistance in Dying. Ottawa, ON: CPHA, 2016.

Canadian Association for Spiritual Care (CASC/ACSS). Responding to Clients Considering or Requesting Medical Assistance in Dying (MAID), Dec 2016. <http://www.spiritualcare.ca/page.asp?ID=272>

College of Family Physicians of Canada. (2015). *A guide for reflection on ethical issues concerning assisted suicide and voluntary euthanasia*. Retrieved from http://www.cfpc.ca/uploadedFiles/Health_Policy/PDFs/Guidefor%20Euthanasia_EN_Final.pdf

National Nursing Framework on Medical Assistance in Dying in Canada, Canadian Association of Nurses in Canada, Ottawa, ON.

Alberta Association for Spiritual Care/Association albertaine de soins spirituels
A Statement to the Membership from the Board of AASC/AASS, August 19, 2016

Social Work Resources

- [Saskatchewan Association of Social Workers Guidance on Medical Assistance in Dying](#)
- [Manitoba College of Social Workers Medical Assistance in Dying Information Sheet](#)
- [Alberta College of Social Workers Medical Assistance in Dying Information Sheet](#)
- [Newfoundland and Labrador Association of Social Workers -- Medical Assistance in Dying: What Social Workers Need to Know](#)
- [Ontario College of Social Workers -- Medical Assistance in Dying: Guidance for Members](#)
- [Nova Scotia College of Social Workers: MAiD from a Regulatory Lens](#)

Quebec

- [l'Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec](#)

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