

Witness to Medically-Assisted Dying in Canada: A Counselling and Psychotherapy Perspective

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I certainly appreciate the opportunity to speak with you today, and I'm delighted to deliver this talk during the Canadian Hospice Palliative Care Association's National Hospice Palliative Care Week – serendipity for sure. In recognition of the Winnipeg Jets fantastic season, I've broken down the talk into three periods.



Introduction

In way of introduction, I would like to assert the following in relation to the arrival of medical assistance in dying in the Canadian context:

First – It Didn't Emerge in Isolation

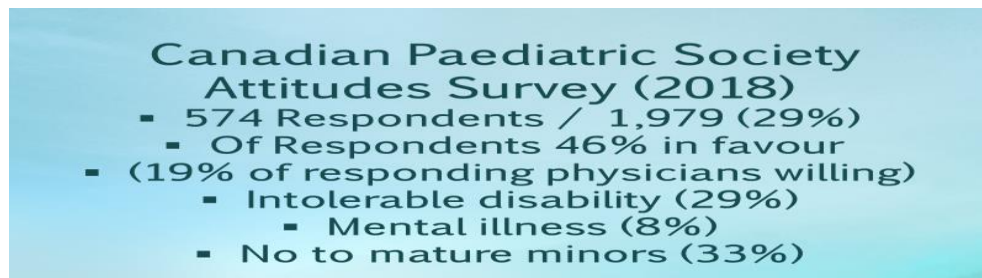
Medically-assisted dying in Canada, as elsewhere, didn't come to pass in isolation and can rather be understood as part of an international, and more particularly cross-border, initiative heavily influenced by and occurring alongside the United States, and can be seen to precede the introduction of physician-assisted dying in the U.S., at least as it became part of the Canadian national consciousness through the Supreme Court of Canada's 1993 decision in *Rodriguez v. British Columbia* (a landmark decision where the prohibition of assisting in a suicide was challenged as contrary to the *Canadian Charter of Rights and Freedoms* by Sue Rodriguez, who was terminally ill).

In a 5-4 decision (I repeat, a 5-4 decision) the Court upheld the *Criminal Code* provision 241(b), prohibiting aiding a person to die by suicide. The year was 1993, two years before any jurisdiction in the world legalized and actualized any form of assisted dying. The Canadian *Criminal Code* on this question remained intact.

Second – Relatively Broad Implementation

The Canadian implementation of medically-assisted dying, coming as it did more than two decades after initially proposed in *Rodriguez*, and as seen in a larger international context, encouraged a relatively broad implementation as compared to other U.S. jurisdictions, and as the legislation currently stands, a less permissive implementation than the European jurisdictions of the Netherlands (April, 2002), Belgium (February, 2008), and Luxembourg (March, 2009), where in each euthanasia is permissible (in Belgium without age restrictions, and in the Netherlands to minors older than 12), and in the Netherlands and Belgium is allowed in cases where mental illness is the sole consideration.

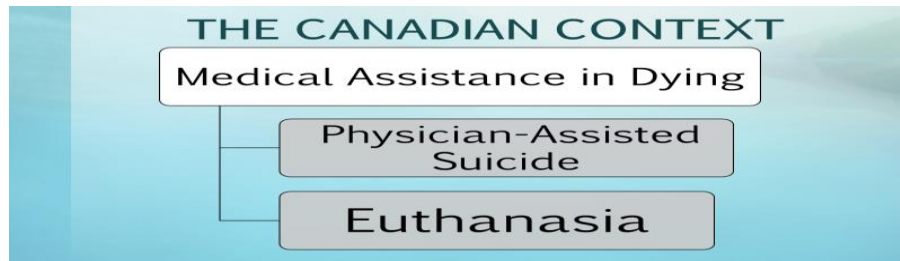
An April 2018 publication of a position paper on Medically-Assisted Dying by the Canadian Paediatric Society, entitled *Medical Assistance in Dying: A Paediatric Perspective*, is revealing concerning the issue of minors potentially receiving both voluntary and involuntary euthanasia in Canada, and, more specifically, reveals attitudes regarding the administration of medically-assisted dying when mental illness is the sole consideration.



As you can see, the CPS-Attitudes survey received 574 responses out of a possible 1,979 (a 29% response rate), with only 487 completing all the questions. Almost one-half (46%) of respondents were in favour of extending the medically-assisted dying option to mature minors, experiencing progressive or terminal illness or intractable pain. (Even if Canadian legislation permitted access to medical assistance in dying for paediatric patients, the CPS-Attitudes survey reported only 19% of responding clinicians would be willing to provide medically-assisted dying to minors.)

Fewer believed access should be extended to children or youth with an intolerable disability (29%) or with intolerable mental illness as the sole indication (8%). Thirty-three per cent of respondents said medically-assisted dying should not be extended to the mature minor population under any circumstance. Regarding eligibility for medically-assisted dying, 55% of respondents believed that an individual's capacity was most important, compared with 22% who favoured a minimum stated age.

Colombia is the lone South American country which permits any form of medically-assisted dying, and more specifically euthanasia. In 2015, Colombia became the fourth nation to permit euthanasia, along with the previously mentioned European nations.



Canada became the fifth nation around the world to permit euthanasia, beginning in 2016. In fact, nearly all medically-assisted dying in Canada *isn't* assisted; it is carried out largely in hospitals or homes by doctors (and increasingly by nurse practitioners) directly. Patients in Canada are not currently able to fill a prescription with a pharmacist, from an assisting physician, to end life at home, on their own, whenever they choose, after receiving the prescription.

Medically-Assisted Deaths Between June 17 and December 31, 2016 (Excludes QC, NU, YT)	
Total number of medically assisted deaths:	507
▪ Number clinician-administered deaths (voluntary euthanasia)	504
▪ Number self-administered deaths (assisted suicide)	3
Settings in which assistance in dying occurred	
▪ In-hospital	249 (50%)
▪ Home	182 (37%)
▪ LTC facility or Nursing home	30 (6%)
▪ Other	37 (7%)

These numbers come from the Government of Canada's first Interim update on medical assistance in dying in Canada June 17 to December 31, 2016. Notice, of the medically-assisted deaths in Canada during the initial six months following implementation, 504 of 507, or 99 per cent, were under the category voluntary euthanasia.

It must be noted here that well before the Supreme Court of Canada's 2015 *Carter* decision and well before the consequent royal assent of Bill C-14 in June 2016, Canada has recognized (in large part as a way of easing the minds of physicians concerned over nefarious accusation) that what is known as palliative sedation (or continuous palliative sedation therapy – CPST), which results in the death of a patient who is palliative, is generally accepted medical practice in Canada.

In palliative sedation, the principle of double effect is invoked to explain the permissibility of an action that causes a serious harm (such as the death of a human being) as a side effect of promoting some good end.

“Nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention.”

Thomas Aquinas

Lukas Radbruch, President of the German Society of Palliative Medicine is quoted, saying: “In the vast majority of cases we, the palliative doctors, truly have something to offer: pain is something we can get a grip on with nearly all our patients and breathing difficulties can be treated effectively. About one in 100 patients who are treated in specialist care units require palliative sedation in their last days - in other words drugs which might cause them to lose consciousness.”

Medically-Assisted Deaths Between January 1 to June 30, 2017 (Excludes QC, NU, YT, NWT)

Total number of medically assisted deaths: 875

- Number clinician-administered deaths (voluntary euthanasia) 874
- Number self-administered deaths (assisted suicide) 1

Settings in which assistance in dying occurred

- In-hospital 368 (42%)
- Home 350 (40%)
- LTC facility or Nursing home 78 (9%)
- Other 79 (9%)

Here we have updated numbers from the second of the Government of Canada’s interim reports on medical assistance in dying. The second Interim Report includes an added feature, Number of Medically Assisted Deaths by Provider. Within the period January 1, 2017 to June 30, 2017, 837 (or 95.7%) of medically-assisted dying was carried out by physicians and 38 (or 4.3%) were carried out by nurse practitioners.

Notice again, as in the first Interim Report, the exclusion of Quebec, which is no small omission in terms of numbers. The territories are omitted over privacy concerns.

In Columbia the implementation was very different. The constitutional court in Colombia ruled in favor of euthanasia back in 1997, but willing doctors were reluctant to implement the ruling due to a separate law which punished participation by doctors with up to three years in prison. To highlight the distinction, and for many the complex ethical differences, between a patient committing assisted suicide or someone else doing so, some vocal advocates of assisted suicide, like Portland Oregon’s Death with Dignity National Center, oppose euthanasia.

The most striking feature of the implementation of medically-assisted dying in Canada, thus far, is the relative absence of controversy over the dominance of euthanasia as the means of administering medically-assisted dying

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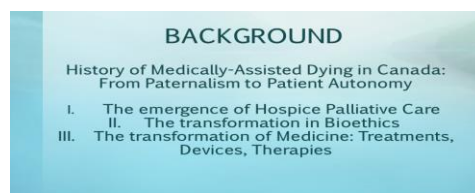
Third – The dust has yet to settle

The dust has yet to settle on the Canadian question of permissiveness regarding the aiding of death in the medical context and beyond. Will Canada’s Parliament ultimately include advanced directives, terminally ill minors, and/or mental illness in an expansion of the current legislation, Bill C-14 *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*?

Three expert panels were launched by the Canadian government in 2016 and are currently compiling the results of their various consultations. The evidence the panels compile will be available to the government to help determine whether access to medical assistance in dying should be expanded in Canada.

The Canadian public is to learn their recommendations by the end of 2018. However, a committee member for the mental health committee suggested to me recently the 2018 timeframe remains ambitious, and results into 2019 represent a more likely outcome.

Jocelyn Downie of Dalhousie University, a prominent member of the expert panel, deems the current federal legislation too restrictive and out of step with the 2015 *Carter* decision. The clause in Bill C-14 stating “natural death must be reasonably foreseeable,” is for Downie particularly disconcerting. Downie is committed to seeing the initiative through. That is, realizing the full breadth of the expansiveness she believes inherent in *Carter*. Downie believes Canada can achieve the best system in the world for end-of-life care, where patients’ wishes are respected, whether through access to aggressive treatment; palliative pain management; or medical assistance in dying.



Background – History of Medically-Assisted Dying in Canada: From Paternalism to Patient Autonomy

The most significant aspect of the transformation of our society that now permits medically-assisted dying is the increased focus on the individual and individual autonomy. Patients’ rights, among civil rights, emerged forcefully beginning in the 1960s, and eclipsed the paternalistic model in medicine.

This transition toward patient autonomy is seen prominently in transformations in bioethics and additionally in medicine, where treatments, devices, and therapies are prolonging and redefining the experiencing of life's ending.

Though the connections may in places be circuitous, it is difficult to conceive of the incorporation of medically-assisted dying (in Canada, or in any worldwide jurisdiction) without these monolithic transformations in bioethics and medicine.

Patient autonomy provides the necessary foundation for conceiving of lawfully assisting a person in hastening their death. In this evolution, no longer sanctity of life, but the autonomous patient is deemed sacrosanct. Free of coercion, the informed and consenting individual achieves mastery over life's ending.

The palliative care model, imbued as it is by a distinct philosophy of caring, has emerged alongside and often in concert with developments in bioethics and life-prolonging medicine, not entirely independent of these developments, yet maintaining a philosophical perspective that provides a corrective to the excesses of curative hubris. Currently, there is no clear consensus over the place of medically-assisted dying within the context of the palliative care philosophy and model of care in Canada.

Is medically-assisted dying a final step in the curative process, when the curative no longer provides cure as intended, or is medically-assisted dying one form of dying, one form of managing pain, a way of massaging the menacing reality of a transformed existence or non-existence? Or, is it something else?

Plainly put, is this going backwards or forwards?



For Aussie Philip Nitschke, former physician and founder and director of the pro-euthanasia group Exit International (the same Philip Nitschke who assisted four people in ending their lives in Australia's Northern Territory before the law was overturned – the first doctor in the world to administer a legal, voluntary, lethal injection) medically-assisted dying is clearly an indication of a societal move forward.

Nitschke pushes patient autonomy to a new level.

How dare the medical community claim the role as gatekeeper to individual, rational choice to suicide. I can suicide if I want to!

Suicide, for Nitschke, is a human right that should be available to whomever chooses it. People can have reasons to want to die outside of medical considerations. Does society have any binding

influence on the individual? For Nitschke, it represents a return to paternalism for a doctor to make a determination whether a person is sick enough to die. Who gave doctors that right, asks Nitschke? Suicide is a fundamental human right, not some conferred medical privilege.

Legislative solutions that don't acknowledge that suicide is a fundamental human right are doomed to fail. At best they will be stop gap measures. I want more than that I want people in our society to be provided with reliable, peaceful end of life drugs.

Philip Nitschke

According to Nitschke, the euthanasia debate has changed. With the internet, drugs are more available around the world. With a bottle of Nembutal in the medicine cabinet, once available at the local pharmacy for sleep, an aging individual can live comfortably with security that allows for extended life expectancy – *it's there if I need it*.

BACKGROUND

The Emergence of Hospice Palliative Care

Making an abrupt turn, from Philip Nitschke to Dame Cicely Saunders, we now look at the emergence of Hospice Palliative Care.



The palliative care movement in Great Britain grew out of the modern hospice movement, founded by Dame Cicely Saunders. Saunders was motivated by both her Christian faith and concerns over social solidarity. Saunders founded the world's most famous hospice, St. Christopher's, outside London. She was quoted, saying: "Our work is done in obedience to the Christian imperative."

Sophie Cloutier notes in establishing the connection between hospitality and ageing (and how hospitality is emerging as an important development in ageing) St. Christopher's bears the name of the patron saint of travellers for a reason. At best, the hospice is seen as a place of rest for the weary traveler, at the end of a long journey.

The palliative care movement in the United States gained prominence through secular and legal developments that began with the push toward patients' rights in the 1960s and culminated in the debate over assisted suicide in the 1990s.

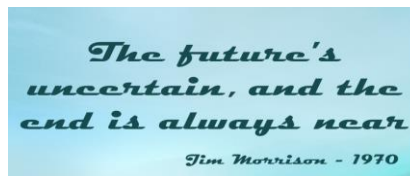
Prominent medical ethicist, Joseph Fins suggests,

The relationship between physician-assisted suicide and palliative care in the ... medical community remains complicated – although palliative care should be judged on its own merits, it is often seen through the prism of an ideological stance about PAS [physician assisted suicide].

That is to say, palliative care is often set up as the ideological opponent of physician-assisted suicide.

Elisabeth Kubler-Ross challenged the long-standing aversion to discussing and studying death, while teaching at the University of Chicago Medical School, and with the release of her seminal work, *On Death and Dying*, published in 1969. (The 50-year anniversary falls in 2019.)

And, death was showing up in the cultural conversation and as part of the continuing integration of existentialism into the psychological and the therapeutic.



For Morrison the end was near. He died in Paris in the summer of 1971...or did he?

Four years later, Woody Allen in his book *Without Feathers* penned the now familiar line: "I'm not afraid of dying. I just don't want to be there when it happens."

The public was increasingly accustomed to talking about, speculating about, even joking about death.

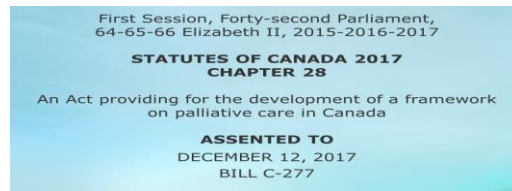
The Canadian public was very much drawn into the fighting in Vietnam. CBC Radio and Television covered the conflict extensively for all the years it was being fought, with correspondents like Joe Schlesinger, Peter Kent, Mike Duffy and Knowlton Nash. For the first time, the visual atrocities of war came daily into the living rooms of Canadians.

Kubler Ross's *On Death and Dying* arrived in the middle of the long casualty lists, and they would continue unabated until 1973.

Vietnam, a developing nation across the globe, one 30th the size of Canada, came to play prominently in transforming Canadian perspectives surrounding death in the final quarter of the 20th century.

Palliative care was slow to take root on our side of the Atlantic. The first U.S. hospice was founded in Connecticut in 1974. 1974 too was the year of the first hospital palliative care unit in Canada, begun at Saint Boniface Hospital in Winnipeg, mere blocks from where we gather today.

But again, the palliative philosophy was slow to take root, and challenges remain.



Consider Private Members Bill C-277, which received royal assent on December 12, 2017. The Summary of the bill reads: “This enactment provides for the development of a framework designed to support improved access for Canadians to palliative care.”

Member of Parliament Marilyn Gladu, of Sarnia, Ontario, the Bill’s sponsor, spoke in the House of Commons at the third reading of her private member’s bill on May 9, 2017.

Gladu said the following: “Canadians need palliative care services now more than ever. Less than 30 percent of Canadians have access to this vital service, which allows them to choose to live as well as they can for as long as they can.”

Gladu went on: “The bill is timely, since the special committee that studied the *Carter* decision on medically-assisted dying legislation said that without good quality palliative care there would be no true choice. We want Canadians to have a choice.”

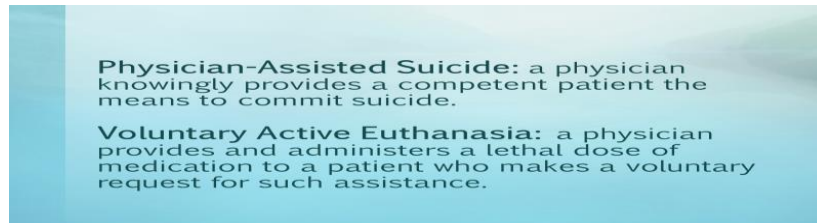
As a parliamentarian, Gladu’s language remained somewhat guarded. Not so with Dr. Shakira Hussein. In a recent debate in Australia over the proposition that euthanasia should be legalized down under, Dr. Hussein was more direct in her support of palliative care: “A society that does not grant speedy and universal access to best practice pain management and palliative care has no business offering euthanasia as a substitute.”

If by 2017 less than 30 percent of Canadians have access to palliative care services, as MP Gladu reported, the division between the medical mainstream model over against a palliative model for end-of-life care seems overwhelmingly evident.

The tension the institution of medically-assisted dying in Canada placed on Parliament to pass the 2017 *Framework on Palliative Care in Canada Act* was a similar tension experienced in the United States in the midst of their physician-assisted suicide debate in the 1990s. By 1998, 20 U.S. states had established commissions to study end-of-life care.

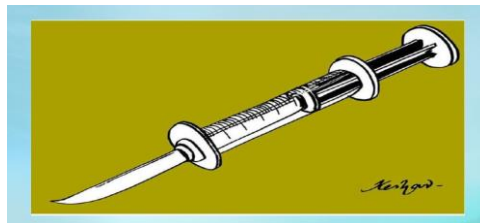


The transformation in Bioethics



In way of clarification, physician-assisted suicide occurs when a physician knowingly provides a competent patient with the means to commit suicide, and the patient makes a voluntary request for this assistance. The patient self-administers the lethal dose of medication.

In contrast, voluntary active euthanasia occurs when a physician provides and administers a lethal dose of medication to a patient who makes a voluntary request for such assistance. Although physician-assisted suicide and voluntary active euthanasia are in theory voluntary requests, the patient has less control when they do not themselves administer a lethal dose of medication. There is concern voluntary active euthanasia is more open to becoming coerced or involuntary precisely because the physician controls the medication administration.



This political cartoon was given the simple title, Euthanasia. An unambiguous critique to say the least.

As previously mentioned, in Canada, the distinction between physician-assisted suicide and voluntary active euthanasia has been subsumed under the umbrella term medically-assisted dying. The semantics here are important. The elimination of the term euthanasia from the Canadian conversation may well have made its use more palatable to the Canadian public.

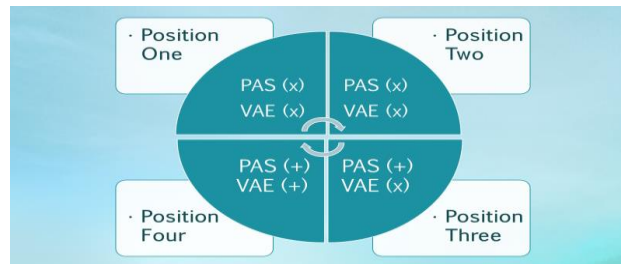
The American Medical Association (the AMA) was recently asked to review its opposition to the legalization of assisted suicide, which dates back to a 2008 position paper from the AMA's Council on Ethical and Judicial Affairs, titled Sedation to Unconsciousness in End-of-Life Care. The AMA was asked to drop "physician-assisted suicide" in favour of the phrase "aid in dying." The AMA's Council rejected the request and reiterated its 2008 position. Here is an excerpt:

In the council's view, despite its negative connotations, the term "physician assisted suicide" *describes the practice with the greatest precision*. Most importantly, it clearly distinguishes the practice from euthanasia. The terms "aid in dying" or "death with dignity" could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

AMA (CEJA)

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The AMA certainly can't be said to be caving to the pressures of public opinion. According to a Gallup poll from June 2017, 73 percent of Americans say, "A doctor should be allowed to end a terminally ill patient's life by painless means if the patient requests it."



Here we have the four basic positions on physician-assisted suicide and voluntary active euthanasia.

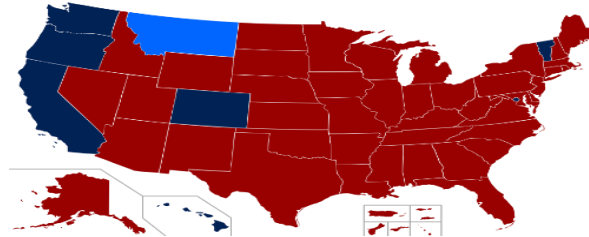
Position one holds that physician-assisted suicide and voluntary active euthanasia are morally wrong and thus proscribed (forbidden). This is the position currently taken by the majority of the nations around the world.

Position two holds physician-assisted suicide and voluntary active euthanasia might be acceptable in rare or exceptional circumstances, yet this legislation would be bad public policy and they should still not be permitted because they might lead to unintended and harmful consequences. (This is the current position held by New York State.)

Position three holds that physician-assisted suicide is permissible and should be legalized. Proponents of this position draw the line on voluntary active euthanasia because they fear it cannot be properly regulated. This mixed position was the basis for legalized physician-assisted suicide in Oregon in 1997.

The fourth position holds that both physician-assisted suicide and voluntary active euthanasia are morally acceptable and should be legalized, because they offer benefit to individuals and society as a whole. Canada falls most comfortably into this fourth position, yet, to date, physician-assisted suicide, and not voluntary active euthanasia, in Canada is severely restricted.

Five U.S. states, and DC have legalized physician-assisted suicide. (Montana doesn't have a law, but rather a Montana Supreme Court ruling protects physicians from prosecution.)



Here's a view of the current breakdown on Physician Assisted Suicide in the United States, as it stands in May 2018. Notice the inclusion of Hawaii. In April 2018, Hawaii overturned its existing legislation to become the seventh U.S. state (and DC) to legalize physician-assisted suicide. The state of Rhode Island is currently considering legalization. New York's Supreme Court upheld a ban on PAS in 2017.

Despite Hawaii's legislation and Rhode Island's hearings, physician-assisted suicide is not gaining ground quickly in the United States. In 2017, physician-assisted suicide bills were introduced in 27 other states and failed to make it to votes.

44 states consider assisted suicide illegal
37 of the 44 have state laws prohibiting assisted suicide

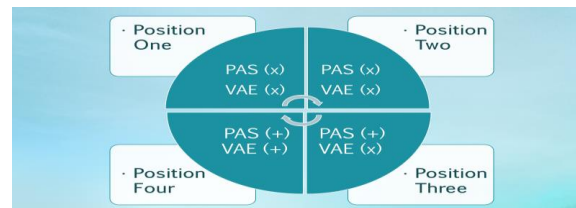
44 U.S. states consider assisted suicide illegal; and 37 states have state laws prohibiting assisted suicide. The federal government and all 50 states prohibit euthanasia under general homicide laws.

The acceptance of euthanasia in Canada is in part due to the view of the hospital (and by extension the physicians who practice there) as a centre of community life within the Canadian universal healthcare system. Though criticized, the hospital in Canada is honoured and trusted. Provincial political campaigns can hinge on whether one party intends to close the local hospital or keep it open. The immense cost of keeping a local hospital operating is often measured over against the political cost of losing an election.

Apart from semantics or the place of the hospital in Canadian life, as the foundational value put forward in support of the right to request medically-assisted dying, autonomy demands primary attention. After all, it's autonomous individuals who are deemed capable of medical decision making, derived from informed consent.



Considerations for Counselling and Psychotherapy in Canada



Canada stands in the fourth position in allowing both physician assisted suicide and euthanasia, or voluntary active euthanasia. Canada can remain in this position without the inclusion of mature minors, those with advanced directives, or those with mental illness as the sole consideration for medically-assisted dying.

When it comes to extending medically-assisted dying in cases of mental illness we do have something to say. Would it prove more impactful for the CCPA to formulate a position on the inclusion of mental health as the sole consideration before the release of the expert panel findings at the end of 2018 or into 2019?

Yes.

Is it still worthwhile if it comes after, regardless of which way the panel recommendations go, and regardless of the federal government's response to the panel findings?

Yes.

It is crucially important that on the organizational level there is no ambivalence on this issue.

Here's why:

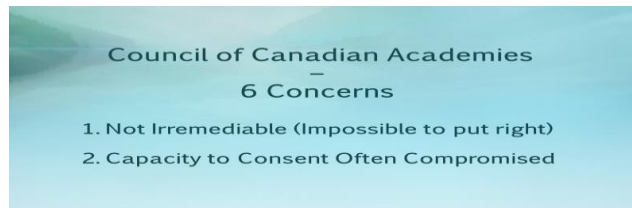
In October 2017, the Institute for Research and Development on Inclusion and Society (IRIS) prepared a background paper for the Council of Canadian Academies, for its assessment of Medical Assistance in Dying.

Under the section titled, Concerns with Access Based Solely on Mental Illness, there are six main concerns over providing access to medical assistance in dying based solely on a mental health condition.

Here I highlight two.

First: No Conclusive Evidence that Mental Health Conditions are Irremediable [that is, impossible to cure or put right].

Second: Capacity to Consent is Often Compromised.



According to IRIS, there is considerable evidence to suggest the apparent ‘futility’ of psychiatric treatments being equated with the conclusion that the condition is in and of itself irremediable. Cases in the Netherlands and Belgium have highlighted the impossibility of making a conclusive finding that an individual’s condition is treatment-resistant. Many individuals whose request has been approved later withdraw their request after receiving alternative treatment and/or therapy.

The Canadian Mental Health Association, in its August 2017 position paper on medical assistance in dying makes clear its opposition to the inclusion of mental illness in the existing legislation as well. The paper states,

While there may be some question as to whether mental illnesses can be included in the term ‘grievous and irremediable medical condition,’ it is our position that the Supreme Court of Canada specifically distinguished their ruling from the laws of other countries such as Belgium which includes ‘euthanasia for minors or persons with psychiatric disorders or minor medical conditions’ (para. 111 of *Carter*). This very important distinction attempts to distance Canada’s legal framework on this issue from other nations that have raised controversy due to their broad policies and administration of the practice. Upon comparison of other jurisdictions that allow for psychiatric-Euthanasia/Assisted Suicide, CMHA’s position that mental illness not be included in this definition becomes clear.

As previously noted, others, like Jocelyn Downie, claim Bill C-14 was responsible for changing the whole tenor of the *Carter* decision.



Secondly, the Council of Canadian Academies notes the capacity to consent is often compromised.

No blanket statement is justified that mental health conditions, by definition, undermine capacity to consent, and jurisprudence in Canada and internationally affirms this, however, clinical depression has been found to interfere with an individual's weighing of short-term and long-term consequences and judgment of circumstances. It can and does compromise consenting capacity.

For Beauchamp and Childress, the obligation to respect autonomy does not extend to persons who cannot act in a sufficiently autonomous manner, and who cannot be rendered autonomous, because they are: immature, incapacitated, ignorant, coerced, or exploited. Infants, irrationally suicidal individuals, and drug-dependent patients are examples of those unable to act autonomously.

Is it time the Canadian Counselling and Psychotherapy Association publish a statement opposing the inclusion of mental illness as the sole basis for medically-assisted dying in Canada? Do we send a contradictory message to our clients and the larger community if we are not united in opposition to the inclusion of mental illness in potential amendments to the existing legislation?

Though it may not be necessary or appropriate for the CCPA to formulate a general position on medically-assisted dying, when it comes to the application of medical assistance in dying specific to mental illness, the CCPA has a clear stake, and I would argue a moral obligation.

Experience matters. Canada is an aging population. Few regions of the country are free from this demographic onslaught. It's not coming down the road; it's now. Our healthcare system is overrun. In the midst of all this, counsellors serve an increasingly vital role in Canadian communities, and greater preparedness is vital.

Becoming steeped in the palliative philosophy and interacting more fluidly with the hospice palliative care professional community is crucial for counsellors and psychotherapists; understanding more about the medically-assisted dying regime in Canada and within one's province/territory/region is crucial; thinking more broadly (that is, epidemiologically), as members of a community public health team, and not insularly as walled-off keepers of a therapeutic hermitage is crucial. All of this is challenging.

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