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Medical Assistance in Dying (MAiD): Ethical Considerations for Psychologists

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Psychologists' Involvement with Medical Assistance in Dying

The terms physician assisted suicide and euthanasia often appear in popular media discussing circumstances in which someone takes steps to cause or hasten a person's death. For purposes of this paper, euthanasia refers to an intentional act by someone (other than the patient or dying person) to cause death and is illegal throughout the United States. In some jurisdictions, encouraging or assisting a person to end their own life can result in criminal charges. Bioethicists sometimes parse the definition given above as "active euthanasia," as contrasted with death by omission, as when withdrawing or withholding treatment, or indirectly causing death as a side effect of treatment (BBC, 2014). Examples might include decisions to suspend or defer chemotherapy in advanced cancer cases or to administering morphine to a patient with severe terminal lung disease and air hunger with full recognition that the morphine will slow respiration accelerate death. MAiD differs from palliative or comfort care by allowing the patient to hasten their own death. For detailed information and links to relevant state laws see: <https://www.compassionandchoices.org/about-us/medical-aid-dying-not-assisted-suicide/>. Many of the jurisdictions authorizing MAiD require the patient to establish residency.

Some people seeking to end their own lives for any reason may find themselves involuntarily committed to a psychiatric facility as a danger to themselves. Although no federal laws mandate reporting suicidal thoughts or risk, most United States jurisdictions designate mental health professionals and others who may encounter such individuals (e.g., physicians, nurses, teachers, home care workers, etc.) as legally mandated reporters or otherwise require them to take protective steps when a patient or person to whom they owe a duty of care

expresses suicidal ideas or intent based on duty to protect laws (i.e., aimed at both protecting others post-Tarasoff and suicide), so-called “red flag” statutes, or firearm regulations (See as examples: Illinois DHS FOID Reporting System; National Conference of State Legislatures; The Network for Public Health Law, 2018; New York State SAFE Act, 2022; United States Concealed Carry Association, 2022).

Medical aid in dying (MAiD) encompasses voluntary euthanasia, where a physician prescribes medication to a competent adult patient with a terminal illness at the patient's request, knowing the patient intends to end their life. The patient can then self-administer the lethal dose of medication at a time of their own choosing. In some circumstances, as when the patient's physical condition restricts their own ability to act, a health care provider may assist at a patient's request. Patients seeking to use MAiD must typically have a terminal illness with a prognosis of death within six months or less. Typically, two physicians must independently attest to the prognosis and a mental health professional must often weigh in to confirm “sound mind,” lack of coercion, intact decisional capacity, consideration of all other alternatives, and similar factors.

A growing number of jurisdictions explicitly exempt physicians and other health care professionals from criminal prosecution when they assist in or directly cause the death of certain patients who voluntarily request it. At the time of this writing some form of MAiD authorization exists as statute or case law in eleven U.S. jurisdictions plus Australia, Belgium, Canada, Columbia, Germany, Luxemburg, Netherlands, and Switzerland (Jones & Simpson, 2018; Mroz, et al, 2021; VandeKieft, 2020). In a 2018 Gallup poll (Brenan, 2018) 72% of Americans agreed that physicians should have the ability to help terminally ill patients die.

However, semantics seem important because the numbers dropped to 65% if the words “commit suicide” appeared in the survey, and only 54% described “physician-assisted suicide” as morally acceptable. Some religious groups have actively opposed MAiD legislation, and it currently remains illegal and subject to criminal prosecution in a majority of U.S. states. As an example, Massachusetts voters narrowly defeated a “physician assisted death initiative” labelled “Act Relative to Death with Dignity” in 2012 with a vote of 51.9% opposed, following strong opposition by the Catholic church.

The Role of Psychology When MAiD is Legally Authorized.

Many jurisdictions that authorize MAiD include a role for psychologists or other mental health professionals to provide information when requested by patients, to determine their capacity to provide competent (fully informed) consent, and to assist individuals contemplating MAiD in evaluating the related decisions, exploring all options, and considering potential consequences of each alternative. Another role for mental health clinicians involves assisting in the determination of whether concurrent mental health issues or disorders contribute to the patient’s experience of intolerable physical and/or psychological suffering, and whether other treatment options acceptable to the patient may exist.

As the case discussion will illustrate, palliative or comfort care is an important option for many patients, but not for all. Some patients will find the level of medication necessary to provide optimal pain relief leads to experiencing a kind of unacceptable “brain fog.” Other conditions may result in an experienced loss of dignity or level of debilitation that palliation efforts cannot address. The American Psychological Association (APA) has adopted a policy statement on palliative care and end of life issues (APA, 2017a) that identifies patient and

societal needs and calls for services related to this life stage but does not specifically address assistance in dying. The Canadian Psychological Association (CPA) has approved detailed MAiD practice guidelines (CPA, 2020) in the context of national legislation discussed later.

An important challenge to making use of MAiD involves the six-month prognosis requirement typically included in most statutes. Many fatal medical conditions may have longer courses including extended periods of significant physical debilitation, discomfort, and mental distress. For example, most people diagnosed with Alzheimer's Disease will likely survive much longer than six months but may not wish to live in a declining or debilitated state. Maintaining decisional capacity in the face of such a diagnosis can pose an insurmountable hurdle for someone whose brain is deteriorating. In addition, symptoms associated with mental illness (e.g., depression, anxiety, paranoia, or hallucinations) can co-occur or develop as a function of neurological deterioration and become a source of additional suffering for patients. Such symptoms can also affect patients' capacity to make competent medical decisions. At least four jurisdictions have established criteria for MAiD that incorporate a broader range of situations in which a non-terminal disorder causes the patient "intractable" or "unbearable pain" or "a grievous and irredeemable medical condition" (Emanuel, et al., 2016).

Family members of such patients may often have strong feelings about MAiD that flow from concerns about the welfare and suffering of their relative. Additional distress among family members can include "burn-out" from care giving, distress about the cost of care, worries about inheritance, cultural or religious beliefs, and more. Family members may disagree among themselves and with the patient regarding the appropriateness of MAiD. Similarly, certain institutions in which a patient resides may subscribe to values that oppose

MAiD. In this context all individuals and institutions in the nexus may seek to engage as third-party participants in any discussions but, as a matter of patient autonomy and self-determination, should have no decisional authority unless an advance directive comes into play by virtue of the patient becoming permanently incompetent. Although such worries may also weigh on the patient, medical and mental health care professionals must ethically focus on the patient's preferences so long as the patient has the ability to communicate with competent decisional capacity.

The Canadian Experience

Canada decriminalized suicide in 1972 and the Province of Quebec adopted MAiD legislation in 2014. A court decision legalized MAiD across Canada in 2016. Political disagreements in the Canadian legislature recently led to removal of MAiD exclusions for patients with nonterminal chronic illnesses and allow its use when psychological or physical suffering becomes intolerable and untreatable (House of Commons of Canada, 2020; Bryden, 2021; Komrad, 2021). On March 17, 2021, at the behest of Dr. Stan Kutcher, a psychiatrist and Canadian Senator, significant changes to Canada's MAiD legislation (Revised Statutes of Canada - RSC 241) came into effect. The change involved a disagreement over whether or not a patient can invoke MAiD if a mental illness is the sole condition causing suffering. A temporary exclusion until March 17, 2023, has allowed the Government of Canada and its national health professional bodies more time to consider any necessary protocols and safeguards before allowing MAiD access to those whose only medical condition is a mental illness.

Patients who have a mental illness along with other medical conditions may currently qualify to seek MAiD in Canada based on "unbearable suffering." The assessment must include

an expert in the patient's particular medical condition that causes the suffering. In addition, the patient must be informed of available and appropriate means to relieve their suffering, including counselling services, mental health and disability support services, community services, and palliative care, and must be offered consultations with professionals who provide those services. This evaluation must take a minimum of 90 days unless the assessments are completed sooner, and the patient stands at immediate risk of losing capacity to consent. Finally, immediately before providing MAiD, the prescribing practitioner must give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD (Komrad, 2021).

Ethical Fundamentals for Psychologists' Involvement in MAiD

Traditional biomedical ethicists will often default to Beauchamp and Childress (2022), arguably the most frequently cited authorities, with special attention focused on their narratives addressing respect for autonomy, non-maleficence, and beneficence. Apart from the general foci, each mental health profession also has tailored ethical standards and guides, but for purposes of this manuscript attention is focused on the psychological ethics. APA's key ethical principles (APA, 2017b) demanding our consideration with respect to MAiD include primarily beneficence/non-maleficence under *Principle A* and respect for people's rights and dignity (including self-determination and personal welfare) *Principle E*. To a lesser extent *Principle B* (fidelity and responsibility), *Principle C* (integrity) and *Principle D* (justice) may also apply. We want to avoid causing harm to those we serve, promote the well-being and autonomy of our patients, uphold the trust patients and society place in us, and assure that we act with honesty, truthfulness, and in a fair and unbiased way to all of those who seek our care.

With the general principles in mind, we must apply elements of the numbered sections of the enforceable *APA Code of Conduct* as described below. Following their numerical sequence element is framed with questions we must ask ourselves. Some readers may feel annoyed by the lack of specific instructions. However, specific fact patterns or contexts may alter our choices and decisions, no single rote pathway will apply to all patients.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If we have mandated obligations under law to report patients who pose harm to themselves and are not covered by a MAiD statute, must we intervene to interrupt the plan by the patient to hasten their death? What level of certainty (on a continuum from suspicion to a clear expressed intent) must we have before acting?

1.03 Conflicts Between Ethics and Organizational Demands

If we work for an organization authorized to offer MAiD services (or opposed to offering them), but hold different personal values about assisting a person in ending their life, how do we balance the conflict? Should we decline to participate if we cannot set aside personal conscious biases? What should we do if a third party (e.g., our employer or government agency) dictates our participation?

2. Competence

What skills will we require to accurately address the requirements of MAiD statutes in our jurisdiction? What personal and professional skills will we require to competently serve patients in an end-of-life context? Where will we acquire education and training to perform such roles? Are we aware of any religious or cultural contexts that require consideration in the patient's decision-making?

2.06 Personal Problems and Conflicts

Do any personal problems or conflicts such as one's own medical condition, similar illness in one's family, or experiencing the death of a loved one from suicide or severe illness create distress or other personal conflicts that should preclude our participation?

3.04 Avoiding Harm

How can we assure that we are not harming patients who seek MAiD by prolonging suffering or by failing to assure that they have considered all reasonable treatment options (particularly when mental health symptoms come into play)?

3.05 Multiple Relationships

How can we best assure that our decision-making or professional behavior in MAiD contexts does not become compromised by multiple roles? Could any aspect of our prior relationship with the patient or some other relationship, such as our cultural, religious, political, or social perspectives compromise our actions?

3.06 Conflict of Interest

Do we hold other social or professional roles, personal core values, or strong beliefs, such as cultural, religious, political, or social perspectives noted under 3.05, that might impair our objectivity in performing a MAiD assessment?

3.07 Third-Party Requests for Services

If asked by someone other than the patient to become involved with MAiD, how do we assure that I hold the patient's interests and well-being paramount?

3.09 Cooperation with Other Professionals

MAiD will typically require interdisciplinary collaboration. How do we best prepare for and function in that context? How do we respond if we have a disagreement with others on the treatment team?

3.10 Informed Consent

How do we assure that the patient can make a fully informed and voluntary decision about MAiD, particularly if anxiety, depression, or some level of cognitive impairment is present? MAiD statutes do not typically apply to children, who cannot legally give consent.

3.11 Psychological Services Delivered to or Through Organizations

How do we assure that the patient's interests and rights are upheld, even though our services come through an organization whose interests may not be totally congruent interests with those of the patient?

4. Privacy and Confidentiality

How do we best protect the privacy and confidentiality of the patient with respect to conflicting obligations we may have under law? How do we deal with cultural contexts in which family members expect to become involved?

9. Assessment

How do we best assess patient competencies and other relevant issues in the MAiD context?

Three Challenging Cases

Ethical, moral, philosophical, theoretical, and theological reasoning lend themselves to extended debate that cannot easily translate to action in the press of real time. Three actual examples may help to flesh out the complexities. The first two described below have contrived

fictitious names and altered details to protect the confidentiality of the parties. Psychologists had a treatment role in each of those cases. The third case involves public information and is fully identifiable per the wishes of the patient, a psychologist (Henig, 2015).

Case 1 – Mike Marlboro

At age 45, Mike was a ranch supervisor in a rural area of a state with MAiD legislation. He had never given that much thought until after his “twitchy muscles” led to a diagnosis of ALS (amyotrophic lateral sclerosis). As he quickly learned, ALS is a progressive fatal disease of the nervous system affecting nerve cells in the brain and spinal cord, causing loss of muscle control, eventual paralysis, and death from respiratory insufficiency. Typically, the disease progresses over 2 to 5 years post diagnosis, but 20% of patients live for more than 5 years, and about 5% live for 20 years or more. Maintaining an optimistic outlook can improve quality of life for people with ALS, but progression of the disease ultimately leads to total dependence on caregivers and often memory problems, decision-making difficulty, and frontotemporal dementia prior to their death.

At the medical center where Mike learned the diagnosis, his treatment team included a psychologist who met with Mike at every clinic visit and stayed connected regularly via telehealth when he returned to his home 200 miles away. Despite an initially stoic and taciturn demeanor, Mike nicknamed his ALS specialist “Dr. Neuron,” and jokingly called his psychologist “Dr. Feelings.” Mike worked hard to cope emotionally with ALS. Dr. Feelings diagnosed him as having an “adjustment disorder with depressed mood.” She saw Mike as a thoughtful, introspective, loner who took pride in his independence and ability to take care of himself. An only child, whose parents were deceased, Mike enjoyed hunting, camping, and socializing with

a half dozen close friends. Still, he did not share his diagnosis with anyone outside the medical team.

About six months post diagnosis, Mike's noticed symptoms of increased fatigue, balance problems, occasional slurred words, and a weakening grip. Dr. Neuron brought Dr. Feelings into a feedback meeting with Mike to explain that his condition seemed to have progressed from early to mid-stage ALS, he should probably quit driving, and he might want to consider moving closer to the city where personal care assistance could be more readily available. Mike took a deep breath and said, "Doc, I think it's time to take another trail." Mike had read about his state's MAiD statute. He said that he had done a lot of thinking about it, and wanted to, "Go out on my own terms." Dr. Neuron explained that he understood and respected Mike's thinking but explained that the statute required that the terminal condition be "expected to result in death within six months," and that Mike still had "a lot more good time left." He wrote Mike a prescription for an anti-depressant, told him not to do anything rash, and urged Mike talk it over with Dr. Feelings, promising to follow up at the clinic visit next month.

Dr. Feelings stayed with Mike after Dr. Neuron left. Mike was subdued, but calm, deliberate, and rational. He expressed anger that the six-month life expectancy requirement might force him to live with becoming more debilitated and dependent. Dr. Feelings listened carefully and attempted focused problem-solving with Mike. At the end of the session Mike seemed in a better frame of mind. He agreed to follow up with a telehealth visit by Dr. Feelings the next day and headed home.

At sunrise, the next morning Drs. Neuron and Feelings received a text message from Mike. He explained that he understood the limitations in the state MAiD law and had stayed up

all night thinking things over. Waiting for the disease to progress further “just would not work” for him. He thanked them both for taking good care of him and included a phone number for the local sheriff’s office, 20 miles from his home. He asked them to, “Please call the sheriff and have them send someone out to the ranch, but there is no need to rush. They will find my body on the front porch.” Immediate calls back to his phone went unanswered.

Case 2 – Neo Plasm

At age 21 and recently graduated from a highly prestigious college Neo would normally have had a promising life ahead of them. They had considered themselves lucky, having survived nearly 5 years following the diagnosis of a soft-tissue sarcoma. This particular “high grade” (aggressive) tumor had progressed to stage 4B, meaning that metastases had spread to areas of the body distant from the original site and subjected Neo to periods of considerable muscle and bone pain. Neo had worked with a psychologist (Dr. Jan) at the cancer treatment center for several years and had often shared their concern about declining quality of life. A few months ago, Neo told Dr. Jan that they had planned “a self-directed exit” if the pain came back again. Although no MAiD law existed in their state, Neo hinted that they could, “Get help from the ‘rents,” as both of his parents were physicians, one a psychiatrist, and “have access to the meds I’d need.”

One afternoon Neo came by the oncology clinic without an appointment and left small gifts for the nurses and physicians who cared for them. Neo seemed upbeat and in no emotional distress. Dr. Jan was in her office when Neo quickly visited and presented her with a small, gift-wrapped box, telling her that they wanted her to have it because she was the wisest person they knew and because she had been a great support to him through cancer treatment

and college. The box contained Neo's Phi Beta Kappa key. Alarm bells of an impending suicide went off in Dr. Jan's head and she paged her supervisor. They consulted and agreed that Dr. Jan should meet with Neo immediately and express concern about their mental state and suicide risk. Dr. Jan pulled Neo into her office for an impromptu session and began discussing her concerns. Neo smiled and said, "I know you care about me but don't worry. Everything will be fine. You can do a mental status exam and run through a suicide checklist if you want." Neo denied any symptoms of distress or suicidal ideation with a sly smile and headed home.

Later that night Neo died peacefully at home. The parents placed a call to Neo's oncologist who went to their home at 11:00 p.m. to sign a death certificate. A mortuary picked up Neo's body and cremated it the next morning.

Case 3: Sandra "Sandy" Bem

Sandy's story appeared in print about a year following her death (Henig, 2015), and readers are encouraged to read the very moving full account from which the following very brief and necessarily superficial summary is drawn.

Sandy at age 65 was an international nationally known psychology professor and personality researcher at Cornell University. One evening in May 2009 she watched an HBO documentary called "The Alzheimer's Project" and experienced a concerning epiphany. Over the prior two years she had experienced what she called "cognitive oddities" such as forgetting the names of things or confusing words. She sought a neuropsychological assessment and learned that she had an amnesic mild cognitive impairment which would progress to Alzheimer's disease. Over ensuing weeks, Sandy shared the diagnosis with Daryl, her ex-husband with whom she remained emotionally close, her adult children, and others closest to

her. She told them that she planned to end her life before she became incapable of doing so. None of those in her inner circle tried to talk her out of eventual suicide, because they all knew that once her, she set her mind to something, she would not back down. Seeking a peaceful exit, Sandy wrote in her journal: "What I want is to die on my own timetable and in my own nonviolent way."

After reading Philip Nitschke's "The Peaceful Pill Handbook," Sandy decided to use the barbiturate pentobarbital, as a reliable, fast-acting, and gentle way to die. She was able to obtain the drug by mail from Mexico and stored it for later use. In 2014, as her condition progressed, she talked with Daryl over dinner about setting a date. Sandy had created a paper trail to make certain that authorities could not hold anyone else responsible for her death. This included a document stating why she wanted to die, saying that no one else had provided help or offered advice on her plan. Sandy made it clear that her death was her decision alone. She set a date with the support of Daryl and her family and took the medication to end her life on May 20, 2014, five years after learning the diagnosis and shortly before her 70th birthday.

Discussion

Mike's personality, lifestyle, and wishes seemed clear but his circumstances ran afoul of his state's "six months to live" criterion. He lacked the information and resources that enabled Sandy to search out and find the means to plan her exit. Dr. Neuron and Dr. Feelings had the knowledge to tell him about alternatives or refer him to some of the same books that Sandy relied on but might have been precluded from doing so by state law or fear of pushing him in that direction. They both failed to sense the determination and immediacy that Mike felt or recognize that the reality of his decline in function clarified by Dr. Neuron might move him to

act. It is possible that more intensive intervention in the moment, while Mike was in the clinic might have delayed his suicide – but would that have been to his advantage, or would he have continued to lose sleep and suffer emotionally as he waited out the inevitable next decline? We do not know about other factors that might have influenced the behavior of Drs. Neuron and Feelings. They certainly understood that Mike, with access to firearms on the ranch, had the means to swiftly end his life. Perhaps Dr. Neuron was so fixed on the fact that Mike was years from dying that he failed to sense Mike's distress. Dr. Feelings felt concerned enough to plan a 24 hour follow up, but she also knew that Mike was not a candidate for an involuntary hospitalization as risk prevention. In the end Mike took charge himself in a manner he was familiar with on the ranch.

Neo presented a more obvious ethical conundrum. They had clearly spoken with their oncologist and psychologist, Dr. Jan, about their quality of life concerns and plans if severe pain returned. A very perceptive Dr. Jan felt worried enough to call her supervisor for guidance. They both understood that Neo was medically and psychiatrically sophisticated. They understood that Neo's parents would likely collaborate with and support Neo's plan. Both Jan and her supervisor recognized that any effort to psychiatrically hospitalize Neo would fail. Neo's psychiatrist parent would help Neo fight that step, and Neo would simply deny any suicidal ideation. Dr. Jan ultimately told Neo that she did have to inquire about suicidality as her professional responsibility. Neo replied, "I respect you for caring and trying all these past few years but go ahead and ask away." Neo specifically denied any suicide risk before heading home.

Oncologists rarely go to patients' a home late at night to authenticate a death. Families rarely rush to have bodies cremated a few hours postmortem, especially when – as with Neo's family – they had a religious tradition of burial rather than cremation. The unspoken understanding among the cancer center's staff was that the physician parents enabled Neo's peaceful passing in violation of the letter of the law and medical ethics. The oncologist enabled any necessity of involving emergency medical personnel and possibly authorities. The death certificate listed cancer and cardiac arrest as causes of death, and no evidence to the contrary existed post-cremation.

Sandy clearly chose her own path with the research, detail, and deliberateness that characterized her work as a behavioral scientist. In the spirit of a true scholar and teachers she resolved to make her story into a highly moving and transparent example for others to learn from. Unlike Mike, she had resources, a substantial network of supportive friends and family, and quite deliberately waited as long as possible before acting.

All three of these patients assumed a degree of control that they were unable to obtain under existing law in the places where they lived. The moral logic of the right to die flows from the right of patients to refuse life-extending medical treatments. When continued treatment would prove futile and bring accompanying physical and emotional discomfort palliation may become a good option for some patients. For others, competently and voluntarily seeking to hasten their death through physician-prescribed medications (or direct physician administration of a lethal medication, if necessary) stands as an ethically defensible option.

What Should I Do?

Mental health practitioners will increasingly find themselves needing to think about MAiD issues. Enabling legislation will continue to spread. Demographics in many countries will result in increased numbers of people living longer with significant debilitating infirmities and reduced quality of life. Requests to become involved in MAiD procedures will not only come to clinicians accustomed to working in medical settings, but also to those in independent practice and outpatient clinics. Some suicidal persons may convince themselves that they have made a rational decision, when the good quality treatment may restore quality and save their lives. Other people similarly situated individuals may find their situation intolerable and eschew further medical or mental health intervention. The best ethical approach for mental health clinicians seems a thoughtful stepwise decision-making process.

First, before ever agreeing to participate in MAiD, we should reflect on the core values that motivate us as clinicians and as people. Consider any personal, philosophical, religious, or other biases we may have regarding a patient's request for MAiD. If we cannot set those aside, we should decline to participate in the process.

Second, we must familiarize ourselves with enabling legislation, regulations, or other parameters we will need to attest to or opine about. We should follow and document our adherence to such procedures.

Third, we should consult with the patient's medical care providers to fully understand the symptoms, prognosis, and likely progression of the disease so that we can confirm the validity of the patient's understanding of their circumstances. This may involve helping to determine whether concurrent mental health issues or disorders contribute to the patient's

experience of intolerable physical and/or psychological suffering, and if there may be effective treatment options that the patient may find acceptable.

Fourth, in a confidential discussion with the patient we should assure ourselves that the request for MAiD has come from them; driven independently by their own concerns; without coercion; with an accurate understanding of their circumstances; and with competent informed consent. This would include an exploration of whether the patient considered alternative steps and the consequences of each.

Finally, we should act in accordance with requirements of enabling statutes or regulations to provide any necessary documentation based on a valid assessment. We should simultaneously recognize that, despite potential legal technicalities, this is a highly vulnerable and emotionally critical time for the patient and their family. We should stand prepared to offer supportive interventions for the patient and follow-up with those left behind.

In Conclusion

The culture of dying in America too often involves end-of-life care provided by strangers in institutional settings. Government and professional regulators often assume a parentalistic stance than effectively diminishes personal control of the dying process. Legalized MAiD offers an important option to those suffer from an irremediable medical condition and desire access to medical procedures to hasten death in a peaceful and dignified manner. Patients confronting chronic terminal illness have legitimate interests in controlling their own dying with quality care and support. Perhaps the most valuable and meaningful aspect of dying would include the presence of a community of care that demonstrates to the dying person that they will not feel abandoned (Campbell, 2019). Psychologists can play a significant role in making this happen.

Ethical, professional, and legal controversies will abound as MAiD becomes more socially prevalent, and it will.

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