Medical Assistance in Dying

Medical Assistance in Dying: the Council of Canadian Academies Review is underway

The change in the law that brought about the legal provision of MAiD in Canada also required an independent review of three particularly complex and controversial possibilities for extending access to specific groups currently excluded:

- Through advance requests for those where the necessary decision-making capacity is likely to be lost,
- For mature minors under 18, and
- For those whose intolerable suffering arises from a sole underlying mental health condition.


Who is currently Eligible for Medical Assistance in Dying?

Under the federal law, to receive medical assistance in dying a patient must:

- Be eligible for publicly funded health care services in Canada
- Be 18 years of age or older
- Make the request voluntarily, free from coercion
- Be capable of making health care decisions, and
- Have a grievous and irremediable* medical condition, which means the patient:
  - Has a serious and incurable illness, disease or disability, and
  - Is in an advanced state of irreversible decline in capability, and
  - Is enduring physical or psychological suffering, caused by the medical condition or the state of decline, that is intolerable to the person, and
  - Natural death has become reasonably foreseeable**
- Give informed consent after having received the relevant information about alternatives, including palliative care

Among the safeguards to prevent inappropriate provision of MAiD:

- Signed and independently witnessed written request
- Two independent written assessments confirming eligibility by medical practitioner or nurse practitioner
- 10 days clear reflection period between request and provision
- Capable consent at the point of request AND at the moment of provision
- Option to withdraw is always available, and checked at the point just before provision

With respect to OT practice

There is no offence under the law if you:

- Provide information to a person on the lawful provision of medical assistance in dying.
- Act on a reasonable but mistaken belief about any fact that is an element of the exemption.
- Abstain on conscience grounds. You must follow the guidelines from your regulatory body.

*Some say that the irremediability criterion excludes mental health related requests, if one subscribes to the idea that mental health is never irremediable. Others disagree and point to the reality of refractory mental illness among some people.

**The criterion of reasonably foreseeable natural death excludes those with solely mental health conditions that are causing the intolerable suffering. If a person meets the criteria because of another condition, the mental health condition does not make them ineligible for MAiD, unless it has also affected their capacity for consent. This is not necessarily the case.
Suicide Prevention

The Statistics are Staggering
In Canada, suicide is one of the top ten causes of death (Mental Health Commission of Canada [MHCC], 2017).
- In Canada, suicide is one of the top ten causes of death (Mental Health Commission of Canada [MHCC], 2017).
- Ripple Effect: Breaking it down into people who died by suicide, in 2009, 3,890 people died by suicide in Canada, a rate of 11.5 people per 100,000 people (Navaneelan, 2009).

Current Legal Context on Suicide Prevention in Canada
Bill C-300
- In fall of 2011 an Act Respecting a Federal Framework for Suicide Prevention was introduced to the House of Commons
- The Bill has fully passed in the House of Commons and it is law that there will be a national strategy on suicide
- December 2016 plan unveiled

The Federal Suicide Prevention Framework
- Acknowledges peak high-risk times across the lifespan: for those aged 15-24 years old suicide is the second leading cause of death
- Though men die more often by suicide, women attempt suicide more often
- There is a disproportionate risk for suicide for LGBTQ youth (Public Health Agency of Canada, 2016)

Resources Allotted
- Mental Health Commission of Canada has received government funding for the next 10 years with suicide prevention as one of the key pillars to address (Mental Health Commission of Canada, 2016).
- Significant effort being invested in a variety of sectors where occupational therapists are or should be involved; mental well-being for all Canadians, First Nation and Inuit Communities, incarcerated peoples, well-being in the workplace, Canadian Armed Forces, veterans (Government of Canada, 2016).

Suicide Prevention Role Paper Key Recommendations (in production)
For the Occupational Therapy Profession:
- Psychological safety be explicitly embedded within the practice context of the Canadian Practice Process Framework.
- All occupational therapy students are equipped with gatekeeper training to facilitate an emerging baseline, profession-wide competence in suicide prevention.
- The occupational therapy profession nurtures a culture where all occupational therapists are supported to take all indications of suicide seriously and ask directly about suicide.
- Acknowledge the philosophical underpinnings of the occupational therapy profession position occupational therapists to uncover suicidal ideation more frequently than other disciplines and occupational therapists are therefore at a greater responsibility to address suicide knowledgeable within clinical practice, research and education.

For the Individual Occupational Therapist:
- Occupational therapists across all practice settings equip themselves with gatekeeper training to manage suicide within their practice.
- Occupational therapists become oriented and familiar with key documents that guide suicide prevention for Canadians, such as “Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention” (Public Health Agency of Canada, 2016).
- Occupational therapists take all indications of suicide seriously and ask directly about suicide.
- Occupational therapists should consider suffering itself as an occupational barrier and look for ways to address the suffering.
- Occupational therapists consider how current occupational therapy models can be used to address suicidal ideation, i.e. CMOP-E and PEO.
- Occupational therapists work to identify the full breadth of skills across the shared roles and unique occupational therapy positions for suicide prevention within their practice setting.
The Panel

Marie-Josée Drolet is an occupational therapist and associate professor in the Department of Occupational Therapy at the Université du Québec à Trois-Rivières (UQTR). Holder of a doctorate in philosophy, specializing in ethics, she teaches professional ethics and does research in applied ethics in occupational therapy. She is the author of the book Acting ethically? A theoretical framework and method designed to overcome ethical tensions in occupational therapy practice, published by CAOT. This book contains the method of ethical deliberation that is in part used in this professional issue forum.

Marie-Josee.Drolet@uqtr.ca

Kim Hewitt is an occupational therapist based out of Guelph, Ontario. Kim has worked in a persistent pain-oriented practice setting, mental health-oriented practice settings and education-oriented settings and suicide has absolutely been present in all practice settings. Kim is an Applied Suicide Intervention Skills Training (ASIST) trainer and has trained over 900 people in suicide crisis intervention skills. As an advocate for the role of OT and suicide prevention, Kim has been involved in research, part of a writing team for the CAOT Role Paper on OT and Suicide Prevention and developing the CAOT Network – Addressing Suicide in Occupational Therapy Practice.

Khewitt@cmhaww.ca, kim@pravah.ca

Kevin Reel is a Toronto-based OT who has worked as a practicing healthcare ethicist for the past 10 years in acute care, mental health and community contexts. His prior OT practice was largely community-based and mainly in the United Kingdom. This involved supporting clients living with and dying from a wide range of conditions, both physical and mental health related. His work in both OT and healthcare ethics have informed his perspectives on the merits of both conventional palliative care and assisted dying, and the need for more comprehensive mental health care. Kevin conducted a Canada-wide survey of OT perspectives on assisted dying in 2016 and is involved with the launch of a new CAOT Practice Network for Palliative Care.

kevin.reel@utoronto.ca
Worksheet for ethical reflection (from Drolet 2018)

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<th>Identifying</th>
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<td>Identify spontaneous moral reactions without rational filters (emotional sub-step useful to identify moral biases) while answering these questions:</td>
<td>Assess spontaneous moral reactions (rational sub-step useful to start an ethical reflection by assessing moral biases) while answering these questions:</td>
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<td>➢ What are your spontaneous moral reactions?</td>
<td>➢ Are these reactions desirable?</td>
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<td>o What does this story arouse in you?</td>
<td>o What do they reveal about your values, beliefs, moral biases?</td>
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<td>o What emotions do you feel?</td>
<td>o Are these values, beliefs and moral biases legitimate?</td>
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<td>o If they influence your practice, is it likely to limit clients’ rights, interests, needs or preferences?</td>
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<td>o Should they influence your practice?</td>
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