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Working with Clients Who Choose Medical Assistance in Dying (MAID): A New Landscape for Counsellors

Travailler avec des clients qui ont choisi l'aide médicale à mourir : Nouvelles perspectives pour les conseillers

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ABSTRACT

The passing of Bill C-14 legalized medical assistance in dying (MAID) in Canada in June 2016. As of October 2017 more than 2,000 Canadians had successfully utilized MAID. Currently, it remains unclear how to best serve the psychological needs of these individuals. The extant literature is reviewed to offer awareness and understanding about who chooses MAID. The rationale for this decision, the impact on family members, and changes in attitudes and experiences of death and dying are provided. Counsellor recommendations are discussed along with future research directions. A call is made to examine existing theories of death and dying to expand and reflect this new experience of dying.

RÉSUMÉ

En juin 2016, l'aide médicale à mourir a été légalisée au Canada avec l'adoption du projet de loi C-14, si bien qu'en octobre 2017, plus de 2 000 Canadiens y avaient recouru. À l'heure actuelle, on ignore encore quelle est la meilleure manière de répondre aux besoins psychologiques des personnes qui réclament cette aide. Cette étude propose un examen de la littérature existante pour faire connaître et comprendre le profil de ces dernières. On y explique les raisons de leur décision, les répercussions sur la famille, le changement dans les attitudes ainsi que l'expérience de la mort, puis on discute des recommandations pour les conseillers et de futures orientations de recherche. Enfin, on invite à examiner les théories sur la mort actuelles pour approfondir la compréhension de cette nouvelle façon de mourir et en assurer la prise en compte.

> Rhea is a 63-year-old woman living in Alberta with her partner of 35 years. She has two adult children and three grandchildren. Rhea is in the final stages of lung cancer and has been told she may have 3-6 months to live. She recalls caring for her father in his battle with lung cancer nine years ago. Rhea reflects to her partner about the pain and suffering her father endured at the end of life and shares her longing for a different passage from life for herself. She also fears the loss of autonomy and physical suffering she saw her father experience, and the deep sorrow it caused her mother, herself, and her brothers to witness his suffering and decline in functioning. Rhea and her partner decide to pursue conversations about medical assistance in dying (MAID) with her doctor. (Note: "Rhea" is a fictitious individual created by the authors)

Medical assistance in dying (MAID) was legalized in Canada in June 2016. Since Bill C-14 was passed, there have been more than 2,000 assisted-deaths across Canada as of October 2017 (Harris, 2017b). Ashby (2016) and Jenkinson (2015) have purported that over the last century, death care attitudes in Canada have been informed by the medical model and revolve around the idea of fighting death and hoping for a different outcome within our death-phobic North American culture. The ability to choose MAID is a departure from how death has been historically managed.

In this manuscript, we explore psychological support and counselling strategies in working with this new population of adults who are considering or have chosen the option of MAID. We provide an overview of physician-assisted death (PAD) worldwide and delineate the process for MAID in Canada. Lastly, we provide directions for future research and review psychological theories about death and dying to outline an integrated approach to working with this newly emerged population of clients. We provide the fictitious vignette of Rhea to describe the experience more tangibly.

Physician-assisted death (PAD) is a term that encompasses two kinds of physician-assisted death. In Canada, the term medical assistance in dying (MAID) is used predominantly. The two kinds of MAID are as follows:

1. Voluntary Euthanasia – A physician injects a drug that causes death. In Canada, this is referred to as “clinician-assisted medical assistance in dying” (Health Canada, 2017).
2. Physician-Assisted Suicide (PAS) – A physician prescribes a drug that causes death, and the individual self-administers the drug. In Canada, this is known as “self-administered medical assistance in dying” (Health Canada, 2017).

PHYSICIAN-ASSISTED DEATH (PAD) GLOBALLY

Switzerland was the first country to legalize physician-assisted suicides (PAS) in 1942 (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016). Starting in the 1980s, non-residents, including Canadians, were permitted to travel to Switzerland for PAS. The cost in 2017 was approximately $20,000 in fees and travel expenses (Harris, 2017b). Despite the drawbacks of preparing to die in another country with strangers and without the known comforts of home, 11 Canadian citizens took this option in 2014. A decline in numbers can be seen with only five Canadians opting for PAS in 2016. With the advent of Bill C-14 that same year, Canadian citizens now have an option for MAID in their homeland, which provides newfound freedom to die on their own terms in familiar territory.

Canada’s new MAID legislation reflects global notoriety as, along with Columbia, we are the only other country in the world to endorse assisted death on constitutional grounds (Karsoho, Fishman, Wright, & Macdonald, 2016). Canada is the first jurisdiction in North America to decriminalize euthanasia in addition to PAS (Karsoho et al., 2016). Other countries that legalized both PAS and euthanasia are the Netherlands and Belgium in 2002, Luxembourg in 2009, and Columbia in 2015 (Emanuel et al., 2016; Karsoho et al., 2016). As well, Oregon was the first U.S. state to legalize PAS in 1997 (Emanuel et al., 2016; Karsoho et al., 2016). Since 1997, four additional U.S. states have joined Oregon and legalized PAS: Washington state, Montana, Vermont, and California (Emanuel et al., 2016). Additionally, Colorado, Washington D.C., and Hawaii have legalized PAS since 2016 (Death with dignity acts, n.d.).

Some similarities exist between the Oregon Death with Dignity Act (DWDA) and Canada's MAID legislation. Both are available only to residents with a terminal illness, and both require confirmation of eligibility by two independent physicians (Coombs Lee, 2014). However, MAID includes euthanasia as well as PAS whereas Oregon only allows for PAS (Karsoho et al., 2016). Further similarities across countries include the eligibility procedure used in Canada, which is most similar to Belgium and the Netherlands in that the same physician follows the individual throughout the process (Michaels, 2016), and provides safeguards such as the 10-day reflection period (Health Canada, 2017; Michaels, 2016). The reflection period is designed to allow individuals to fully consider their decision and provide final consent to proceed with MAID.

MAID IN CANADA

For counsellors and psychologists interested in working with individuals who are dying, and perhaps even for those who are not actively seeking these clients, it is essential to understand MAID. Given that MAID is a departure from the way in which death has been approached in the past, it is imperative to explore specific ways to support individuals who choose MAID. In May 2018, the Canadian Psychological Association's Task Force on End-Of-Life published *Medical Assistance in Dying and End-of-Life Care* (Mikail et al., 2018). All psychologists are encouraged to review this document regardless of whether they are working directly with clients surrounding end-of-life issues, because it is likely they will work directly with a client or their loved ones at some point in their career. For those directly working with individuals considering or approved for MAID, it is imperative to become familiar with this document. Among the strengths of the ideas conveyed, we appreciate the delineation of psychologists' roles surrounding MAID. In brief, a psychologist's role can include determining a client's competence and capacity to provide consent; providing consultation and counselling support services to clients, family members, and medical professionals involved; supporting clients and end-of-life decisions; participating at government or institutional levels to impact policy and legislation around end-of-life care; advocating for end-of-life care for clients; researching end-of-life topics; and educating and training other psychologists about end-of-life topics and MAID. Counsellors and psychologists supporting this new population of clients require a full understanding of how one is approved for MAID, and how the process unfolds for those selecting this end-of-life option in Canada.

Understanding the Option of MAID in Canada

Bill C-14 allows for two types of assistance with death as described earlier: clinician-assisted medical assistance in dying and self-administered medical assistance in dying (Health Canada, 2017). In both cases, only physician or nurse practitioners are legally permitted to provide this service. However, pharmacists, other health care providers, family members, or other individuals that are asked to be involved can provide additional assistance (Health Canada, 2017). Additional aid can include anything other than administering the drug, such as being with and providing comfort and support for the person at the time of their death.

Considering Rhea, she and her partner discuss these options at length. Rhea would prefer to die at home rather than in a hospital or hospice. Additionally, because Rhea has no control over the lung cancer and how the illness is affecting her body, she experiences a profound sense of autonomy in choosing the time and location of her death.

Rhea and her partner examine documents provided by Health Canada to determine the conditions that must be met to qualify for MAID. They learn that applicants must (a) be eligible for health services funded by the federal government, or a province or territory, (b) not be a visitor to Canada, (c) be at least 18 years old and mentally competent, (d) have a grievous and irremediable medical condition, (e) make a voluntary request for MAID that is not the result of outside pressure or undue influence, and lastly (f) provide informed consent to receive MAID at every stage in the process (Health Canada, 2017, para 7). Rhea is relieved that she meets all criteria as outlined by Health Canada. She and her partner also learn that while a grievous and irremediable medical condition, such as lung cancer, is required for eligibility for MAID, others may be eligible even without a terminal illness.

That is, Health Canada indicates the conditions required in order for MAID to be viable for those without a fatal condition include (a) having a serious illness, disease, or disability; (b) being in an advanced state of decline that cannot be reversed; (c) experiencing unbearable physical or mental suffering from the illness, disease, or disability, or being in a state of decline that cannot be relieved under regular conditions; and (d) being at a point where one's natural death is imminent or reasonably foreseeable. These conditions broaden the scope of eligibility for MAID beyond having a terminal illness (Health Canada, 2017, para. 8).

The Process for Approval of MAID in Canada

In the first six months following the legalization of MAID, it was estimated that approximately three medical assisted deaths took place each week on Vancouver Island (Barron, 2017). Notably, for every person who was approved for MAID on Vancouver Island, between 5 and 10 applicants were deemed ineligible and denied MAID (Smart, 2017), which means the process can be stressful and uncertain. Demystifying and understanding the stages in the approval process of MAID is essential in supporting clients to cope through this journey.

Rhea is hopeful given the option of MAID, yet she is also terrified that she may be denied the choice to die with dignity on her terms before the disease takes its course.

According to Health Canada (2017), the steps to be approved for MAID begin with a discussion with one's physician or nurse practitioner. These health practitioners determine whether the person is eligible based on the Health Canada eligibility criteria listed above. While the exact paperwork that is required varies by each province or territory, common to all is a mandatory written request for MAID signed by the individual and two independent witnesses. Furthermore, an additional physician or nurse practitioner, not associated with the initiating physician in any way, must provide a written statement confirming the initiating physician's or nurse practitioner's credentials to assess eligibility for MAID (Health Canada, 2017).

Once approved for MAID, individuals must wait at least 10 days before the service is provided (Health Canada, 2017). This 10-day reflection period is included as a safeguard to ensure there is time for the individual to accept and endorse the finality of MAID fully. Exceptions to the 10-day waiting period involve circumstances where death is likely to occur sooner than 10 days, or where capacity to provide consent right before the procedure could be lost in less than 10 days. A further safeguard provided by Health Canada (2017) includes the individual's ability to withdraw their application at any time for any reason. Given what Rhea and her partner learn, they search the Health Canada website to find contact information for local doctors who are trained to assist with the approval for MAID.

Mental Health Illness and MAID in Canada

An individual in the final stages of cancer who is also clinically depressed may qualify for MAID if the health practitioner deems the person to meet conditions outlined by Health Canada (2017, para. 8), unless the depression is deemed to impair one's decision-making abilities. Mental illness alone does not qualify an individual for MAID, which Gulli (2016) described as highly debatable and open to scrutiny. Persons in the federal government have started an independent review into the issue of requests for MAID by those who only suffer from a mental illness with no other medical condition (Health Canada, 2017). A report to cull the evidence and "facilitate an informed, evidence-based dialogue among Canadians and decision makers" (para. 49) about mental illness as a sole qualifier for MAID is expected to be tabled in Parliament December 2018 (Health Canada, 2017). This council will also review issues surrounding mature minors requesting MAID, as well as requests for MAID by individuals who are suffering from an illness and seeking approval for MAID in advance but are not dying in the foreseeable future.

Informed Consent and MAID in Canada

The ability to provide informed consent is a required condition for approval for MAID (Health Canada, 2017). Additionally, informed consent must be confirmed once again by the physician or nurse practitioner right before treatment is administered. As mentioned earlier, individuals can change their minds at any time, and statistics from the United States demonstrate that many do (Stabile & Grant, 2016). Further data will be needed to determine if the same occurs in Canada, as well as what percentage of people withdraw their consent or are unable to provide final consent after being approved for MAID.

Examining what happened in the United States, in Portland, Oregon in 2014, 155 people were approved for PAS. Of those individuals, 105 successfully ended their life by PAS (Stabile & Grant, 2016). The 68% of those completing MAID out of those approved is also reflected in Washington state where 72% of the 176 residents approved in 2014 (i.e., 126 individuals) took the lethal medication. The data about who withdrew their request, and why, is unknown. Over time, the percentage of Canadians who complete a medically-assisted death versus those who withdraw from the process can be determined.

Counsellors and psychologists working with this population are best informed when they are aware that potentially 30% of individuals approved for MAID will choose not to follow through, or will be unable to follow through if their illness progresses to a point where they can no longer provide informed consent. The role of the counsellor or psychologist is not to change their minds but to compassionately support clients to make empowered decisions for their death, whether going ahead with MAID or not. For some counsellors this may require a conceptual shift as we are trained in suicide prevention, which involves working clients away from wanting to die towards wanting to live. It is important to distinguish that a person who seeks MAID is not suicidal. They already have a "grievous and irremediable medical condition" (Health Canada, 2017, para. 7). They do not want to die, but they are dying.

The desire to control the way one passes away is very different coming from someone who is not physically dying from a medical condition but wishes to die. At present, respecting the right for clients to choose death involving MAID when eligibility cannot be based solely on mental health suffering involves examining our ethics of care, standards of practice, and the Canadian Code of Ethics, which is a discussion beyond the scope of this manuscript.

WHO CHOOSES MAID

The federal government is committed to collecting data and monitoring statistics about MAID (Health Canada, 2017). Early indications in Canada (Harris, 2017a; Slaughter, 2016), and from other countries providing PAS for a longer period, identify that primary conditions experienced by people who seek MAID are cancer and neurological conditions (Emanuel et al., 2016). So far in Canada, individuals who received MAID ranged in age from 18 to 91 years with an average age of 73 (Harris, 2017a). Rhea fits in with most individuals who are considering MAID as a result of the progression of cancer. With no foreseeable cure, she wishes to have control over the way she will die.

The desire for Autonomy in Choosing When and How to Die

Beyond the medical rationale for selecting MAID, from a psychological standpoint, Emanuel and colleagues (2016), Ganzini, Goy, Dobscha, and Prigerson (2009), Gulli, (2016), and Stabile and Grant (2016) indicated the primary reason for choosing MAID is autonomy. That is, individuals experiencing the grievous and irremediable conditions required to be eligible for MAID face physical, cognitive, and emotional decline as their disease progresses (Rodriguez-Prat, Monforte-Rovo, Porta-Sales, Excribano, & Balaguer, 2016). Rodriguez-Prat and colleagues (2016) found that for individuals facing the end of life, loss of autonomy is often experienced as a loss of dignity. For Rhea the loss of autonomy to lung cancer is palpable especially given her first-hand experience witnessing the death of her father nine years ago from the same fate. MAID is a viable option that provides Rhea with the choice to die with greater control by choosing the time and location of her death, as well as who is present. The significance of autonomy is also apparent in the published accounts of people who chose MAID. Indeed, individuals whose experience of dignity is based on autonomy are more likely to choose MAID than those whose experience of dignity is more intrinsic and not based on external factors such as autonomy (Rodriguez-Prat et al., 2016). Scholars in the field have also indicated that those who choose PAS tended to be more highly educated (Emanuel et al., 2016; Ganzini et al., 2009) and less religious (Smith, Goy, Harvath, & Ganzini, 2011).

Stories of MAID

Narratives of individuals who chose MAID are published in newspapers and found in online publications. These individuals publicly share insights about their experience and allow for an in-depth understanding of the process. What stands out in the words of those who chose MAID is the sense of relief they felt once they were approved for MAID (Barron, 2017; Maynard, 2014; Smart, 2017). For example, Brittany Maynard (2014) published her story that captured the experience of gaining control of her death. She was 29-years old at the time when she was diagnosed with brain cancer. Maynard moved from California to Oregon to take advantage of the dying with dignity laws. Realizing no medical treatment would save her life, and that death would likely be painful and involve cognitive and personality changes as the disease progressed, she began researching PAS. After discussions with her family, Maynard decided that PAS was the right option for her. In her own words:

> Having this choice at the end of my life has become incredibly important. It has given me a sense of peace during a tumultuous time that otherwise would be dominated by fear, uncertainty and pain. Now I'm able to move forward in my remaining days or weeks I have on this beautiful Earth, to seek joy and love and to spend time traveling to outdoor wonders of nature with those I love. And I know that I have a safety net. (Maynard, 2014, para. 16)

The sense of peace that came with knowing how one will die, and how it created opportunities for her to make the most of one's time left, is commonly felt by those approved for MAID.

In January 2018, two Vancouver Island residents shared their stories. Noreen Campbell, a 71-year-old retired nurse from Victoria, shared her story in the Times Colonist newspaper (Smart, 2017). Campbell applied for MAID two days after the law came into effect in June 2016. She was approved in August and chose to wait until her symptom management became too much for her, which occurred in January 2017. Campbell, who suffered from oral cancer and chronic obstructive pulmonary disease, was still mobile, able to talk, and was living at home. In the time between approval and being ready to die, Campbell said that knowing she was approved for MAID gave her a chance to finish some things she wanted to do, such as writing a manuscript. In the newspaper account, Campbell recounted that she witnessed many deaths during her career as a nurse, and as a result she wished to die quickly once she was ready rather than slowly over several days. With the help of MAID, she died within the parameters she chose: at home in the presence of her partner and with her daughters at her side (Smart, 2017).

Other accounts in media include one in a newspaper called The Cowichan Valley Citizen, where Ernie Sievewright shared that he was suffering from a serious neurologic condition known as cauda equina syndrome. He also wrote about his wife Kay who suffered from complications of multiple sclerosis (Barron, 2017). The couple had hoped to be able to die together on the same day. They sought permission for MAID before it was legalized, which meant it was a longer and more daunting process for them. In the end, Ernie and Kay died four days apart, and Ernie stated his appreciation in being able to be there for his wife as she took her last breaths (Barron, 2017). He remarked that seeing how peaceful of a process it was comforted him and helped him visualize his upcoming death (Barron, 2017).

The sense of comfort and relief that comes with being approved for MAID is shared by the loved ones as well as the dying person, as illustrated in the next story. In Ontario, 56-year-old Rob Rollins was diagnosed with throat cancer in July 2015. He was reported to have tried everything the medical establishment could offer including chemotherapy, radiation, and a throat dissection which resulted in loss of ability to eat and requiring a feeding tube. In October 2016, Rollins was told nothing more could be done and that he would likely die within six months. In November 2016, he started the application process for MAID. He was approved and died in January 2017 at home with his husband, doctor, and closest friend. His husband, John MacTavish, was interviewed three months following Rollins' death and stated that although he missed him every day, he did not regret his role in supporting his husband through MAID. Because Rollins was able to control the way he died, together in their home, MacTavish found "comfort in the relief – even happiness – Rollins had in his last three days" (Ireland, 2017, para. 39).

Overall, these stories of those who chose MAID reflect the importance of autonomy, and the sense of peace and empowerment often experienced by those choosing MAID. These are the very reasons Rhea is considering MAID.

THE EXPERIENCE OF DEATH IN CANADA

Understanding and responding to the needs of this newly identified population and their families requires a deconstruction, and possibly reconstruction, of the current cultural and everyday experience of death in Canada.

The Cultural Experience of Death

It is alarming how little is known about the reality of death and dying in North America, despite the plethora of graphic violence and death viewed daily as part of the entertainment industry (Jenkinson, 2015), in movies, and in videogames. In fact, "images of what the end [of life] looks like are scant, uncelebrated and frequently morbid" (Warraich, 2016, para. 8). Nevertheless, with knowledge of the reality of death being limited, it can be argued that death denial is an important part of healthy functioning (Vahrmeyer & Cassar, 2017). However, too much denial can lead to death-phobia, which can create an unhealthy relationship with death and poor quality of life. Wong and Tomer (2011) stressed that death anxiety is an undeniable part of "our collective and individual efforts to resolve this inescapable and intractable existential given" (p. 99). Cultural dialogue surrounding the experience of death is indeed fraught with fear, anxiety, and avoidance, although new perspectives are evolving. Living in a culture where MAID is available, where control is placed in the hands of those who are dying, summons an examination about the experience of death in new ways, and invites the necessity for increased open dialogue surrounding the end-of-life and death. To improve end-of-life care, Ashby (2016) reinforced the need for a culture of acceptance around death and dying.

In this vein, a grassroots movement introducing death cafés and death doulas has been gaining in popularity and expands the way death is discussed and regarded (Browne, 2015). The opening of death cafés as a casual social gathering space is central to this movement. The idea of a death café is to make room for new dialogue around death, and to release some of the taboo normally associated with discussing death within a death-phobic culture (Nyatanga, 2017). Likewise, in the way that birth doulas support new life into the world, death doulas support the dying as they depart from the world. They are also referred to as end-of-life doulas or transition coaches (McCarthy, 2016). What a death doula does in the interest of supporting the dying and their families can vary widely. Death doula services range from sitting with the dying person and watching television together (Tugend, 2015), to organizing a creative funeral, to creating tailored rituals such as forgiveness rituals and healing ceremonies to fit the individual family needs (Browne, 2015). Despite the differences in how they work, what death doulas all share in common is the desire to demystify the process of dying, and to help people and their loved ones make the most of their last days (Browne, 2015; McCarthy, 2016).

Although Rhea is sad to be leaving life and her loved ones, she is not afraid of death; rather she is afraid of suffering. Knowing that she is approved for MAID alleviates the fear of potential protracted suffering, and enables her to focus on how she wants to live the remaining months she has left. As well, approval for MAID eliminates her fear that friends and family would witness her physical and mental deterioration, as she had witnessed with her father's death. She and her partner talk with a death doula to ensure they are considering everything in preparation for Rhea's death. Rhea also wishes for her and her partner to work with a counsellor who can be a continued source of support for her partner following her death.

Medical Advancement and Experience of Death

Over the last century in North America, management of death has been transferred from family care to the medical system (Ashby, 2016; Jenkinson, 2015; Karsoho et al., 2016). With the advent of new medical technologies, how we die has changed from a singular event to a prolonged series of escalating health challenges (Ashby, 2016; Jenkinson, 2015; Stabile & Grant, 2016; Warraich, 2016), and death is treated as something to be conquered, overcome, or cured (Stabile & Grant, 2016).

With a hoped-for promise of more time and returning to life as it was before illness (Jenkinson, 2015), medical interventions indeed have saved lives, while at the same time transformed the way a grievous and irremediable medical condition is managed and experienced. Medical interventions have become a fierce weapon enlisted to combat death, but knowing when to stop is the new challenge (Andrews & Nathaniel, 2015; Karsoho et al., 2016). Individuals with a terminal diagnosis, as well as their family members and friends, naturally want to feel as though they have done everything they can for themselves and their loved ones in facing death (Jenkinson, 2015; Murray, 2013), which often means stopping at nothing. Much of the suffering around death is brought on by the iatrogenic effect of medical interventions aimed at prolonging life at any cost (Jenkinson, 2015; Karsoho et al., 2016).

Unfortunately, more time usually "means more time to live their dying" (Jenkinson, 2015, p. 35). As such, advancement in medical science has prolonged the dying phase of life, often involving multiple illnesses, dependency, physical decline, and diminished cognitive capacity, rather than the singular event it was in previous centuries (Ashby, 2016; Jenkinson, 2015; Stabile & Grant, 2016; Warraich, 2016).

If asked, most people express a desire for a long life and hope for a quick and painless death at home (Jenkinson, 2015). While an overwhelming majority of Canadians wish to die at home the reality is that most of them will die in hospital (Cairns & Ahmad, 2011), which is a result of our current trend of outsourcing care for the dying to the medical establishment (Ashby, 2016). In contrast to the norm of dying in a hospital, almost all MAID deaths are chosen to take place at home (Coombs Lee, 2014), harkening back to how death unfolded centuries ago. In further contrast to dying in a hospital, MAID deaths occur rapidly following ingestion or injection of lethal medication (Coombs Lee, 2014).

The Experience of Death with MAID for Family Members

To date, no published peer-reviewed studies are available that focus on the experience of MAID for individuals, although many are found written anecdotally on social media and newspapers. There are, however, studies that focus on the experience of MAID for family members. To understand how PAS affected surviving family members compared to other forms of death, Ganzini and colleagues (2009) surveyed 95 Oregonians whose loved ones died from MAID, compared to a control group of 63 Oregonians whose loved ones died of complications from cancer or amyotrophic lateral sclerosis (without MAID). Family members were surveyed between four months and three years following the death of their loved ones. It was found that the utilization of MAID did not increase grief or depression following death. In fact, the opposite occurred: Researchers found that family members of those who chose MAID felt better prepared for the death and had fewer regrets about how the death occurred. Limitation in use of a convenience sample and low proportion of participation among family members was outlined by Ganzini and colleagues (2009), which limited generalizability as participants may have experienced more positive mental health overall.

A similar study by Smith and colleagues (2011) utilized a 33-item questionnaire to measure family members' perception of the dying experience for those whose loved ones chose PAS in Oregon. Similar to the 2009 research they conducted, Smith and colleagues (2011) found that PAS was not perceived as any worse than a non-PAS death. Additionally, PAS deaths were rated more highly regarding symptom control and preparedness for death than non-PAS deaths. Furthermore, in line with media reports from those who chose MAID and felt relief once they were approved, Smith and colleagues (2011) found that family members of those who were approved for PAS reported that they smiled and laughed more in their final weeks of life than those who requested PAS but were not eligible. Analogous research studies in Canada are necessary to determine how family members and the individuals themselves experience the process of MAID.

THEORETICAL VIEWS OF DYING

Psychological Theories of Dying

Older psychological theories of death and dying, such as Glaser and Strauss' awareness of dying theory (1965) and Kubler-Ross' stages theory (1969), have merits to inform us about the experience of death (Andrews & Nathaniel, 2015) but fall short in fully acknowledging the experience of this new population of dying people who are choosing MAID.

The five-stages theory of dying developed by Kubler-Ross (1969) is one of the most enduring and well-known theories by the masses. Kubler-Ross's five stages of dying include (a) denial, (b) anger, (c) bargaining, (d) depression, and (e) acceptance. Critics argued that these stages are too mechanical, limiting, and step-wise, and do not reflect the recursive process that fluctuates between moments of fear, hope, calm, and sadness in addition to the five stages identified (Copp, 1998). Likewise, Kubler-Ross' theory embodies an inherently negative frame of death, as demonstrated in the choice of wording for the stages previously mentioned. This falls short of what is possible when supporting clients who are dying and certainly requires an amendment to reflect the more positive experiences for those who consider and choose MAID.

Turning to another theory of dying, Andrews and Nathaniel (2015) highlighted the relevance of Glaser and Strauss' theory which includes four stages of awareness, and how the dying person, medical personnel, and family members interact during each of those stages. The four stages of awareness are (a) closed awareness, (b) suspicious awareness, (c) mutual pretence, (d) and open awareness (Glaser & Strauss, 1965). In closed awareness, medical personnel know that the individual is dying but the individual is not aware (Andrews & Nathaniel, 2015). In this stage, individuals hold the false belief they will recover and are unable to prepare themselves and plan for proper rituals. Certainly, there is no opportunity in this stage for intention and control about how one dies as afforded in MAID.

The stage of suspicious awareness occurs when individuals suspect they are dying but the medical personnel actively work to deny their suspicion (Andrews & Nathaniel, 2015). In mutual pretence, everyone is aware that the individual is dying but they behave as if they are not. We believe mutual pretence is borne out of a death-phobic culture in that mutual pretence captures the behavioural and attitudinal norms in North America when one faces a grievous and irremediable medical condition. That is, a joint illusion is often maintained by discussing only safe topics of conversation and involves outright denial of anything that hints of imminent death, which is thought of as insensitive, rude, and unnecessarily awkward.

The mutual pretence is practiced to create an atmosphere of serenity around the dying person and is thought to protect privacy, dignity, and embarrassment. On the contrary, dying is extremely stressful for everyone involved and leaves the individual with no one to share their fears. One of the most challenging parts of dying as outlined by Andrews and Nathaniel (2015) is the energy required to maintain the mutual pretence, which narrows the opportunity for closure or honest expression. When everyone is busy maintaining the pretence that someone is not dying, they are privately feeling sad about the event. Someone who has been approved for MAID, or is in the process of choosing MAID, is ready to move beyond this pretence. This may allow for an opportunity to openly express sadness and make room for supporting sadness with rather than sadness about (Jenkinson, 2015).

According to Andrews and Nathaniel's (2015) awareness of dying theory, as the dying person begins to deteriorate physically, there is movement into the stage of open awareness. Open awareness occurs when everyone acknowledges that the individual is actively dying. Choosing MAID is an indication that individuals have reached the open awareness stage, but not necessarily because one has reached a point of obvious physical decline. They know that they are going to die, and they would like to have control over how and when it will happen. Awareness and acceptance of one's prognosis are essential to opting for MAID. We propose eliminating Glaser and Strauss' closed awareness and suspicious awareness stages and foresee less time spent in mutual pretense given that the option of MAID may hasten individuals to accept their fate earlier. Knowing they have an option with MAID can greatly reduce the fear of the unknown regarding debilitation and loss of bodily control while moving toward death, and may prompt individuals into the stage of open awareness sooner.

Wong, Reker, and Gesser (1994) developed a more recent theory of death awareness and acceptance. They validated the Death Attitude Profile-Revised (DAP-R) that identifies three types of death acceptance: (a) neutral acceptance (NA), which is recognizing the inevitability of death from a rational perspective; (b) approach acceptance (AA), which is accepting that death is a gateway to a better existence in the afterlife; and (c) escape acceptance (EA), which focuses on preferring death as a better option to the pain and misery currently experienced in life, as in suicides and assisted-suicides (Wong et al., 1994; Wong, 2008).

Additionally, two other dimensions are assessed in the 36-item DAP-R that represent death non-acceptance: fear of death and death avoidance. These two dimensions were meaningfully separated to distinguish those who ponder death and are afraid of it (fear of death) from those who avoid thinking about it as a way to cope (death avoidance). An individual approved for MAID is not likely to show a DAP-R score that reflects non-acceptance of death. While they more likely will identify as having a neutral acceptance, approach acceptance, or an escape acceptance, we believe that individuals are not fixed in their death attitude, particularly when at the end-of-life. Individuals will vary and often cycle from death acceptance to non-acceptance, and from fear to calm and peace. Furthermore, we feel that EA stated as the death attitude of those seeking assisted suicides may not entirely capture how those approved for MAID feel towards death.

While a new theory of death and dying that encompasses the experience of MAID is necessary, given existing theories, we propose adding stages and dimensions that reflect preparation and planning one's chosen death in order to update and possibly reconceptualize Glaser and Strauss' (1965), Wong et al.'s (1994), and Kubler-Ross' (1969) theories of dying. We firmly assert that there exists a dimension, beyond the three levels of death acceptance identified by Wong and colleagues (1994), that includes meaningful acceptance of death such as meaningful integration of death (MID). We conceive of MID as owning and integrating death as not only a natural and inevitable process but also a meaningful part of life. Rather than a rational, unexamined, or passive acceptance to end-of-life, MID represents how one explores and grapples with the mystery of death and what it means to stand at the threshold and be in the liminal stage between living and dying.

WORKING WITH INDIVIDUALS WHO CHOOSE MAID

Although a current lack of scholarly articles exists about counselling individuals who choose MAID, much can be gleaned by reviewing qualitative examples of working with terminally ill clients as some of the findings translate well for clients contemplating MAID. For instance, Imes, Clance, Gailis, and Atkeson (2002) detailed a gestalt/existential approach to counselling clients with a terminal illness. They outlined the following elements as particularly important: validation and empathy of the individual's experience, carefully listening to the individual's version of their story, paying attention to bodily sensations, willingness to give advice when appropriate, the use of humour when appropriate, exploration of existential meaning, and lack of investment in outcome (Imes et al., 2002). Response to serious illness can be shaped by several factors, including relationships, family history, socioeconomic status, and cultural contexts (Imes et al., 2002). Imes and colleagues advised that every dying client is different and counselling must be adapted to fit each unique client.

While every dying client is different, most individuals facing death are compelled to search for the meaning of their life, which can be prompted with activities such as life-review, letter writing, and story-telling (Wong, 2008). In fact, meaning management theory was developed by Wong to provide a conceptual framework and counselling approaches (Wong, 1999) to facilitate death acceptance by deepening spirituality and increasing understanding and meaning in life, despite life circumstances.

Additionally, dignity therapy (Hack et al., 2010) is a therapeutic approach focused on meaning in life. That is, counsellors foster a safe environment for clients to review the most salient aspects of their lives in order to identify core values that promote feelings of pride and dignity in the life they have lived. Likewise, inspired by existentialism, Breitbart and Applebaum (2011) developed meaning-centred group psychotherapy to reduce despair and hopelessness and increase meaning in the face of death. Many of these approaches and interventions align with working with clients who choose MAID.

We believe the choice to pursue MAID implies additional characteristics and need for support that may not be fully understood at present. To meet these needs, we propose merging new grassroots theories and themes about death and dying with current treatment modalities for an integrated approach. Firstly, the primary difference in working with someone who has chosen MAID, or is interested in pursuing MAID, is that they have reached the open awareness stage (Andrews & Nathaniel, 2015) of acknowledging their death, at least to themselves. It is possible that clients may seek counselling while they are in a more closed stage. Secondly, in our social milieu we largely emphasize "living well" while "dying well" receives insufficient attention and focus. Ideally we would have both, and the introduction of MAID is a monumental shift in perspectives of dying. Indeed, having a choice about how and when we die sparks a new population that requires support in new ways. When working with adults and their families who opt for MAID, there is an opportunity to meet death in a new way. Specific therapeutic strategies for counsellors and psychologists working with this unique population are described below.

Individual and Group Counselling Options

Death touches everyone in the dying person's sphere of family and friendship. Some people may desire individual counselling to work through personal issues around grieving and loss. Additionally, group counselling could provide an opportunity to share grief or resolve conflicts, and build a community for individuals around the experience. The structure for group counselling could be in the form of a ritual to provide connection, forgiveness, closure, or whatever would be most meaningful for the group. Participants can also range from closed groups for those in the process of MAID to open groups for individuals and family members in this journey.

Group counselling can provide a safe container to express sadness. The dying person can express how sad they are to be leaving life and loved ones. The loved ones can express how they wish the person was not dying. Everyone can miss each other together (Jenkinson, 2015) rather than alone. Sadness shared and acknowledged can make room for other emotions. A quote from Noreen Campbell describes this well. In preparing for MAID with her family, "we have had a string of celebrations – tears sure – but so much laughter" (Smart, 2017, p. A2). In Rhea's case, she may choose to come for individual, couples, group, or family counselling.

Personal Suitability

Just as not everyone will be drawn to MAID, not every counsellor will be comfortable working with clients who choose MAID. It is critical for a counsellor or psychologist considering this work to check in with their values to confirm suitability to this work, and to do any self-work and self-reflection needed to be present for a client going through MAID. Some religions have expressed direct opposition to MAID (Ireland, 2017) and counsellors who belong to these religions may not be comfortable providing this service.

Indeed, perhaps the biggest call in preparation for working with clients surrounding MAID concerns counsellors' own comfort with death and dying, and their ideologies, beliefs, and spirituality. Counsellors and psychologists who already work with a palliative care population are familiar with working with the dying, and have likely embarked on the soul-searching and work in acknowledging their mortality and fears of death. Nevertheless, even counsellors in the palliative care field may wrestle with the fact that clients choose to initiate death with MAID, which is a departure from living until the body gives out.

Counsellors working in palliative care, however, are not exclusive to seeing clients who are considering or have chosen MAID. In effect, working with clients who choose MAID is a new landscape for general counselling practitioners, as it increases the potential that clients initiate discussion about death, dying, and the option for MAID in everyday clinical practice. To be ready for this challenge means that counsellors are open to alternative views and ideas of dying, and are at a point in their journey where talking about death is easy and straightforward. Just as sex therapists are most effective when they are comfortable with their sexuality, counsellors working with clients surrounding death must come to terms with their death; otherwise, the work will be very challenging, and potential harm/risk to clients can occur. We suggest that counsellors and psychologists learn more about and attend death cafés, to increase their level of comfort surrounding death and dying.

We also recommend remaining open and fluid in the therapeutic work with clients as it is inevitable that some clients will be denied MAID (Smart, 2017). Additionally, a percentage of people who are approved for MAID will change their minds and decide not to follow through (Stabile & Grant, 2016). Likewise, remaining fluid and open means understanding things can change over time. Clients may fluctuate significantly in their decision. As such, following the client's lead and resisting preconceived notions about what is needed is best practice. We recommend counsellors and psychologists who are unfamiliar with seeing clients surrounding the topic of MAID either appropriately refer out, or obtain appropriate supervision in adherence with Section II.6 of the Canadian Psychological Association's Code of Ethics for Psychologists (2017), which is essential to building competence in this new area of work.

Change the Language Around Dying

Jenkinson (2015) said, "… if I don't use the d word [death] when I'm there, what secret am I helping you keep?" (p. 68). Words are important. Skerrett (2010) denoted how words used to describe and convey something have the power to shape the experience of that thing. Much of the language we currently use to talk about death stems from the death-phobic nature of our culture (Jenkinson, 2015). Euphemisms play a strong role in talk of death. Euphemisms imply that the topic they are covering up is too shocking, fearful, or shameful to speak about directly. North Americans are so accustomed to euphemisms around death (e.g., people have passed, or are lost) that they feel natural. However, when counsellors are comfortable using direct language, new possibilities open for reframing and demystifying death in the counselling room and beyond.

Support Creation of Meaningful Ritual

Ritual can create meaning out of chaos. A carefully constructed ritual can create a time-limited container within which it is safe to express emotion and facilitate a transformation of feelings, behaviours, or attitudes (Reeves, 2011). Reeves (2011) outlined the following requirements for an effective psychotherapeutic ritual: preparation and planning; the use of symbols; participation, including the participation of invited others; an acknowledgment of past, present, and future; and statement of future wishes or expectations regarding the topic of the ritual. For ritual to work, clients need to be strongly motivated to participate in the ritual and in the co-creation of the ritual (Reeves, 2011).

Some clients may have religious or spiritual rituals that are meaningful. In those instances, they can be supported in reaching out to the people who can help them make that happen. Indeed, ritual can be a great way to connect to the bigger picture and to acknowledge those who have gone before and those who will come in the future.

CONCLUSION

MAID was newly legalized in Canada with the passing of Bill C-14 in June 2016. Medical personnel, hospital workers, home care administrators, and hospice professionals in various Canadian provinces and territories are in the process of learning how to best support those who are wishing to, or have chosen, where and when they will die. Although there is currently no requirement to see a mental health practitioner within the mandated steps for approval for MAID, there are many ways counsellors and psychologists can support this new population. This includes being updated on and aware of the latest research and new developments around death and dying, such as the insurgence of death cafés and death doulas. Psychological support also involves counselling the dying person and/or their loved ones, either individually or together. Creating space for honest discussion of death and the multiplicity of emotions surrounding it is paramount in counselling those who are considering MAID, bearing in mind that individual needs vary, and no one approach is right for every person.

In addition to the studies conducted in Oregon about the effects of PAD on surviving family members (Ganzini et al., 2009; Smith et al., 2011), first-person qualitative studies about what this new population of adults choosing MAID most desires as they prepare for death, and the ways in which counsellors and psychologists can best support their journey, will be tremendously valuable. Likewise, further research will lead to more updated theories and newly recognized stages of death and dying that add to or augment theories such as Kubler-Ross (1969), Glaser and Strauss' (1965), and Wong et al.'s (1994) theories of death and dying. We proposed the addition of MID among the three dimensions of death acceptance identified by Wong and colleagues (1994), which requires validation through research. Overall, in this 21st century, new theories developed through research surrounding death and dying are urgently needed given the legalization of MAID.

MAID is early in its inception in Canada, and there is much to learn. The option of MAID opens opportunities to meet death in a new way. There is space for counsellors and psychologists to support these individuals and their families as they prepare to face death; and, as MAID becomes more widely accepted and practiced in Canada, it can contribute to a future where greater openness and comfort with death and dying assuages the North American high death-phobia culture we currently exist within.

> After completing the MAID application process, Rhea was approved. She felt tremendous relief knowing that she can control when and where she dies. MAID freed her up to focus on what she wished to do in the time she had left. She returned to see a counsellor she had been seeing on and off over the past three years and went back to her for support through this process. At times her

partner joined her in session, and they were able to work through their grief, anger, and sadness together. The counsellor also supported Rhea in choosing when, where, and how to die. At Rhea's request, the counsellor supported them in creating a ritual they could do with family and close friends. Finally, on a warm September evening as the leaves began to turn, Rhea was seated in her favourite chair on her back porch overlooking the river with her dog curled up in her lap. Her partner and her two daughters were at her side. Her doctor arrived, and when they were ready, her family members held hands surrounding her, and her partner held her close whispering to her as the doctor administered the medication that ended Rhea's life. Her passing was quick and painless. Her family members supported each other as they mourned her passing, grateful that it happened just as she had wanted. They also knew what would happen following her death as Rhea had helped prepare for her funeral.

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