

Survey of Mental Health Care Providers' Perspectives on the Everyday Ethics of Medical-Aid-in-Dying for People with a Mental Illness

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Article abstract

Context: In most jurisdictions where medical-aid-in-dying (MAiD) is available, this option is reserved for individuals suffering from incurable physical conditions. Currently, in Canada, people who have a mental illness are legally excluded from accessing MAiD. **Methods:** We developed a questionnaire for mental health care providers to better understand their perspectives related to ethical issues in relation to MAiD in the context of severe and persistent suffering caused by mental illness. We used a mixed-methods survey approach, using a concurrent embedded model with both closed and open-ended questions. **Findings:** 477 healthcare providers from the province of Québec (Canada) completed the questionnaire. One third of the sample (34.4%) were nurses, one quarter psychologists (24.3%) and one quarter psycho-educators (24%). Nearly half of the respondents (48.4%) considered that people with a severe mental illness should be granted the right to opt for MAiD as a way to end their suffering. Respondents were more likely to feel comfortable listening to the person and participating in discussions related to MAiD for a mental illness than offering care or the means for the person to access MAiD. Most (86.2%) reported that they had not received adequate/sufficient training, education or preparation in order to address ethical questions surrounding MAiD. **Conclusions:** The findings highlight how extending MAiD to people with a mental illness would affect daily practices for mental healthcare providers who work directly with people who may request MAiD. The survey results also reinforce the need for adequate training and professional education in this complex area of care.



ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Survey of Mental Health Care Providers' Perspectives on the Everyday Ethics of Medical-Aid-in-Dying for People with a Mental Illness

Marjorie Montreuil^{1,2,4}, Monique Séguin^{2,3}, Catherine P. Gros^{1,2,5}, Eric Racine^{4,6,7}

Résumé

Contexte: Dans la plupart des juridictions où l'aide médicale à mourir (AMM) est disponible, cette option est réservée aux personnes souffrant d'affections physiques incurables. À l'heure actuelle, au Canada, les personnes atteintes d'une maladie mentale sont légalement exclues de l'AMM. **Méthodes:** Nous avons développé un questionnaire à l'intention des soignants en santé mentale afin de mieux comprendre leurs points de vue sur les questions éthiques liées à l'AMM dans le contexte de souffrances graves et persistantes causées par une maladie mentale. Nous avons employé une méthode mixte, utilisant un modèle intégré avec des questions fermées et ouvertes. **Résultats:** 477 soignants de la province du Québec (Canada) ont rempli le questionnaire. Un tiers de l'échantillon (34,4%) étaient des infirmières, un quart des psychologues (24,3%) et un quart des psychoéducateurs (24%). Près de la moitié des personnes interrogées (48,4%) ont estimé que les personnes atteintes d'une maladie mentale grave devraient avoir le droit d'opter pour l'AMM afin de mettre fin à leurs souffrances. Les répondants étaient plus susceptibles de se sentir à l'aise d'écouter la personne et de prendre part aux discussions sur l'AMM pour une maladie mentale que d'offrir des soins ou les moyens à la personne d'accéder à l'AMM. La plupart (86,2%) ont déclaré ne pas avoir reçu de formation, d'éducation ou de préparation adéquate/suffisante pour traiter les questions éthiques liées à l'AMM. **Conclusions:** Les résultats soulignent comment l'extension de l'AMM aux personnes atteintes de maladie mentale affecterait les pratiques quotidiennes des soignants en santé mentale travaillant directement avec des personnes susceptibles de demander l'AMM. Les résultats soulignent également les besoins de formation et d'éducation professionnelle adéquates dans ce domaine complexe de soins.

Mots-clés

suicide assisté, aide médicale à mourir, enquêtes et questionnaire, santé mentale, prestataires de soins de santé, éthique

Abstract

Context: In most jurisdictions where medical-aid-in-dying (MAiD) is available, this option is reserved for individuals suffering from incurable physical conditions. Currently, in Canada, people who have a mental illness are legally excluded from accessing MAiD. **Methods:** We developed a questionnaire for mental health care providers to better understand their perspectives related to ethical issues in relation to MAiD in the context of severe and persistent suffering caused by mental illness. We used a mixed-methods survey approach, using a concurrent embedded model with both closed and open-ended questions. **Findings:** 477 healthcare providers from the province of Québec (Canada) completed the questionnaire. One third of the sample (34.4%) were nurses, one quarter psychologists (24.3%) and one quarter psycho-educators (24%). Nearly half of the respondents (48.4%) considered that people with a severe mental illness should be granted the right to opt for MAiD as a way to end their suffering. Respondents were more likely to feel comfortable listening to the person and participating in discussions related to MAiD for a mental illness than offering care or the means for the person to access MAiD. Most (86.2%) reported that they had not received adequate/sufficient training, education or preparation in order to address ethical questions surrounding MAiD. **Conclusions:** The findings highlight how extending MAiD to people with a mental illness would affect daily practices for mental healthcare providers who work directly with people who may request MAiD. The survey results also reinforce the need for adequate training and professional education in this complex area of care.

Keywords

assisted suicide, medical-aid-in-dying, surveys and questionnaire, mental health, healthcare providers, ethics

Introduction

Whether individuals suffering from an incurable illness should have the legal right to access medical-aid-in-dying (MAiD) remains a subject of ongoing debate worldwide. Even more controversial is the question of whether MAiD should also be available as a means for people to end suffering caused by severe mental illness. While a number of countries have passed legislation authorizing MAiD for people with life-limiting physical conditions, Belgium, Luxembourg and the Netherlands are currently the only countries in which MAiD is also allowed for a mental illness. This practice is tolerated, but not officially adopted, in Switzerland (1).

Since 2016, eligible Canadian citizens have the right to request and receive MAiD. Canadian federal legislation stipulates that MAiD is reserved for people with a "grievous and irremediable" illness whose death is "reasonably foreseeable" (2); a recently introduced bill (February 24, 2020), however, proposes changes to Canada's *Criminal code* provision on MAiD that would, whilst assuring procedural safeguards, remove the 'reasonably foreseeable death' criteria (3). The law governing MAiD in the province of Quebec was somewhat narrower since individuals requesting MAiD had to have the additional criteria of being at the end of life (4,5), although these two criteria were invalidated by the Superior Court of Quebec on September 11, 2019 (6). Across all Canadian provinces and Territories, including Quebec, access to MAiD is denied for people whose suffering is related to psychiatric illness alone – a situation which has sparked significant public debate (7,8). In 2016, the federal government asked for an expert report on requests for MAiD for patients for whom mental illness is the only medical condition (9). Released in 2018, this report highlighted the multiplicity of perspectives on MAiD for a severe mental illness (10).

In light of the above, we conducted a survey in order to explore the perspectives of health care providers (HCPs) working in mental health regarding the ethical issues they encounter in their practice (or would encounter if the law were extended to people with a mental illness) with patients who experience intense mental suffering and who might choose to die as a result.

There has been much debate within the academic literature regarding the permissibility of access to MAiD on the grounds of mental illness alone, and associated ethical, legal, and practical challenges (9,11-13). Concerns include issues of capacity and capacity assessment, as well as the conflict between MAiD and the impetus in mental health care to prevent suicide. Little research has examined HCPs' perspectives on ethical aspects of MAiD for mental illness alone, especially among HCPs who specialize in this area. Karesa and McBride (14) surveyed Canadian psychologists' knowledge and perceptions of MAiD from both personal and professional perspectives. They found that respondents supported MAiD for terminal, but not mental, illness. Further, respondents had limited confidence in their ability to assess the competence of terminally ill patients to consent and felt they lacked the training to do so (14). A survey of 528 psychiatrists in Canada on their attitudes toward MAiD for mental illness found that most psychiatrists (70.6%) did not support this practice (15). Surveys have also been conducted with physicians and psychiatrists in the United States and the Netherlands on their attitudes and willingness to provide MAiD in the context of mental illness, and highlighted HCPs' low levels of confidence in their ability to assess the appropriateness of MAiD in the case of a mental illness diagnosis (16,17). Sheehan et al. (13), in a review of cases of requests for MAiD for a mental illness, similarly emphasized a need for educational resources to train current and future mental health providers about MAiD.

The Everyday Ethics of Medical Aid in Dying

The field of bioethics has traditionally focused on “dramatic” ethical issues, associated with, for example, uncommon high-technology and life-threatening interventions (18). We here address MAiD from both this traditional perspective and an everyday ethics perspective. Indeed, focusing exclusively on high stakes situations may lead to oversights regarding ethically charged situations that arise in the day-to-day work of HCPs (19). Recognizing and unpacking these issues is important, both to facilitate their appropriate management in the clinic, but also to ensure that ethics education and resources for HCPs provide the tools to effectively address these issues (19,20).

There is limited literature on the issues of everyday ethics related to MAiD in the context of mental illness alone. Within the literature related to MAiD in general, different ethical concerns for HCPs have been identified through surveys and qualitative studies. These concerns include: assessment of the decision-making capacity of the person who requests MAiD (21), the importance of respecting the person's wishes while preventing potential abuse of decision-making power (22), the pressure HCPs can receive from patients and/or family members to provide MAiD (23,24), and difficulty in navigating discussions with caregivers, especially in cases in which the person is non-verbal (25,26). The emotional impact of MAiD on HCPs has also been emphasized, highlighting the intensity of this practice, as well as the potential negative emotions that compete with the HCPs' will to respect the person's wishes, provide relief and offer a “good death” (27,28). Personal religious beliefs can also influence professionals' views and attitudes toward MAiD, affecting their daily experiences in relation to these practices (16,17). MAiD has also been described as contrary to HCPs' mandate to heal, which could lead to death being perceived as a routine part of everyday practice and thus trivialized (29).

Suicide and Medical Aid in Dying

The distinction between suicide and MAiD is not entirely clear. MAiD is sometimes described as the “thoughtful desire to see your death hastened to end suffering caused by a life-threatening illness” (30, p.15, free translation), whereas suicide involves the desire to end one's life due to suffering from a difficult situation that is not, in itself, considered to be life-limiting. Similarly, the not-for-profit organization Dying With Dignity Canada emphasizes that suicide, or the desire to end one's life, may be a symptom of a mental illness, such as schizophrenia or severe depression, guided by “feelings of hopelessness” whereas MAiD is characterized by wanting “the comfort of knowing that, if worse comes to worst, [patients] faced with a terminal illness will be afforded the choice of a gentle death” (31).

In countries where MAiD for mental illness is legally permitted (i.e., Belgium, Luxembourg, the Netherlands), proponents argue that the suffering due to a mental illness is comparable to the suffering from other medical conditions (32,33). This view changes the focus of psychiatric practice from suicide prevention in all instances, to a recognition that ending one's life could be acceptable if there is “unbearable or untreatable suffering” caused by a mental illness. On the other hand, some argue that in consideration of the vulnerable status of people with a mental illness, allowing MAiD for mental illness alone would be against the recovery model largely prevalent in mental health care (34), and a failure to help people who might feel hopeless, isolated and devalued in our society (35).

It remains unclear whether the general issues identified in the literature on MAiD (in cases of physical/terminal illness and on suicide) represent the ethical challenges HCPs perceive in relation to MAiD in the context of mental suffering alone, in the event it were legally permitted (18). Producing a more robust understanding of the potential everyday ethical challenges of MAiD for mental illness would offer insight into the implications for mental health providers of adopting these practices. We surveyed mental HCPs in order to understand the perceived ethical issues they encounter when caring for patients who wish to die based on severe and persistent mental illness. Our specific study question was: What are the perspectives of mental HCPs in Quebec (Canada) on the ethics of MAiD in the context of severe and persistent suffering caused by mental illness alone? We also explored mental HCPs' perceived training needs in relation to ethical issues related to MAiD.

Methods

Sub-heading We used a mixed-methods survey approach, using a concurrent embedded model in which a questionnaire was developed that included both closed and open-ended questions (36). The questionnaire had four main sections: 1) demographic information; 2) practices related to MAiD; 3) everyday ethics; and 4) training needs. In each section, close-ended questions asked participants how frequently they experience ethical challenges associated with the topic under study. Ethical challenges were identified in a literature review and in consultation with an (interdisciplinary) interprofessional working group composed of four HCPs (i.e., two nurses, one psychologist and one social worker, as well as an ethicist). Open-ended questions asked participants to elaborate on their replies to the close-ended questions (i.e., rationale for their choice, explanation, example from their practice) and included specific questions such as “What other ethical challenges have you encountered in your own practice with patients who express a desire to die?” Questions from existing questionnaires on MAiD and everyday ethics for HCPs were adapted to our specific study questions (14,20,37). The questionnaire also collected demographic information about respondents’ profession or job title, work environment, age, years of practice, previous formal ethics training or education, and religious/spiritual beliefs. The study received approval from the Research Ethics Board of the *Institut de recherches cliniques de Montréal* and was conducted in accordance with the Canadian Tri-Council Policy Statement principles. Informed consent was obtained from each participant before participating to the study.

Pilot-Testing

Before the survey was launched, it was pilot-tested via a pre-test (38) and examination of the best means to collect the data. Six mental health experts with different professional/work titles were recruited to offer feedback on the questionnaire. For example, questions were asked regarding clarity of the questions, how they were understood, and people’s willingness to answer the questions. A pilot-test was also performed with one mental health team in the form of two workshops lasting 75 minutes each, in which members of the team reviewed the questionnaire. Feedback from the experts and the cognitive pre-test were used to revise the questionnaire. The survey was made available in French and English.

Data Collection Procedures

To facilitate recruitment for the survey, seven professional or clinical associations/colleges within Québec were contacted. The questionnaire was available both online (through the SurveyMonkey platform) and in paper form to accommodate people’s preferences. Envelopes with pre-paid postage were given to participants to mail the completed paper questionnaires back to the research team. Data from paper forms were subsequently entered in the online survey software by a member of the research team to facilitate analysis. Each participant who had completed the survey was eligible to enter a raffle to win a prize comprised of two sets of books on the topic of ethics for HCPs (39).

Data Analysis

All quantitative analyses were conducted with SPSS for Windows version 20 (IBM 2011). Frequencies were computed for categorical questions, and descriptive statistics (mean and standard deviations) were computed for continuous questions. Differences between groups based on profession, age and level of professional experience were assessed with chi-square statistics (categorical questions) and univariate analysis of variance (continuous questions). Odds ratio (OR) and their 95% confidence intervals (CI) were calculated when significant chi-square statistics were detected. Qualitative analyses were conducted through a coding process (40). A matrix was created in Excel that included all the codes identified. We then compared and contrasted the codes to create themes. In the presentation of the results, we combined the quantitative and qualitative data as relevant, following a concurrent mixed-methods framework (41).

Results

The present sample was composed of 477 HCPs from the province of Québec, Canada. Approximately one third of the sample were nurses, one fourth were psychologists, and one fourth were psycho-educators. While our initial survey intended to reach a wide range of health and social professionals, very few outside of the categories of nurses, psychologists or psycho-educators responded (their numbers are presented in Table 1), and these other professionals were excluded from further statistical analysis based on statistical relevance. Table 1 presents the socio-demographic and professional profiles of the respondents, and the setting where the professionals work is further categorized according to profession in Table 2. It is noteworthy that most participants had prior training in ethics, with only 10.5% reporting no prior training. While only 9.9% of respondents reported being religious and practicing and 25.8% reported being religious but not practicing, more than a quarter (26%) reported that their religious beliefs and affiliations have an influence on their work.

Table 1. Respondents' socio-demographic and professional profiles

		Frequencies	
		Percentages, % (n)	
Profession	Nurses	34.4	(159)
	Psychologists ^a	24.3	(116)
	Psycho-educators	24.0	(111)
	Social workers	6.71	(32)
	Social interveners	2.8	(13)
	Specialized educators	1.1	(5)
	Occupational therapists	1.3	(6)
	Physicians	0.6	(3)
	Nursing assistants	0.2	(1)
	Patient care attendants	0.2	(1)
	Other	3.2	(15)
Workplace	Public services in the community	23.9	(114)
	Private practice	19.1	(91)
	External clinic	17.2	(82)
	General psychiatric unit	14.7	(70)
	Specialized psychiatric unit	13.2	(63)
	Community organization	8.80	(42)
	Other	19.5	(93)
Age (in years)	18-24	3.70	(17)
	25-34	22.1	(102)
	35-49	42.6	(197)
	50-64	26.6	(123)
	65+	5.00	(23)
Years of professional experience	0-5	19.0	(88)
	6-10	18.4	(85)
	11-15	19.0	(88)
	16-20	12.3	(57)
	20+	31.2	(144)
Previous training in ethics	University course	59.7	(285)
	Discussion groups	26.0	(124)
	Workshops	23.5	(112)
	Written information	19.7	(94)
	Peer support	17.8	(85)
	Presentation from an expert	16.6	(79)
	Mentoring	11.1	(53)
	Online training	10.9	(52)
	Specific training	9.60	(46)
	None	10.5	(50)
	Other	4.6	(22)

^a The category "psychologists" also includes sexologists who participated to the survey.

Table 2. Workplace of the respondents by profession

Workplace ^a	Nurses (n = 159)		Psycho-educators (n = 111)		Psychologists (n = 116)	
	Percentages, % (n)		Percentages, % (n)		Percentages, % (n)	
Specialized psychiatric unit	29.6	(47)	3.6	(4)	3.6	(4)
General psychiatric unit	35.8	(57)	0.9	(1)	0.9	(8)
External clinic	25.2	(40)	9.0	(10)	9.0	(18)
Private practice	3.1	(5)	11.7	(13)	11.7	(64)
Public service in the community	17.0	(27)	48.6	(54)	48.6	(18)
Community organization	1.3	(2)	8.1	(9)	8.1	(5)
Other	19.5	(31)	25.2	(28)	25.2	(19)

^a Respondents could choose multiple workplaces therefore the total of each sample size column does not equate to the total number of respondents per profession (number of respondents per profession was used to calculate percentages)

Experience and attitude regarding MAiD for a terminal physical illness

Table 3 presents the quantitative results and statistical analyses of data pertaining to the experiences and attitudes of respondents from the top three professions in the sample, regarding MAiD for individuals with a terminal physical illness. Half of the respondents reported having provided care to people with a terminal illness (49.6%) and a quarter (26.3%) reported

having provided care to people who indicated the desire to receive MAiD. Nurses were more likely than psycho-educators (OR = 6.41, 95% CI: 3.62-11.33) and psychologists (OR = 3.98, 95% CI: 2.32-6.82) to have provided care to people with a terminal illness ($\chi^2(2) = 47.36$, $p < .001$). Similarly, nurses were more likely than psycho-educators (OR = 3.23, 95% CI: 1.67-6.28) and psychologists (OR = 2.21, 95% CI: 1.21-4.02) to have provided care to people who indicated wanting to receive MAiD ($\chi^2(2) = 14.17$, $p < .001$).

Table 3. Experience and attitude regarding MAiD for individuals with a terminal physical illness, all respondents and by profession

	All respondents (n=407)		Nurses (n=141)		Psycho-educators (n=99)		Psychologists (n=103)	
	Percentages, % (n)		Percentages, % (n)		Percentages, % (n)		Percentages, % (n)	
Within your work, have you provided care to people with a terminal illness? ^a								
Yes	49.6	(202)	71.6	(101)	28.3	(28)	38.8	(40)
No	46.7	(190)	27.0	(38)	67.7	(67)	56.3	(58)
Uncertain	3.7	(15)	1.4	(2)	4.0	(4)	4.9	(5)
Have you provided care to people who indicated they would like to receive MAiD? ^a								
Yes	26.3	(107)	34.8	(49)	14.1	(14)	19.4	(20)
No	71	(289)	63.8	(90)	83.8	(83)	74.8	(77)
Uncertain	2.7	(11)	1.40	(2)	2.0	(2)	5.8	(6)
In your opinion, should people with a terminal physical illness and who have the capacity to consent to care have the right to opt for MAiD?								
Yes	78.6	(320)	82.3	(116)	87.9	(87)	69.9	(72)
Yes, but only under certain conditions	14.0	(57)	12.8	(18)	9.1	(9)	16.5	(17)
No	1.0	(4)	2.1	(3)	0	(0)	0	(0)
Uncertain	5.7	(23)	1.4	(2)	3.0	(3)	12.6	(13)
Prefer not to answer	0.7	(3)	1.4	(2)	0	(0)	1.0	(1)
In general, do you believe you have received adequate training, education, or some other sufficient preparation to address ethical questions surrounding MAiD for those with a terminal physical illness? ^a								
Yes	16.5	(67)	24.8	(35)	5.10	(5)	17.5	(18)
No	78.9	(321)	69.5	(98)	92.9	(92)	76.7	(79)
Uncertain	4.7	(19)	5.7	(8)	2.0	(2)	5.8	(6)

^a There is a statistically significant association between profession and the answer to this question ($p < .001$; ***); *uncertain* and *prefer not to answer* responses were not included for the statistical analyses

The idea that people with a terminal physical illness have the right to receive MAiD is largely accepted, with 78.6% of the respondents agreeing with this notion and an additional 14% agreeing provided that specific conditions are met. No significant differences were detected based on respondents' profession, age or professional experience. However, the vast majority of respondents (78.9%) believed they had not received the training, education or other preparation required to adequately address the ethical questions surrounding MAiD for this population ($\chi^2(2) = 17.28$, $p < .001$). Psycho-educators were more likely than nurses (OR = 5.77, 95% CI: 2.47-13.46) and psychologists (OR = 3.99, 95% CI: 1.63-9.76) to report not having received enough training to respond to the ethical questions about MAiD for people with a terminal physical illness. No significant differences were detected on this question based on respondents' age and levels of professional experience.

Experience and attitude regarding MAiD for a severe and persistent mental illness

Three quarters (75.9%) of respondents reported having provided care to people who said they wanted to die because of severe and persistent mental or psychological suffering, as shown in Table 4. Similarly, over two thirds (69%) of respondents believe that their work and profession would be involved with practices pertaining to MAiD for individuals who suffer solely from a severe and persistent psychiatric/mental illness, in the event that the law is extended to this population. Acceptance for this eventual practice was shared by almost half of the participants (48.4%), who agreed that people with only a severe mental illness may have the right to opt for MAiD (agree = 21.9%; agree only in specific conditions 26.5%). Respondents' age and years of professional experience were not found to be significantly related to acceptance level, but respondents' profession was ($\chi^2(2) = 6.54$, $p < .05$). Specifically, nurses (OR = 0.42, 95% CI: 0.25-0.71) and psycho-educators (OR = 0.48, 95% CI: 0.28-0.86) were more likely than psychologists to agree that people with only a severe mental illness should have the right to opt for MAiD, at least under certain conditions. More psychologists were uncertain about their position compared to the other professions.

Table 4. Experience and attitude regarding MAiD for individuals with a severe psychiatric/mental illness, all respondents and by profession

	All respondents (n=407) ^a		Nurses (n=141) ^a		Psycho-educators (n=99)		Psychologists (n=103) ^a	
	Percentages, % (n)		Percentages, % (n)		Percentages, % (n)		Percentages, % (n)	
Have you provided care to people who said they want to die in relation to mental/psychological suffering?								
Yes	75.9	(309)	74.5	(105)	70.7	(70)	78.6	(81)
No	22.4	(91)	24.1	(34)	27.3	(27)	19.4	(20)
Uncertain	1.7	(7)	1.4	(2)	2.0	(2)	1.9	(2)
In your opinion, should people with only a severe psychiatric/mental illness (i.e., people who do NOT have a terminal physical illness) and who have the capacity to consent to care have the right to opt for MAiD?								
Yes	21.9	(89)	24.8	(35)	29.3	(29)	12.6	(13)
Yes, but only under certain conditions	26.5	(108)	33.3	(47)	25.3	(25)	24.3	(25)
No	24.6	(100)	23.4	(33)	20.2	(20)	27.2	(28)
Uncertain	26.5	(108)	17.7	(25)	25.3	(25)	35.0	(36)
Prefer not to answer	0.5	(2)	0.70	(1)	0.0	(0)	1.0	(1)
In the event that the law on MAiD extends to individuals who suffer solely from a severe and persistent psychiatric/mental illness, do you anticipate that your work/profession will be involved in these practices? ^b								
Yes	69.0	(281)	73.8	(104)	63.6	(63)	63.1	(65)
No	10.8	(44)	7.1	(10)	15.2	(15)	15.5	(16)
Uncertain	19.9	(81)	19.1	(27)	21.2	(21)	20.4	(21)
In general, do you believe you have received adequate training, education, or some other sufficient preparation to address ethical questions surrounding MAiD for people with a severe psychiatric/mental illness? ^b								
Yes	7.1	(31)	7.1	(10)	5.1	(5)	10.7	(11)
No	86.2	(351)	85.8	(121)	87.9	(87)	84.5	(87)
Uncertain	5.9	(24)	6.4	(9)	7.1	(7)	4.9	(5)

^a The n for the last two questions equals 406, as one respondent from the nurses and one from the psychologists chose the *does not apply* answer;

^b There is a statistically significant association between profession and the answer to this question ($p < .05$; *, and $p < .001$; ***, respectively); *uncertain* and *prefer not to answer* responses were not included for the statistical analyses. An overwhelmingly high percentage of respondents (86.2%) reported the belief that they had not received adequate or sufficient training, education or other preparation in order to address the ethical questions surrounding MAiD for people with a severe psychiatric/mental illness (Table 4). This data is slightly higher but similar to insufficient training to address the ethical questions surrounding MAiD for a physical illness (78.9%). No significant differences were detected based on respondents' professions, age, and years of professional experience.

For the open-ended question asking about the difference between MAiD and suicide, the main difference stated by 151 respondents pertained to a temporary state for suicide versus a permanent wish to die for MAiD. Many respondents (103) also mentioned that suicide was an impulsive decision (e.g., as part of a crisis situation) in contrast to MAiD, which respondents viewed as a thoughtful process involving the capacity to make informed decisions. Still in relation to the difference between MAiD and suicide, 47 respondents associated MAiD with people who experience suffering due to a chronic illness that also affects the person's quality of life. In contrast, suicide was viewed as a response to intense mental suffering that is contextual and situation-specific in nature. Thirty-nine respondents perceived that people who request MAiD have a "real desire to die", while suicidal people seek "relief" or escape from temporary suffering. Other respondents reported that they saw no difference between the two terms, while a few highlighted that the practice of MAiD was guided by a law, while suicide was not. Some respondents shared their concern that distinguishing between MAiD and suicide in a mental health context is problematic and worrisome.

Levels of comfort with MAiD for people with severe mental illness

Respondents were asked to evaluate their level of comfort (on a scale of 0 corresponding to "not at all" to 9 "absolutely") in relation to five dimensions pertaining to MAiD for people with severe psychiatric/mental illness, should the law be extended to this population (Table 5). On average, respondents reported a fairly high level of comfort related to the dimension of *communicating*, such as listening and discussing the topic of MAiD with a person who has a psychiatric/mental illness (mean = 7.46, SD = 2.02) and *participating in a discussion* associated with MAiD with a person who suffers from a psychiatric/mental illness (mean = 6.80, SD = 2.55).

Table 5. Levels of comfort with five dimensions of MAiD for people with severe psychiatric/mental illness, all respondents

	All respondents
	Mean (SD)
Communicating (i.e., listening and discussing) with a person who has a psychiatric/mental illness about MAiD	7.46 (2.02)
Accompanying/providing care to an individual who suffers from a psychiatric/mental illness and who said he would like to receive MAiD	5.95 (2.96)
Participating in a discussion associated with MAiD with a person who suffers from a psychiatric/mental illness	6.80 (2.55)
Assessing the abilities of a person who suffers from a psychiatric/mental illness to make a decision about MAiD	3.65 (3.11)
Providing the necessary means to an individual so that he/she can access MAiD	3.52 (3.34)

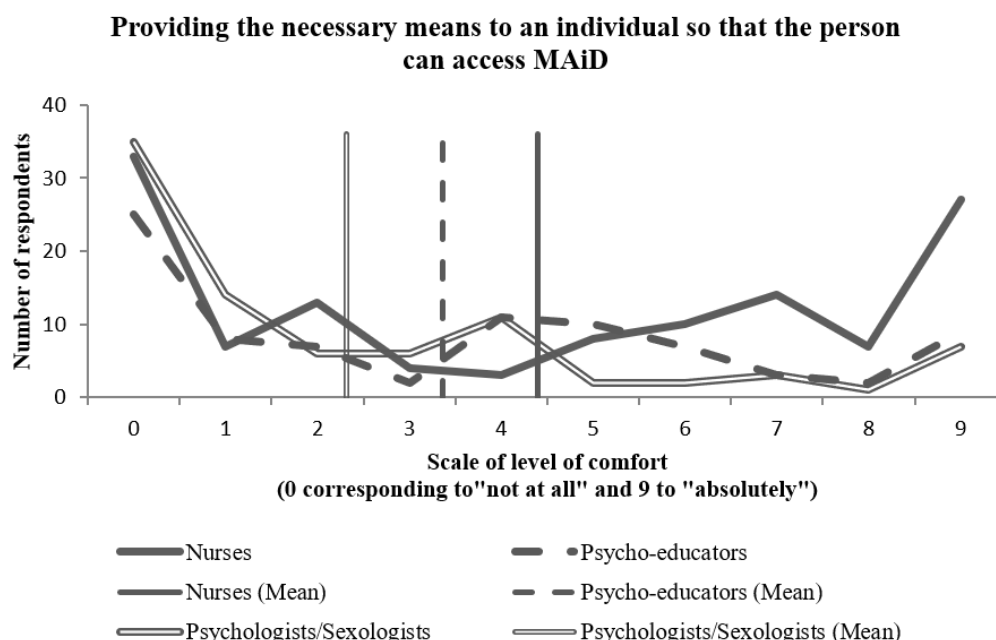
The scale used was from 0 corresponding to "not at all" to 9 "absolutely"

Per respondents' age. Significant differences were found on the dimension related to *assessing the abilities* of a person who suffers from a psychiatric/mental illness to make a decision about MAiD based on participants' age ($F(4, 350) = 3.372, p < .01$). The 65+ age group (mean = 5.59, SD = 3.54) reported significantly higher levels of comfort than the 25-34 years old group (mean = 2.88, SD = 3.19) and the 35-49 years old group (mean = 3.58, SD = 3.29). Similarly, the 50-64 years old group (mean = 4.12, SD = 3.31) reported levels of comfort with this dimension significantly higher than the 25-34 years old group (mean = 2.88, SD = 3.19).

Per respondents' level of professional experience. Significant differences were also detected on three dimensions (*accompanying/providing care*, *participating in a discussion*, and *assessing the abilities*) based on respondents' levels of professional experience with more experience being associated with higher levels of comfort. Respondents who had 20 years of professional experience or more reported significantly higher levels of comfort in the three above-mentioned dimensions ($F(4,363) = 3.59, p < .01$; $F(4,380) = 3.79, p < .01$; $F(4,350) = 3.63, p < .01$) than the other groups.

Per respondent's profession. Significant differences, based on respondents' profession, were found for all but one dimension (*communicating* with a person who has a psychiatric/mental illness about MAiD). Overall, nurses reported statistically higher levels of comfort than psycho-educators and/or psychologists within the four other dimensions pertaining to MAiD for people with severe psychiatric/mental illnesses. Specifically, nurses reported significantly higher levels of comfort ($F(2,306) = 3.04, p < 0.05$ *) than psycho-educators in the dimension of *accompanying/providing care* and significantly higher levels of comfort ($F(2,318) = 3.97, p < .05$) than psychologists in the dimension *participating in a discussion*. Nurses reported significantly higher level of comfort ($F(2,291) = 4.42, p < .01$; $F(2,295) = 10.48, p < .001$) than psycho-educators and psychologists in the dimensions of *assessing the abilities* and *providing the necessary means*, respectively. The distribution of responses for the levels of comfort with *providing the necessary means* so a person can access MAiD is noteworthy: contrary to psychologists and psycho-educators, the nurses' responses show high peaks at both ends of the scale (Figure 1). While the mean is lower than neutral, indicating lower levels of comfort, the standard deviation is quite large and highlights that many nurses were quite comfortable in providing the necessary means to an individual to access MAiD for a psychiatric/mental illness alone.

Figure 1. Distribution of responses (including means), by profession, for the dimension pertaining to the levels of comfort with *providing the necessary means* to an individual to access MAiD



Per respondents' previous education through specific training type. Regarding previous education, a small proportion of respondents (9.6%) who reported receiving specific training in ethics and who felt adequately prepared to address questions related to MAiD for people with physical illness, also had statistically significant higher mean scores in their reported level of comfort along all five dimensions ($F(1,395) = 5.178, p < .05$; $F(1,366) = 21.068, p < .001$; $F(1,383) = 6.540, p < .05$; $F(1,353) = 5.018, p < .05$; $F(1,358) = 22.834, p < .001$).

We also examined whether being in agreement with MAiD had an impact on the participants' level of comfort with the various procedures related to MAiD. We analyzed the differences in the levels of comfort within the five dimensions of MAiD for people with severe psychiatric/mental illness between the respondents' answer to the question "In your opinion, should people with only a severe psychiatric/mental illness (i.e., people who do NOT have a terminal physical illness) and who have the capacity to consent to care have the right to opt for MAiD?". We found that there was a statistically significant difference in the levels of comfort pertaining to the different dimensions of MAiD based on the respondents' answer to the question above ($F(15,751.27) = 5., p < 0.0005$, Wilk's $\lambda = 0.761$, partial $\eta^2 = .087$). The answers to whether or not people with only a severe psychiatric/mental illness should have the right to opt for MAiD have a statistically significant effect on the levels of comfort for all five dimensions of MAiD ($F(3,276) = 12.72, p < 0.0005$; $F(3,276) = 17.09, p < 0.0005$; $F(3,276) = 16.69, p < 0.0005$; $F(3,276) = 11.80, p < 0.0005$; $F(3,276) = 18.85, p < 0.0005$). Mean scores in the reported levels of comfort along all five dimensions were statistically significantly different between those who answered 'Yes' and 'Yes, but only under certain conditions' with those who answered 'No' and 'Unsure', but not between those who answered 'Yes' and 'Yes, but only under certain conditions' and those who answered 'No' and 'Unsure'.

Discussion

In this study, we surveyed HCPs' about their perspectives on the ethics of MAiD in the context of severe and persistent suffering caused by mental illness, as well as on their training needs in terms of ethical issues related to MAiD.

MAiD and Suicide

When addressing MAiD in the context of a mental illness, general, everyday issues related to suicide are at the forefront. The survey results highlight that HCPs tend to see suicide as a more impulsive and temporary state, which contrasts with MAiD as a more reflective process that is sustained over time. This view aligns with the report from the Council of Canadian Academies on MAiD for a mental disorder as the only medical condition in a person who wishes to die (9). In this report, which presents the state of knowledge on this topic, two perspectives are presented on suicide and MAiD, which both differentiate them: 1) the perspective that suicide is against the value of life (both in secular and religious terms) and that a person who is suicidal does not have sound decision-making capacity due to symptoms of a mental health disorder; and 2) the perspective that people who are suicidal have the potential to live a fulfilling life if appropriate means are put in place to support them (without reference to religious beliefs). The ideas of impulsivity and ambivalence are presented in the report for both perspectives as important characteristics of suicide and this is in alignment with the survey results. These characteristics were presented as

specific to suicide, as MAiD cannot be accessed impulsively and has to be a decision that is sustained over time. The view that MAiD and suicide are different is also shared by both proponents and opponents of MAiD for a mental illness (42,43).

In contrast, certain suicide prevention associations and authors do not differentiate between MAiD and suicide, since both MAiD and suicide represent self-directed death (44-46). This view is exemplified in certain countries where MAiD is labelled as “assisted-suicide” (i.e., in Luxembourg, Netherlands and Switzerland). In Canada, where our survey was conducted, the use of the term “suicide” is not part of the main discourse on MAiD. Opening up the discussion to MAiD in the context of a mental illness raises this issue directly and this would have a tangible effect on HCPs working with people considered to be suicidal in a mental health context. For example, currently in Canada, people who are suicidal are largely perceived as not having the capacity to make an informed decision in relation to their well-being. This view also tends to be present in the context of a serious and persistent mental illness (42,43). Extending MAiD to people with a mental illness would challenge these views, the stigma attached to mental illness, and how HCPs care for people with a mental illness who wish to die based on mental suffering. Many survey respondents highlighted the capacity to make an informed decision as a difference between suicide and MAiD. This ethical issue related to capacity would require further attention to better understand how it would affect clinical practice in mental health and suicide prevention.

Everyday Ethics in Mental Health Care Related to MAiD

In a mental health context, allowing MAiD for a mental illness only would likely change HCPs everyday practices. A salient example would be the therapeutic relationship and care. By changing the focus of mental health care from suicide prevention to discussion of potentially accessing MAiD, there would be a form of acceptance of a person ending their life. For instance, in Belgium, it has been reported that for certain people who are suicidal, knowing they could have access to MAiD (referred to as euthanasia in Belgium) and being able to discuss this option led them to choose to continue living, “because simply having this option gave them enough peace of mind to continue living” (32). There would thus be a shift in HCPs daily interactions with people who might wish to die based on mental suffering.

Certain authors argue that extending MAiD to mental suffering alone could lead to a decrease in the will to develop a therapeutic relationship with people who are suicidal and lead to a feeling of hopelessness for the HCP (47). Since HCPs often work in emotionally charged environments, this may contribute to compassion fatigue and a decreased involvement with people who are suicidal and seek MAiD. This argument has been critiqued as being too narrow and not recognizing that the feeling of hopelessness could be felt with or without the availability of MAiD in this context (43). These divergent perspectives reflect the division within the survey results, with about half of respondents supporting and half not supporting extending MAiD to people with a mental illness.

Most HCPs in the survey considered they would be somewhat comfortable discussing MAiD with a person who has a mental illness. However, this comfort decreased in relation to assessing, accompanying or providing care to a person who would want to receive MAiD for a mental illness and dropped significantly in relation to providing the means. Nurses were notably more comfortable than other HCPs with these aspects of care. Nurses are directly affected by the legalization of MAiD (48) and extending it to mental illness would also directly affect their practice, as reported in this survey. These changes to health care practices – in the current Canadian context of MAiD not being available in the case of a mental illness – already warrant specific training to address the emerging needs for all HCPs (48).

Mental HCPs’ Training Needs in Relation to MAiD

The perceived need for training on MAiD in a mental health context was clear from the survey results. Most HCPs who responded to the survey reported they had not received adequate training and support to address ethical issues related to MAiD. Participants who disagreed on – or were unsure about – access to MAiD in a mental health context had statistically significant lower levels of comfort than their counterparts who considered that access to MAiD should be allowed – or allowed under certain conditions – in a mental health context. These results align with other studies conducted on MAiD in different countries where MAiD is permissible (49-54). It is noteworthy that education and specific training in ethics does positively impact the reported levels of comfort along all five dimensions for MAiD. In terms of support to address ethical issues related to MAiD in a mental health context (without MAiD being permissible for people with a mental illness), training could be offered on how to accompany a person who wants to access MAiD, provide care, as well as participate in a discussion with the person and family. Issues around suicide and MAiD would be of primary relevance. They could, for example, be addressed following a more reflective approach in which HCPs are invited to share their own experiences to foster engagement in discussing this sensitive topic (55,56). This approach is also encouraged in training related to suicide prevention given the numerous ethical issues at play (18,57), which would also be of value for MAiD. This training could be a companion to further efforts to raise greater awareness about general health care ethics. Given the extensive nature of public debates about MAiD in Quebec and in Canada over the last years, this topic has become iconic of certain issues related to palliative care, end-of-life, therapeutic communication, and informed decision-making. It could thus be an opportunity to increase health care ethics training and to tackle common issues related to moral awareness in the workplace.

Limitations

This study was conducted with HCPs who self-declared as working in mental health contexts, and for statistical analyses, we only included data from groups in which there were sufficient numbers of respondents for comparative analyses. Physicians, who are the ones performing the evaluation for a person to access MAiD in Canada, were noticeably almost absent (only 3 respondents). A study of their perspectives on the everyday ethics of MAiD would also be of great interest. Moreover, this study was conducted solely in the province of Quebec. Given the cultural differences between Quebec and the rest of Canada, the results may not be representative of the views of Canadian HCPs nationally.

Within the questionnaire used for this survey, we chose to study MAiD in the context of severe and persistent mental illness, which could have affected the results. This decision was made in alignment with current practices related to MAiD for a mental illness in other countries. We also asked questions related to HCPs' training needs in relation to MAiD and suicide with the current Canadian legislation (which excludes people with a mental illness from accessing MAiD), while asking questions related to how extending MAiD to people with a mental illness will influence practice. This distinction was clearly mentioned in the questionnaire but might have affected the training needs identified.

Future Directions

This survey presents the perspectives of 477 HCPs from the province of Québec, Canada, on the everyday ethics of MAiD for people suffering with mental illness. Extending the survey to other Canadian provinces, as well as to countries considering MAiD for a mental illness would be warranted. Understanding the everyday ethics of MAiD contributes to enhancing an understanding of how it may affect daily practices for HCPs who work directly with people who may request MAiD. While offering an important view, this survey does not necessarily present the perspectives of people who have a mental illness or who are suicidal (or have been), nor the perspectives of their relatives. Future work on additional perspectives would bring many additional voices to this conversation that are currently missing in the discussions on MAiD for a mental illness. We anticipate various issues related to research ethics would be raised in order to ethically discuss this sensitive topic, but with adequate safeguards it would greatly contribute to a more thorough understanding of this important issue.

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Aucun à déclarer

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Conflicts of Interest

None to declare

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References

1. Jones RM, Simpson AIF. Medical assistance in dying: challenges for psychiatry. *Front Psychiatry*. 2018;9:678.
2. Chapter 3 : An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), Bill C-14, House of Commons, First Session, Forty-second Parliament, 64-65 Elizabeth II Sess. (2016).
3. Department of Justice. [Proposed changes to Canada's medical assistance in dying legislation](#). Government of Canada; 2020.
4. Government of Canada. [Medical assistance in dying](#). Government of Canada; 2019 [updated 24.04.2019].
5. Gouvernement du Québec. [Medical aid in dying](#). Government of Quebec; 2019.
6. Truchon v. Attorney General of Canada, 500-17-099119-177 (2019).
7. Chiose S. [Adam Maier-Clayton's death renews debate on assisted-dying access for those with mental illness](#). The Globe and Mail. 2017 Apr 16.
8. Glauser W, Nolan M, Petch J. [Should people with mental health disorders have access to physician-assisted death?](#) *Healthy Debate*. 2016 Jan 21.
9. Council of Canadian Academies. [The state of knowledge on medical assistance in dying where a mental disorder is the sole underlying medical condition](#). Ottawa (ON): The Expert Panel Working Group on MAiD Where a Mental Disorder Is the Sole Underlying Medical Condition. 2018.
10. Council of Canadian Academies. [The state of knowledge on advance requests for medical assistance in dying](#). 2018.
11. Appelbaum PS. [Should mental disorders be a basis for physician-assisted death?](#) *Psychiatric Services*. 2017;68(4):315-7.
12. Schuklenk U, van de Vathorst S. [Treatment-resistant major depressive disorder and assisted dying](#). *Journal of Medical Ethics*. 2015;41(8):577.
13. Sheehan K, Gaiand KS, Downar J. [Medical assistance in dying: special issues for patients with mental illness](#). *Curr Opin Psychiatry*. 2017;30(1):26-30.
14. Karesa S, McBride D. [A sign of the changing times? Perceptions of Canadian psychologists on assisted death](#). *Canadian Psychology/Psychologie canadienne*. 2016;57(3):188-92.
15. Rousseau S, Turner S, Chochinov HM, Enns MW, Sareen J. [A national survey of Canadian psychiatrists' attitudes toward medical assistance in death](#). *Canadian journal of psychiatry / Revue canadienne de psychiatrie*. 2017;62(11):787-94.
16. Bolt EE, Snijderwind MC, Willems DL, van der Heide A, Onwuteaka-Philipsen BD. [Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living?](#) *Journal of Medical Ethics*. 2015;41(8):592.
17. Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD. [Attitudes of Oregon psychiatrists toward physician-assisted suicide](#). *American Journal of Psychiatry*. 1996;153(11):1469-75.
18. Zizzo N, E Bell, Racine E. [What is everyday ethics? a review and a proposal for an integrative concept](#). *Journal of Clinical Ethics*. 2016;27(2):117-28.
19. Zizzo F. [The integration of mental health into primary care: international perspectives](#). 2015. In: *The World Book of Family Medicine - European Edition*. Istanbul, Turkey: WONCA Europe [88-90].
20. Moon M, Taylor HA, McDonald EL, Hughes MT, Carrese JA. [Everyday ethics issues in the outpatient clinical practice of pediatric residents](#). *Archives of pediatrics & adolescent medicine*. 2009;163(9):838-43.
21. Kissane DW, Kelly BJ. [Demoralisation, depression and desire for death: problems with the Dutch guidelines for euthanasia of the mentally ill](#). *Australian and New Zealand Journal of Psychiatry*. 2000;34(2):325-33.
22. Lavoie M, Godin G, Vezina-Im LA, Blondeau D, Martineau I, Roy L. [Psychosocial determinants of physicians' intention to practice euthanasia in palliative care](#). *BMC Medical Ethics*. 2015;16:6.
23. Blanker MH, Koerhuis-Roessink M, Swart SJ, Zuurmond WWA, van der Heide A, Perez RSGM, et al. [Pressure during decision making of continuous sedation in end-of-life situations in Dutch general practice](#). *BMC Family Practice*. 2012;13(1):68.
24. Swart SJ, Brinkkemper T, Rietjens JA, Blanker MH, van Zuylen L, Ribbe M, et al. [Physicians' and nurses' experiences with continuous palliative sedation in the Netherlands](#). *Arch Intern Med*. 2010;170(14):1271-4.
25. Draper BM. [Suicidal behavior and assisted suicide in dementia](#). *Int Psychogeriatr*. 2015;27(10):1601-11.
26. Tomlinson E, Spector A, Nurock S, Stott J. [Euthanasia and physician-assisted suicide in dementia: A qualitative study of the views of former dementia carers](#). *Palliat Med*. 2015;29(8):720-6.
27. Denier Y, Dierckx de Casterle B, De Bal N, Gastmans C. ["It's intense, you know." Nurses' experiences in caring for patients requesting euthanasia](#). *Medicine Health Care and Philosophy*. 2010;13(1):41-8.
28. van Marwijk H, Haverkate I, van Royen P, The AM. [Impact of euthanasia on primary care physicians in the Netherlands](#). *Palliat Med*. 2007;21(7):609-14.

29. Boudreau JD, Somerville M. Euthanasia and assisted suicide: a physician's and ethicist's perspectives. *Medicolegal and Bioethics*. 2014.
30. Gupta M, Rivest J, Leclair S, Blouin S, Chammas M. [Exploration de la souffrance psychique dans le cadre d'une demande d'aide médicale à mourir](#). Groupe de recherche sur la souffrance psychique et l'AMM, Département de psychiatrie, CHUM et CRCHUM; 2017.
31. Dying With Dignity Canada. [Why medically assisted dying is not suicide](#). 2016 Sept 23.
32. Melville NA. [Assisted suicide for mental illness gaining ground](#). Medscape. 2015 Jul 31.
33. Thienpont L, Verhofstadt M, Van Loon T, Distelmans W, Audenaert K, De Deyn PP. [Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study](#). *BMJ Open*. 2015;5(7):e007454.
34. Mental Health Commission of Canada. [Recovery Guidelines](#). Ottawa, ON: Mental Health Commission of Canada; 2015.
35. Chochinov HM. [The risky concept of mental illness assisted suicide](#). The Huffington Post. 2016 Mar 28 (Updated 2017 Mar 29).
36. Creswell JW. *Research design: Qualitative, quantitative, and mixed methods approaches*, 3rd ed. Thousand Oaks, CA, US: Sage Publications, Inc; 2009. 260 p.
37. Bator EX, Philpott B, Costa AP. [This moral coil: a cross-sectional survey of Canadian medical student attitudes toward medical assistance in dying](#). *BMC Med Ethics*. 2017;18(1):58.
38. Collins D. [Pretesting survey instruments: An overview of cognitive methods](#). *Quality of Life Research*. 2003;12(3):229-38.
39. Bowling MJ, Rimer BK, Lyons EJ, Golin CE, Frydman G, Ribisl KM. [Methodologic challenges of e-health research](#). *Evaluation and Program Planning*. 2006;29(4):390-6.
40. Maxwell JA. *Qualitative research design: an interactive approach: An Interactive Approach*: SAGE Publications; 2013.
41. Creswell JW, Plano Clark VL. *Designing and conducting mixed methods research*. Los Angeles, CA: SAGE Publications; 2011.
42. Dembo J, Schuklenk U, Reggler J. ["For their own good": a response to popular arguments against permitting medical assistance in dying \(MAID\) where mental illness is the sole underlying condition](#). *Canadian Journal of Psychiatry / Revue canadienne de psychiatrie*. 2018;63(7):451-6.
43. Rooney W, Schuklenk U, van de Vathorst S. [Are concerns about irremediableness, vulnerability, or competence sufficient to justify excluding all psychiatric patients from medical aid in dying?](#) *Health Care Anal*. 2018;26(4):326-43.
44. Centre for Suicide Prevention. [Physician-Assisted Death/MAID and Suicide](#). 2018.
45. Kim SYH, Conwell Y, Caine ED. [Suicide and physician-assisted death for persons with psychiatric disorders: how much overlap?](#) *JAMA Psychiatry*. 2018;75(11):1099-100.
46. Vandenberghe J. [Physician-assisted suicide and psychiatric illness](#). *N Engl J Med*. 2018;378(10):885-7.
47. Blikshavn T, Husum TL, Magelssen M. [Four reasons why assisted dying should not be offered for depression](#). *J Bioeth Inq*. 2017;14(1):151-7.
48. Suva G, Penney T, McPherson CJ. [Medical assistance in dying: a scoping review to inform nurses' practice](#). *J Hosp Palliat Nurs*. 2019;21(1):46-53.
49. Castelli Dransart DA, Scozzari E, Voélin S. [Stances on assisted suicide by health and social care professionals working with older persons in Switzerland](#). *Ethics & Behavior*. 2017;27(7):599-614.
50. Downar J, Green S, Radhakrishnan A, Wales J, Kim G, Seccareccia D, et al. [An entrustable professional activity descriptor for medical aid in dying: a mixed-methods study](#). *CMAJ Open*. 2018;6(4):E657-E63.
51. Feldt KS, Bond GE, Jacobson D, Clymin J. [Washington State Death with Dignity Act: implications for long-term care](#). *Journal of Gerontological Nursing*. 2011;37(10):32-40.
52. Liz Cunha de Oliveira M, de Oliveira Cavalcanti E, Alves V, Costa da Silva A. [Euthanasia from the perspective of nursing undergraduate students: concepts and challenges](#). *Reme: Revista Mineira de Enfermagem*. 2014;18(1):134-14.
53. Marcoux I, Boivin A, Arsenault C, Toupin M, Youssef J. [Health care professionals' comprehension of the legal status of end-of-life practices in Quebec: study of clinical scenarios](#). *Can Fam Physician*. 2015;61(4):e196-e203.
54. Van Wesemael Y, Cohen J, Onwuteaka-Philipsen BD, Bilsen J, Deliens L. [Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium](#). *BMC Health Services Research*. 2009;9(1):220.
55. Johns C. *Becoming a reflective practitioner*: John Wiley & Sons; 2009.
56. Schön DA. *The reflective practitioner: how professionals think in action*. London: Routledge; 1992. 384 p.
57. Fiske H. *Hope in Action: Solution-focused conversations about suicide*. Taylor & Francis; 2012.