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Questioning the Ethics of Assisted Dying for the Mentally Ill

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Article abstract

Since Canada legalized medical assistance in dying (MAID) in 2016, it has become one of the most permissive regimes in the world for euthanasia and assisted suicide. The number of deaths has risen rapidly and the categories of eligibility continue to expand. The country is poised, as of March 2024, to allow MAID for those whose sole underlying condition is mental illness, generating considerable debate. Advocates of MAID for mental illness often frame it as a question of equal access, but this extension involves considerable complexities not present in other cases. This paper examines psychiatric MAID in the Canadian context, engaging directly with the most pertinent arguments of the practice's advocates. The paper argues that independent of any prior commitments vis-à-vis the permissibility of MAID per se, there is a clear ethical and legal necessity to oppose extending MAID on the grounds of mental illness if we follow the parameters set up within the Canadian regime. The paper advances three arguments: first, that mental illnesses cannot be deemed *irremediable*, as required by the Canadian law; second, that we cannot establish with adequate certainty that a mentally ill patient has the *decision-making capacity* to choose MAID; and third, that allowing psychiatric MAID will have a *devastatingimpact* on care and support of the mentally ill.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Questioning the Ethics of Assisted Dying for the Mentally Ill

Patrick Craine[a]

Résumé
Depuis que le Canada a légalisé l'aide médicale à mourir (AMM) en 2016, il est devenu l'un des régimes les plus permissifs au monde en matière d'euthanasie et de suicide assisté. Le nombre de décès a augmenté rapidement et les catégories d'admissibilité continuent de s'élargir. Le pays est sur le point, à partir de mars 2024, d'autoriser l'AMM pour les personnes dont la seule condition sous-jacente est la maladie mentale, ce qui a suscité un débat considérable. Les défenseurs de l'AMM pour les maladies mentales considèrent souvent qu'il s'agit d'une question d'égalité d'accès, mais cette extension implique des complexités considérables que l'on ne retrouve pas dans d'autres cas. Cet article examine l'AMM psychiatrique dans le contexte canadien, en s'attaquant directement aux arguments les plus pertinents des défenseurs de cette pratique. Il affirme qu'indépendamment de tout engagement préalable vis-à-vis de l'admissibilité de l'AMM en soi, il existe une nécessité éthique et juridique évidente de s'opposer à l'extension de l'AMM pour des raisons de maladie mentale si l'on suit les paramètres établis dans le cadre du régime canadien. Le document avance trois arguments : premièrement, les maladies mentales ne peuvent pas être considérées comme *irrémédiables*, comme l'exige la loi canadienne; deuxièmement, nous ne pouvons pas établir avec suffisamment de certitude qu'un patient atteint d'une maladie mentale a la *capacité de prendre des décisions* pour choisir l'AMM; et troisièmement, l'autorisation de l'AMM psychiatrique aura un *impact dévastateur* sur les soins et l'assistance aux malades mentaux.

Abstract
Since Canada legalized medical assistance in dying (MAID) in 2016, it has become one of the most permissive regimes in the world for euthanasia and assisted suicide. The number of deaths has risen rapidly and the categories of eligibility continue to expand. The country is poised, as of March 2024, to allow MAID for those whose sole underlying condition is mental illness, generating considerable debate. Advocates of MAID for mental illness often frame it as a question of equal access, but this extension involves considerable complexities not present in other cases. This paper examines psychiatric MAID in the Canadian context, engaging directly with the most pertinent arguments of the practice's advocates. The paper argues that independent of any prior commitments vis-à-vis the permissibility of MAID per se, there is a clear ethical and legal necessity to oppose extending MAID on the grounds of mental illness if we follow the parameters set up within the Canadian regime. The paper advances three arguments: first, that mental illnesses cannot be deemed *irremediable*, as required by the Canadian law; second, that we cannot establish with adequate certainty that a mentally ill patient has the *decision-making capacity* to choose MAID; and third, that allowing psychiatric MAID will have a *devastating impact* on care and support of the mentally ill.

Mots-clés
aide médicale à mourir, AMM, éthique, euthanasie, suicide assisté, maladie mentale, Canada

Keywords
medical assistance in dying, MAID, ethics, euthanasia, assisted suicide, mental illness, Canada

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INTRODUCTION

Since Canada legalized medical assistance in dying (MAID) in 2016, it has become one of the most permissive regimes in the world for euthanasia and assisted suicide. The number of deaths due to MAID in Canada now dwarfs other jurisdictions where the practice has been legalized for decades, such as the Netherlands and Belgium. In 2022, there were 13,241 reported MAID deaths, up 31.2% from 2021, and up 135% since 2019 (1). Amid these rising numbers, the categories of those eligible for MAID has been increasing steadily. The public has been gripped in recent years by news reports about MAID approvals for people who are driven by poverty, lack of housing, or inadequate access to health care or social services (2-4). The country's justice minister has recently upheld MAID as a charter right for "all Canadians" in response to questions about people choosing MAID for reasons of poverty (5). The influential College of Physicians in Quebec is now calling to allow MAID for sick newborns (6). While Canada's MAID regime was originally conceived as an attempt to balance the principles of patient autonomy and protection of the vulnerable, it seems that the pursuit of autonomy has become predominant. Now Canada is looking at extending its MAID regime even further. A parliamentary committee recommended in February 2023 that access be extended to mature minors, and that advance requests be allowed for patients who expect to be incapacitated (7). In June 2023, the Quebec National Assembly passed a bill approving advanced requests, extending access to those with significant and persistent disability, and requiring palliative care facilities to offer MAID (8). The biggest point of debate for many months in 2022-2023 was the pending allowance of MAID for those whose sole underlying condition is mental illness. Though initially slated to begin in March 2023, Parliament pushed it back one year to March 2024. Advocates of MAID for mental illness often frame it as a question of equal access, but this extension of MAID involves additional complexities.

My purpose in this paper is to examine MAID for those whose sole underlying condition is mental illness, as it is presented in the Canadian context, engaging directly with the most pertinent arguments of advocates of this practice. My thesis is that the

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extension of the law is wrong, legally and ethically, and specifically on the terms established by Canada's own MAID regime. I begin by considering the background, reviewing the existing implementation of MAID for mental illness in other countries, and then looking at the legislative and judicial context for MAID in Canada that has led to the impending allowance of MAID for mental illness. I then present three arguments for my thesis. First, I argue that mental illnesses cannot be deemed *irremediable*. Second, I argue that we cannot establish with adequate certainty that a mentally ill patient has the *decision-making capacity* to choose MAID. With these first two arguments, I maintain that MAID for mental illness cannot meet two of the key eligibility criteria in the Canadian law. In my third argument, I contend that allowing psychiatric MAID will have a *devastating impact* on care and support of the mentally ill, looking particularly at three areas: psychiatric care, suicide prevention, and social/structural supports. In a final section, I examine the impact of MAID access for people with disabilities since it was legalized in 2021 and argue that this experience should serve as a warning against extending access to the mentally ill.

My argument in this paper is independent of any prior commitments vis-à-vis the permissibility of MAID per se. I contend that regardless of whether one considers MAID permissible, there is a clear necessity to oppose extending MAID on the grounds of mental illness if we follow the parameters set up within the Canadian regime. This is a position held, in fact, by many experts who support the legalization of MAID and by many psychiatrists who participate in its provision.

LEGISLATIVE AND JUDICIAL BACKGROUND

International context

Before considering the situation in Canada, we need to look briefly at the international context. Euthanasia/assisted suicide for psychiatric reasons is currently permitted in the Netherlands, Belgium, Luxembourg, and Switzerland. The experiences in the Netherlands and Belgium, where it occurs most prominently, have shaped the Canadian debate. And the Netherlands, in particular, has led the way on this issue. The scholarly debate on physician-assisted death for psychiatric disorders was touched off there in the 1980s, but it has been permitted in practice since the 1990s (9). The issue came to international prominence with the Dutch Supreme Court's 1994 ruling in the Chabot case, involving a 50-year-old woman who sought to end her life after suffering depression in the wake of losing her two sons. The psychiatrist Chabot had observed her in his private guesthouse for two months and met with her to discuss her desire for death. During this time, she refused treatment, both psychotherapy and medication. Thus, Chabot chose to prescribe her a drug to assist her death. The Dutch Supreme Court found him guilty of assisted suicide, but without penalty, and they deemed that psychiatric suffering is a legitimate ground for physician-assisted death.

The Dutch Psychiatry Association published the first guidelines for physician-assisted death in cases of psychiatric suffering four years later, in 1998, and in 2002 the practice was decriminalized by the Dutch Parliament. The issue was largely dormant afterwards, as there were only a few cases reported yearly up until 2010. However, cases began to increase significantly in 2011, connected to the foundation of the End of Life Clinic, which aims to help patients whose physicians oppose physician-assisted death. The number of cases reached its peak in 2021, with 115 reported cases out of 7,666 total cases of euthanasia (1.5% of total cases) (10). In 2022, there were again 115 reported cases of psychiatric euthanasia, out of 8,720 total cases of euthanasia (1.3% of total cases) (11).

In Belgium, euthanasia has been legal for both physical and mental illness, without fatal diagnosis, since 2002. The number of reported cases also increased there over time, peaking in 2015 with 63 cases. In 2021, the most recent data available, there were 45 reported cases out of 2,700 total euthanasia cases, representing 1.7% of all cases (12).

Canadian context

When MAID was first introduced in Canada, it was framed as "end of life" care. The first bill legalizing MAID, in Quebec in 2014, was called the *Act Respecting End-of-Life Care*. The federal Bill C-14, passed in 2016, required that natural death be "reasonably foreseeable" for MAID eligibility. However, the end-of-life criterion was not part of the criteria for MAID indicated in the 2015 Supreme Court decision in *Carter v. Canada*, and many contested it on these grounds. In particular, it was challenged by Jean Truchon and Nicole Gladu, who both suffered from incurable degenerative diseases. They argued that this criterion was an undue restriction that prevented their access to MAID. The Quebec Superior Court agreed, and on September 11, 2019, the court issued its *Truchon* decision striking down the end-of-life criterion (13).

Bill C-14 did not exclude those suffering from mental illness from access to MAID; however, it required that they meet all the other eligibility criteria. So, the requirement of natural death as "reasonably foreseeable" excluded most, if not all, people who sought MAID where mental illness was the sole underlying condition. One would be eligible for MAID if there was another condition present, even if mental illness was the patient's motivating factor for choosing MAID (14).[1] However, the removal of the end-of-life criterion with the *Truchon* decision opened the door to MAID for mental disorder as the sole underlying condition. The ruling applied only in Quebec, but the Canadian government would soon respond with a new bill, C-7, applying its finding across the country.

[1] Canada's Department of Justice explained: "People with a mental illness or physical disability would not be excluded from the regime but would … be able to access medical assistance in dying [only] if they met all of the eligibility criteria" (14).

Quebec responded by amending their legislation to remove the end-of-life criterion. However, they also specified that, for an indefinite period, the allowance of MAID would not apply in cases of mental illness as the sole underlying condition. Instead, the Quebec National Assembly set up a Select Committee to investigate extensions of MAID. To the surprise of many, when the Select Committee issued their report in December 2021, they recommended against allowing MAID for mental illness as the sole underlying condition (15).

After being granted two extensions, the Canadian Parliament passed Bill C-7, and it received Royal Assent on March 17, 2021 (16). The bill does two things: it amends the safeguards for those whose death is reasonably foreseeable, and it introduces a second path to MAID for those whose death is not reasonably foreseeable. This second path opened up MAID access to people with disabilities and would allow MAID for those whose sole underlying condition is mental illness; however, the bill explicitly specified that mental illness would not qualify as a “grievous and irremediable medical condition” until March 17, 2023. Within this timeframe, the bill required that there be an independent expert review conducted regarding protocols, guidance, and safeguards for MAID in cases of mental illness. The deadline has now been extended to March 2024 (17).

Let us examine the bill’s provisions, as they pertain to mental illness as the sole underlying condition. After Bill C-7, there are now five eligibility criteria for MAID. The person must 1) be at least 18 years of age, with decision-making capacity, 2) be eligible for government-funded health services, 3) make a voluntary request, 4) give informed consent, 5) and suffer from a “grievous and irremediable” condition. There are three criteria for a condition to be considered “grievous and irremediable”: it must i) be a serious and incurable illness, disease, or disability, ii) putting the person in an advanced state of irreversible decline in capability, and iii) causing enduring and intolerable physical or psychological suffering that cannot be alleviated under conditions the person considers acceptable. Two major points of debate have arisen about the eligibility criteria as they pertain to mental illness. First, on the notion of irremediability or incurability, which seems much more complicated to determine for mental illness than physical illness. Second, on the issue of decision-making capacity, which would seem to be at risk in cases of mental illness. We will look at both questions carefully.

The bill implements a number of safeguards depending on whether natural death is reasonably foreseeable. Two of the “track 2” safeguards in particular have raised serious concerns in how they apply to cases of MAID for mental illness. First, it implements a 90-day waiting period. Many experts have warned this is not long enough for some cases of mental illness. Some episodes of depression, for example, can last longer than this time span. Second, it requires that patients be “informed” of alternative options to relieve suffering and “seriously consider” them. Many have criticized this safeguard for not requiring MAID requesters to actually pursue alternatives before MAID is approved. Notably, both the Netherlands and Belgium require this (18,19). Critics believe this requirement has helped to keep the number of cases relatively low, and without it there is fear that the numbers could be much higher in Canada.

Since the implementation of MAID in Canada, the question of its application for mental illness as the sole underlying condition has been subject to exhaustive study and debate among scholars, in government-appointed expert panels, and parliamentary hearings. This literature will be crucial to informing the discussion that follows. To help situate us, I will mention a few of the key interventions. First, in December 2016 Canada’s Ministers of Health and Justice commissioned a study of the current state of knowledge on this issue from the Council of Canadian Academies, which formed an expert working group. In 2018, they released a 270-page report focused on presenting the available evidence and summarizing the various views. Second, in August 2021, the government established the Expert Panel on MAID and Mental Illness to satisfy Bill C-7’s requirement of independent review on the question. In May 2022, the Expert Panel released its report supporting the extension of MAID to the mentally ill. Third, in April 2021 the Canadian Parliament established a Special Joint Committee on MAID. This committee gave special attention to the question of mental illness. The committee held hearings with experts and interested parties and received many important briefs; they released their final report on February 15, 2023 supporting the government’s extension of the deadline to 2024.

ARGUMENT 1: IRREMEDIABILITY

The question of irremediability is a pillar of Canada’s MAID regime: the requester must be afflicted with a “grievous and irremediable” medical condition that is both incurable and irreversible. If mental disorder is the sole condition motivating a MAID request, then the crucial question is whether mental disorders can truly be deemed irremediable. In theory, this is one of the key objective criteria that remains after the removal of the “reasonably foreseeable” natural death requirement. However, as we shall see, the debate here hinges on whether irremediability should be interpreted as an *objective* standard or a *subjective* standard (20).[2] Notably the Quebec Select Committee listed this question of irremediability as the first reason they recommended against opening MAID for mental disorder. They found no consensus in the testimony from psychiatrists and other specialists on whether mental illness can be deemed irremediable, and so concluded this was cause for doubt and great caution (15). In what follows, I first examine the view that mental illness can never be deemed irremediable, and then the claim that they can sometimes be deemed irremediable.

[2] Examples of articles arguing for an objective standard include (21-22), and those arguing for a subjective standard include (23-24).

Argument: Mental disorders cannot be deemed 'irremediable'

Many psychiatrists and researchers testified to both the Quebec Select Committee and the Canadian Parliament's Joint Committee that it is impossible to deem mental disorders irremediable. Irremediability is a criterion developed for somatic conditions that is shoehorned into applicability for psychiatric conditions, failing to account for the distinct nature of mental illness. In somatic conditions, the causes are empirically observable, and so are in general more easily understood, and the effects are more universally applicable across cases. This allows for easier accumulation of data upon which to base prognoses. However, in psychiatric conditions the causes are more mysterious and deeply borne, while also being more susceptible to external factors. Experiences of psychiatric illness and responses to treatment are thus highly individual, making prognoses impossible to establish.

As a result, while somatic conditions can be deemed irremediable based on evaluation of past cases, mental illnesses by nature have an *unpredictable trajectory*. Christopher Cowley explains well this distinction (25). He observes that with a somatic illness, an inability to predict its course is due to ignorance of the causal mechanisms underlying the illness. But a mental illness that arises in response to outside events is "highly individual" in nature, "based on the singularity of the individual's biography and perspective and on the singularity of the interaction with those events." As a result, the principles for therapeutic treatment are "much cruder" and there is "much greater room for mystery." As Dr. Mark Sinyor, Assistant Professor of Psychiatry at the University of Toronto, told Parliament's Special Joint Committee, a decision about euthanasia would thus necessarily be "based on hunches and guesswork that could be wildly inaccurate" (26).

This point was emphasized in an influential intervention at the federal level from a body called the Expert Advisory Group, composed of leading experts, including the former president of the Canadian Psychiatric Association. In a report to Parliament in 2020, the Expert Advisory Group argued that while many physical disorders such as advanced cancer and neurodegenerative conditions have a predictable trajectory, allowing reasonably reliable determinations of prognosis, one can never assign such a clear prognosis for mental disorders (19). Even if irremediability is possible in the case of mental illness, physicians cannot form a prognosis in advance; they can only recognize it after the fact. The Expert Advisory Group noted that the Council of Canadian Academies working group, in which many of them participated, had conducted an extensive review leading up to their 2018 report, and "could not find evidence from anywhere in the world that supports being able to identify irremediability in individual cases of mental illness" (19, p.12).[3] This position is supported by expert bodies, such as the Centre for Addiction and Mental Health (29),[4] and interested groups such as the Canadian Association for Suicide Prevention (30). In 2020, the Expert Advisory Group was also able to claim the support of the Canadian Psychiatric Association (31). However, the CPA changed their position later that year (32).[5]

The challenge of determining irremediability in the case of mental illness also comes to the fore in recent developments within the philosophy of psychiatry that underscore the profound influence of social factors on mental illness. In a 2022 article, Hane Htut Maung draws on this research to make an "externalist argument" against MAID for mental illness (34). He observes that philosophers of psychiatry are beginning to reconceptualize mental illness, moving from an *internalist model* in which it is seen primarily as a brain state or process towards an *externalist model* that, while acknowledging the internal factors, sees the illness as constitutively dependent on the person's environment. This reappraisal of social impacts on mental illness compounds the unpredictability of the progression of these illnesses and underscores that determinations of irremediability may not account for the full scope of interventions available. On the externalist model, an illness that seems irremediable may in fact be improved in a new social context.

According to the Expert Advisory Group, the fact that there are psychiatrists who think they can deem mental illness irremediable shows the grave risk of opening access. It indicates that there are patients who will be deemed irremediable by some psychiatrists, even though such a prognosis is impossible. Some of these patients would, in fact, improve if given the chance. Thus, they warn, people will be helped to die who would have gotten better (19). Further, even those who support opening access to MAID for the mentally ill have acknowledged the impossibility of determining irremediability, if the term is interpreted objectively (19). For example, Dembo, Schuklenk, and Reggler write that "it is impossible to predict response or remission with certainty," but argue that nonetheless patients with capacity should be able to decide on the question of irremediability for themselves (35, p.453).

Additionally, a case study co-written by Dembo, one of the just-mentioned authors, presents a clear instance where the psychiatric team thought the patient was irremediable, but turned out to be wrong. The study was published in 2013, before legalization of MAID. Dembo presents "Patient 1" who suffers from schizophrenia and obsessive-compulsive disorder and had been resistant to all manner of treatment for nearly ten years (36). Dembo writes that she and her team "believed that there was almost no likelihood that she could recover." However, after another treatment attempt, the patient's symptoms

[3] In their 2022 brief (27), the Expert Advisory Group maintains that in the interim, "No evidence has emerged to change these conclusions [from the 2020 Report], but rather to reinforce them"; they cite (28). Notably, a scoping review published in October 2022, focusing on a review of relevant studies in the PubMed database regarding treatment-resistant depression, found that "current evidence does not support the view that clinicians can accurately predict long-term chances of recovery in a particular person with [treatment-resistant depression]" (20).

[4] The Centre for Addiction and Mental Health states: "At any point in time it may appear that an individual is not responding to any interventions – that their illness is currently irremediable – but it is not possible to determine with any certainty the course of this individual's illness. There is simply not enough evidence available in the mental health field at this time for clinicians to ascertain whether a particular individual has an irremediable mental illness" (29).

[5] The CPA updated its position again in 2021 (33).

disappeared, and she had been well for two years at the time Dembo was writing. According to Dembo, “At the time, we could not possibly have known” that she would recover.

The Canadian government’s Expert Panel itself also acknowledged the extreme difficulty of forming prognoses for mental illness. The panel writes: “The evolution of many mental disorders, like some other chronic conditions, is difficult to predict for a given individual. There is limited knowledge about the long-term prognosis for many conditions, and it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual patient” (37, p.9).[6]

Counter-argument: Mental disorders can be deemed ‘irremediable’

So, it seems that there is wide agreement that the objective standard of irremediability cannot be met. But if the Expert Panel and other MAID-for-mental-illness advocates admit it is not possible to predict future outcomes in these cases, how do they argue that the irremediability criterion can apply?

They do so by adopting a different definition of incurability and irreversibility that subjectivizes the criterion, reframing it in autonomous terms. The definition the Expert Panel adopts allows a determination of irremediability to be the result of a “shared understanding” between patient and physician “on the basis of the evolution and response to past interventions” (37, p.41). They write: “In the context of MAiD [where mental disorder is the sole underlying medical condition], a grievous and irremediable medical condition exists in circumstances where a person has a longstanding condition leading to functional decline and for which they have not found relief from suffering despite an extensive history of attempts with different types of interventions and supports” (37, p.53). In their recommendations they state that “it is not possible to provide fixed rules” for determining incurability and irreversibility, leaving the decision to individual assessors “on a case-by-case basis” (37, p.55).

The option for autonomy in this definition of irremediability came out strongly in the testimony to Parliament’s Special Joint Committee. Dr. Mona Gupta, the Expert Panel chair, said in cases where we know little about an illness’s long-term evolution, “What is the degree of certainty required? … If we think about what an incurable condition is and draw a parallel with other chronic illnesses, we can say that the threshold is met once all the conventional treatments have been exhausted” (39). When asked if it is acceptable that a person could choose MAID when their condition might have improved, Gupta said: “I think the question is, who should decide whether that’s an acceptable risk? In allowing MAID in our country, we’ve said that is a choice for that individual to make that request. … I think it’s acceptable for the individual to make that decision, yes” (39). Dr. Derryck Smith, Clinical Professor Emeritus at the University of British Columbia’s Department of Psychiatry and former board member of Dying with Dignity, told the committee that irremediability comes into play “when there are no more treatments available that are ‘acceptable’ to the patient. Under law, the patient cannot be forced to take any types of treatments that are available. They must agree. If a person refuses additional treatment, I would, therefore, consider them to be irremediable” (40).

Gupta and Smith propose here that patients themselves are competent to determine the irremediability of their own illness. The risk of such a proposal is underscored by research from van Veen et al., who find that mentally ill patients’ perceptions of irremediability may in fact be influenced by symptoms of their mental illness, namely hopelessness and treatment refusal (41).

Response: Irremediability must be interpreted objectively

Given this clear lack of consensus among psychiatrists on whether mental illness is irremediable, the Quebec Select Committee was right to recommend against allowing MAID for mental illness. But it seems the disagreement hinges on a question that is more legal and philosophical than medical, namely: How is irremediability, as established in the Canadian law, to be interpreted? As an objective or subjective standard? It seems there is wide agreement that the objective standard of irremediability cannot be met. As framed in the original Quebec regime, the Carter decision, and Bill C-14, irremediability required an objective interpretation. Reinterpreting it as a subjective standard would be a fundamental change to the law, with far-reaching consequences for other vulnerable groups as well. I argue that if Canada is to go in this direction, it ought to subject this point to debate and change the language, rather than simply applying a meaning to “irremediable” that defies normal usage of the word. The prospect of declaring illnesses as “irremediable” that indeed are not irremediable in the normal use of the term is deeply problematic. We risk ipso facto declaring patients who could improve as incapable of improvement, and thus risk diminishing the hope that is so essential to recovery in mental health care.

ARGUMENT 2: DECISION-MAKING CAPACITY

My contention is that a psychiatrist cannot determine with adequate certainty that a patient with a “grievous” mental illness has the capacity to make a decision for MAID. The principle of informed consent is a pillar of modern medicine, considered central to the value of patient autonomy. Consequently, the requirement that the patient themselves make an informed request, voluntarily, is a pillar of Canada’s MAID regime. However, informed consent is impossible unless a patient possesses decision-making capacity. We can describe it as an individual’s ability to understand and appreciate the nature and consequences of the treatment decision before them (42). Canadian law presumes that all adults, including adults with mental disorders, have capacity to make medical decisions (43,44). However, capacity can be deemed lacking if there are reasonable grounds for

[6] Additionally, a report from the Association des médecins psychiatres du Québec, which found in favour of allowing MAID for sole mental illness, acknowledges: “It is possible that a person who has recourse to MAID could have regained the desire to live at some point in the future.” They add: “Assessors will have to answer this ethical question [regarding certainty of eligibility] each and every time they evaluate a request” (38, p.28).

doubt with respect to a particular treatment decision (37). Doctors assess capacity before treatment, and where necessary will use capacity assessment tools. Affirming the decision-making capacity of the mentally ill is essential to ensuring epistemic justice in the medical system and overcoming tendencies to ableism, sanism, and paternalism (45). The mentally ill must be afforded their proper responsibility as epistemic agents in their own healthcare decisions. But it would also constitute an epistemic injustice to wrongly attribute capacity to a vulnerable patient, and thereby fail in the duty to protect them in their time of greatest need.[7]

Argument: 'Grievous' mental illness diminishes capacity for MAID decision

Assessing capacity in people with mental disorders is complex and varies greatly based on the type of illness and its severity. Many with good reason have questioned whether those overcome by a "grievous" mental health condition – the bar required for MAID – are truly in a position to possess capacity for so grave a decision as MAID. Some would eliminate MAID for mental illness on these grounds (46,47). There are two factors to highlight here.

First, it is recognized that mental disorders can result in diminished capacity. Some mental disorders such as dementia, intellectual disabilities, and sometimes schizophrenia, lead to an evident decline in patients' cognitive abilities, sometimes to the extent that they do not have the ability to understand the decision before them, or to appreciate how the disorder is influencing their thinking. Other mental disorders impair capacity because they affect the patient's emotions and moods, such as depression, anxiety disorders, and bipolar disorder. When an illness reaches a grievous stage, it can dominate the person's consciousness, altering judgment, and overcoming the normal exercise of will. As the illness progresses, the patient's personal agency is increasingly compromised. Once it has reached a "grievous stage" we can rightly ask whether decisions are made by the illness itself rather than the patient.[8] Though highly controversial and fraught with ethical, legal, and practical complexities, society has continued to recognize a need for so-called "paternalism" in some of these cases when it allows patients to be committed for psychiatric treatment against their will (49).

Second, assessing capacity is complicated by the fact that the desire for death is a symptom of many mental disorders. Even advocates of MAID for mental illness are concerned that we determine the request for MAID is not motivated by suicidality (37). Clinicians must distinguish between a desire for death that is a result of the condition, such as suicidal ideation, and a desire that emanates from an autonomous and well-considered decision (18). This is commonly acknowledged to be a very hard distinction to make. The challenge is exacerbated, perhaps to the point of insurmountability, when we consider the long-lasting and chronic nature of many mental disorders, and the profound effect that mental disorder can play in shaping one's values, potentially warping them to favour a choice for death. So even if a request for death seems purely rational and not arising from mental illness, that does not mean that the illness did not shape the underlying values that led to the request.

Counter-argument: A blanket ban is unjustified

Do these characteristics weighing against decisional capacity justify a blanket ban on MAID for mental illness? In standard practice for other treatment decisions, the mere diagnosis of a mental disorder or the presence of symptoms of such a disorder is not considered adequate to determine incapacity. Rather, the decision about capacity requires clinical assessment and must be made on a case-by-case basis (18). As Van Staden and Kruger write, "The clinical assessment of a particular patient's capacity to give informed consent in a case of mental disorder is better informed by the consideration of conditions necessary to give informed consent than by making inferences from the general features implied by a specific diagnosis" (50). Many experts, while recognizing the complexity of assessing capacity in these cases and acknowledging that some may indeed be incapable, argue that decisions about MAID for mental illness should similarly be made on a case-by-case basis.

There are two main arguments. The first is that a blanket ban would be overbroad and thus prevent MAID for a segment of requesters who in fact have capacity. This segment would thus be "sentenced" to endure their suffering unjustly, amounting to "arbitrary" discrimination on the grounds of mental illness (51). The second argument, advanced strongly by the Expert Panel, asserts that concerns about capacity, and risks of error in capacity determinations, are "equally challenging" in the case of other serious medical decisions for which there is no blanket ban, such as withdrawal of life-saving treatment (37, p.10). They write: "In other areas of practice, difficulties in assessing capacity are not resolved by refusing to permit access to the intervention to all persons or a subgroup of persons" (37, p.42). Rather, such decisions are resolved on a case-by-case basis and not provided to specific individuals who are deemed incapable of giving consent.

Response: We cannot determine capacity with adequate certainty

In response, I maintain that even if we admit, for the sake of argument, that there are in fact some "grievously" mentally ill patients capable of making a MAID decision, we cannot make a judgment of capacity in particular cases with *sufficient certainty* to justify a formal determination of capacity.

First, we must recognize the high degree of rigor required in a MAID capacity determination. The law specifies that determinations of capacity must be specific to individual treatment decisions at a specific time, and not merely based on a

[7] As Kidd et al. note, reducing the severity of an illness, such as through wrongful depathologization, is also a form of epistemic injustice. They make this point with respect to obsessive compulsive disorder: "When we wrongly depathologize a condition, we fail to recognize its severity, since its pathological dimensions are omitted, reducing OCD to personality traits such as tidiness." (45, p.10).

[8] Philosopher and ethicist Louis Charland explores this dynamic in the case of anorexia nervosa (48).

general measure of capacity (52). Moreover, it is a widely acknowledged principle that the degree of capacity required increases along with the stakes of the decision (18). The greater the stakes, the greater the capacity required, and the greater the scrutiny necessary for determining capacity. As ethicist Scott Kim writes, “It is widely accepted that the level of abilities required — the threshold for competence — increases as the risk-to-benefit ratio increases” (53, p.34). Thus because of the high stakes of a decision for MAID, involving a choice to deliberately end one’s life, the review of a patient’s capacity to make an informed and free decision is of utmost importance.

Second, there is good reason to question whether it is even possible to meet this high degree of rigor required in assessing capacity regarding MAID for mental illness. Research on decision-making capacity is still at a nascent stage, and the question of determining decision-making capacity is in fact highly controversial for researchers and health professionals (52). They disagree about how to conduct such assessments objectively. The current standard practice is highly subjective, relying on the judgment of the individual physician, who has often received little training. Moreover, as the Council of Canadian Academies report noted, “there is conflicting evidence on the reliability of capacity assessments” (18, p.67). Some studies find high rates of disagreement between capacity assessors (54,55). Research on capacity in the context of MAID for mental disorder is minimal (9). Further, there are concerns that capacity assessments in other jurisdictions, particularly the Netherlands, lack adequate rigor (9,52).

As Charland et al. argue in a widely-cited 2016 article, the current “gold standard” for assessing decision-making capacity – the MacArthur Treatment Competence Assessment Tool (56) – is seriously deficient because of a bias towards establishing capacity on legal grounds (52). This results in an exclusive focus on cognitive abilities, failing to capture the crucial affective aspect of psychiatric disorders. Of course, the role of feelings and emotions is central in such a weighty decision as MAID, even more so when we are dealing with psychiatric disorders (52). Charland argues that the traditional tools, then, may “be seriously empirically wanting and even empirically invalid” (48). Because of the tools’ cognitive orientation, mentally ill patients can often generate false positives. But in reality, writes Charland, “patients in these circumstances cannot possibly be considered ‘competent’ or ‘capable’ to make their own treatment decisions when they are so affectively biased and ruled by their disease. As they themselves report, they have ‘lost control’ and feel powerless in relation to their disease.” Given these concerns, Charland et al. argue that our mechanisms for assessing capacity cannot bear the weight of the rigor demanded by the MAID regime (52). Their concern was echoed by the chair of the Council of Canadian Academies working group: Dr. Kwame McKenzie told CBC: “It’s not clear that we have ways of measuring peoples’ capacity to make decisions that are robust enough so that we wouldn’t make mistakes one way or the other” (57).

Is it just a matter of developing better tools? Researchers continue to propose better methods of assessing capacity (58-61). But, I maintain, no assessment will be capable of precluding the possibility of false positives. If am I right in this, then there can be no adequate assessment. In a MAID decision, the stakes are so high that we cannot accept error. MAID, of course, is an active intervention that brings about the death of the patient. In this light, we can compare it to the famous analogy of the hunter in the woods who is responsible for ensuring that his target is indeed a deer rather than a human being. If the hunter errs and shoots a human being, he remains responsible for that death despite all good intentions. Likewise, the apparent evil of unjustly consigning patients with capacity to unwanted suffering is outweighed by the risk of putting to death a vulnerable person who lacks capacity for the decision, and thus failing in our duty to protect their life.

The Expert Panel rightly insists on the need for “rigorous” capacity assessments (37). But it is clear that they fail to appreciate how high are the stakes, and the degree of rigor required, when they equate the capacity of a patient to choose MAID with the capacity for choosing removal of lifesaving treatment. The latter decision is clearly very high stakes and capacity assessment must be very rigorous. But there is a sharp distinction between MAID and withdrawal of treatment. MAID is a deliberate and intentional choice for death; the second is not.[9] The Expert Panel argument is consequentialist, dismissing the crucial distinction between an *intended* and a *foreseen* result.

I underline here the fact that the Canadian law requires that a condition be “grievous” to qualify for MAID. Thus, I do not argue in this instance that mental illness itself intrinsically renders one incapable of making a decision for MAID: we are discussing only mental illness that reaches the high bar of gravity set by the Canadian law. Refusing to legalize MAID for mental illness on these grounds is not, then, an instance of epistemic injustice, but a requirement of justice. Mental illness deemed “grievous” enough to qualify for MAID should itself be adequate to determine lack of capacity for the gravest of decisions, to deliberately end life. But even if we admit the *theoretical possibility* of capacity, I maintain that we cannot be sufficiently certain of such a judgment in a particular case to form a *determination* of capacity. This argument about capacity has rightfully not been the central concern advanced by opponents of MAID for the mentally ill, but it is nonetheless an essential consideration. While not definitive on its own, coupled with my other two arguments, it contributes to a clear and strong case against legally extending MAID to the mentally ill.

ARGUMENT 3: IMPACT ON CARE AND SUPPORT OF THE MENTALLY ILL

Allowing MAID for mental illness will, arguably, have a devastating impact on care of the mentally ill in our society, and in three important areas: psychiatric care, suicide prevention, and social and structural supports.

[9] The Expert Advisory Group makes the same point about the distinction between MAID and withdrawal of treatment (19).

Psychiatric care

While Canadian law frames MAID as an exception to the fundamental principle against deliberately taking human life, a unique feature of the country's MAID regime has been that euthanasia and assisted suicide are classified positively as a form of *care*.[10] In a 2023 article, Trudo Lemmens explores how Canada has uniquely framed MAID as *therapy*, explaining how this has resulted in its becoming the most expansive euthanasia regime in the world (62). Framing MAID as care transforms the medical profession, as care for patients is now presented as including deliberately and intentionally bringing about their death. Extending MAID to mental illness will have the same effect on psychiatric care. It risks undermining the essential trust between patients and caregivers, which is often very fragile, and difficult to establish and maintain. In mental health care, hope for recovery is essential. But it becomes very difficult when the option of MAID is available. There is a real risk that MAID could come to be seen as the only solution to eliminate the patient's suffering. Psychiatrists report that it is difficult to care for a person who has decided on MAID; even though many treatments remain, the choice of MAID closes them off to other options.

Despite the concern for autonomy, allowing access to MAID for mental illness curtails patients' freedom by abandoning them to their disorder. A medical system that sees MAID as a form of care heaps a dreadful burden on the patient when they are at their most vulnerable. A person who does not truly desire MAID must carry the fear that they might seek it out in a dark period. When they most need the support and protection of his caregivers, the patient is abandoned and forced to be their own protector. A ban on MAID for mental illness is an important protection for this person, "freeing" him from falling into this false solution to suffering.

Suicide prevention

Canada and all Western societies recognize suicide prevention as a grave matter of public interest. This is attested in the preamble of Bill C-14, which describes suicide as a significant public health issue (63). In 2012, the Canadian Parliament passed an Act establishing a national framework for suicide prevention (64). The World Health Organization says "health-care services need to incorporate suicide prevention as a core component" (65, p.9). However, the response to suicide was complicated when MAID was legalized. Canada now recognizes an *acceptable* form of suicide that we assist and an *unacceptable* form of suicide that we seek to prevent. The challenge is thus how to distinguish between the two; and MAID for mental illness blurs this line even more. With the "reasonably foreseeable" natural death criterion, MAID was still limited to the context of people who were on the verge of death. But in considering MAID for mental illness, we are now looking at allowing MAID based on health conditions that have as their very symptoms the desire to die. In considering which suicides to assist when it comes to people with mental illness, some stress the importance of ensuring that the desire for death does not arise as a symptom of the mental health condition. However, it is not at all clear that we can reliably distinguish between mentally ill MAID requesters who are suicidal and those whose desire is well-considered and autonomous (18). The Expert Panel ultimately acknowledges that it may not be possible: "In allowing MAiD in such cases, society is making an ethical choice to enable certain people to receive MAiD on a case-by-case basis regardless of whether MAiD and suicide are considered to be distinct or not" (37, p.66.)

The logic of suicide prevention is that life is valuable, and thus suicide is not truly good for the person. Even if the person professes a desire to die, we see that desire as rooted in a disorder and thus as not being what they truly want. We must intervene to prevent them from making a bad decision and help them recover the sense of the value of life. This logic runs counter to the logic of MAID, which prioritizes autonomy and the person's own assessment of what is in their best interest. There is a justifiable concern that accepting the logic of MAID will result in it displacing the logic of suicide prevention. Deeming some suicides acceptable weakens the conviction of the need to prevent suicide, and in fact legitimizes it as an acceptable choice. This confuses the messaging we are sending to society on this important issue, setting up suicide as an accepted solution to suffering, and risking establishing it as a social norm.

Social and structural support

The mentally ill already face significant social and structural vulnerabilities. They often suffer from poverty, lack of housing, and lack of family and social support. They face significant stigma and discrimination, and access to mental health care that they need is severely lacking, with great geographical, social, and financial barriers. There is a grave risk that opening access to MAID will only exacerbate these challenges. MAID risks being seen by society as a solution to these social problems, removing the impetus to seek real solutions and offer real help. There is also an important risk of MAID being chosen as an escape from life suffering stemming from these vulnerabilities rather than from the illness itself. In the face of these problems, the call for autonomy for the mentally ill falls flat. How can we speak of autonomy to choose death, when patients are not given viable support to choose life? As psychiatrist Dr. John Maher told the Parliament's Special Joint Committee, "Death is not an acceptable substitute for good treatment, food, housing and compassion" (66).

Allowing MAID for the mentally ill also risks exacerbating discrimination against the mentally ill by sending the message that their life is not worth living. The Expert Advisory Group warns that MAID for mental illness would be the "ultimate form" of discrimination because MAID will be offered "for all sorts of life suffering, even when their mental disorder could have gotten better" (19, p.5). MAID also risks increasing the sense of being a burden on family and society, potentially plunging them further into illness. The stigma and discrimination faced by the mentally ill appears in both an avoidance of seeking treatment,

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[10] This classification of euthanasia/assisted suicide as *care* is explicit in Quebec's law, and implicit through association in the federal law.

and in the severe lack of access to treatment. Dr. Maher, who says he oversees teams that care for the 7,000 sickest mentally ill patients in Ontario, told Parliament's Special Joint Committee in May 2022 that they have 6,000 patients on their waitlist and the wait-time is up to five years. "I would like to know, have any of you had a serious illness where you've had to wait five years for treatment?" he asked the parliamentarians. "This is stigmatization entrenched in our system" (67).

Can we really consider MAID for the mentally ill while patients are struggling to even access treatment? Bill C-7 requires that MAID requesters be "informed" about treatment options, but there is no requirement that patients be given *access* to these treatments. We face the frightening prospect that MAID could be approved not only without requiring the patient to exhaust treatment options, but where the patient in fact *wanted* to pursue treatment but could not access it (57). In fact, Dr. Ellen Wiebe, a family doctor and MAID provider, told the Special Joint Committee that she would consider a five-year wait to access treatment as sufficient cause to approve MAID as irremediable (68).

MAID FOR PEOPLE WITH DISABILITIES: A WARNING WE OUGHT TO HEED

Canada's decision to open MAID access to non-terminal conditions makes it available to two major classes: people with disabilities and the mentally ill. There are important intersections between these two vulnerable groups, with each facing systemic challenges in our society associated with, respectively, ableism and sanism. Bill C-7 excluded the mentally ill from MAID for a time, but people with disabilities have had access since the bill came into force in March 2021. The experience of MAID for people with disabilities sheds important light on what MAID for the mentally ill will look like. In fact, examining this experience shows that the dangers I warn of for the mentally ill are already coming to pass for people with disabilities.

Disability scholar Heidi Janz observes that while euthanasia advocates hailed C-7 as a victory for autonomy, disability-rights advocates "mourned" the new law: "These disability-rights advocates recognized that, contrary to the claims of its champions, Bill C-7 would not advance the human rights of people with disabilities; rather it would enshrine into law the quintessential ableist stereotype that it's better to be dead than disabled" (69, p.299). Just like the mentally ill, people with disabilities systemically lack access to social determinants of health such as stable employment, adequate and affordable housing, and support services (69). In such a situation, accessibility to MAID presents people with disabilities with a "Hobson's choice," says Janz; that is, they are put in "a situation in which it seems that you can choose between different things or actions, but there is really only one thing that you can take or do." Since the passage of Bill C-7, she explains, "death by MAID is their only remaining alternative to abject poverty and/or incarceration in a long term care facility" (69, p.304).

Indeed, a mounting body of evidence suggests that people with disabilities are resorting to MAID due to a lack of access to sufficient social and structural support systems. A 2023 article on the state of Canada's MAID regime by Coelho et al. points out that Canada's data collection is inadequate because it is largely reliant on self-reporting by MAID providers, and there is little oversight. As a result, one must rely heavily on narrative accounts reported in the media to evaluate the system (70). Since Bill C-7's passage, the media has been flooded with stories of people who are choosing MAID simply because they cannot access the support they need to live with their disability. Various researchers and journalists have gathered such accounts (69-72). I list here three examples:

1. "Sophia," a 51-year-old Ontario woman with severe chemical sensitivities, opted for MAID in February 2022 when she could not secure adequate housing free from cigarette smoke and cleaners (3). In a video filmed eight days before her death, she said, "The government sees me as expendable trash, a complainer, useless and a pain in the ass."

2. "Denise," a wheelchair-bound 31-year-old woman, told media in the spring of 2022 that she received initial approval for MAID after she could not find housing that would accommodate her chronic illnesses (2). Living only on a meagre income from Ontario's Disability Support Program, she told the reporter, "I've applied for MAiD essentially...because of abject poverty." Fortunately, "Denise" ended up opting out of MAID after an outpouring of support in response to the initial report on her challenges (73).

3. Michael Fraser, a 55-year-old Toronto man who was housebound due to disability and unable to afford rent, received MAID in July 2022 (4). He said the decision was based on "a constellation of factors — intractable disease, poverty, childhood sexual trauma, mental health challenges and the option of an assisted death."

We have good reason to expect that the experience of people with disabilities will be reflected in the experience of the mentally ill. In fact, as is clear from Fraser's case, mental illness is already a major contributing factor to MAID decisions. Based on the experience of people with disabilities, disability rights groups have been sounding the alarm over the risk to the mentally ill in the lead up to the legalization of MAID for mental illness in March 2024. As a coalition of over 50 organizations wrote to Canada's justice minister in December 2022: "We know, as do you, that the existing law is not working and has not worked, and that people with disabilities have been dying by MAiD due to their life circumstances and oppression. To legalize MAiD for mental illness would pour gas on a fire that is already out of control" (74).

CONCLUSION

In this paper I have argued on three grounds against opening access to MAID where mental illness is the sole underlying condition. First, I argued that we must adopt an objective interpretation of irremediability, and that on this objective interpretation mental illness cannot be deemed irremediable, as required by the MAID eligibility criteria. Second, I argued that grievously mentally ill patients cannot be deemed with adequate certainty to have the capacity to choose MAID, and thus MAID for mental illness fails to meet a second key eligibility criterion. Third, I argued that allowing access to MAID on grounds of mental illness will have a devastating impact on care and support of the mentally ill, including psychiatric care, suicide prevention, and social/structural supports.

If Canada does move forward with this expansion of MAID to those suffering from mental illness, as it seems it will, how bad will it be? Expert bodies supporting access to MAID on the grounds of mental illness assure us that the number of cases will be low, pointing to data from the Netherlands and Belgium. Only a small number of requests for psychiatric euthanasia in these countries are approved,[11] and psychiatric euthanasia deaths represent only about 1.5% of total euthanasia deaths. The reality is that it is impossible to predict what will happen if Canada opens access to psychiatric MAID. But I suggest that we have good reason to think that Canada will have many more cases than they do in the Netherlands and Belgium.

We need to remember that when MAID was legalized in Canada in 2016, the claim was that it would not have a sweeping effect on the country's attitudes towards life and death, because the numbers would be low, only occurring in "exceptional cases." The justification here was an appeal to the experience of the Netherlands and Belgium (75). However, our experience in Canada has been radically different than predicted. The number of MAID deaths are already significantly higher than the Netherlands and Belgium and continue to grow significantly every year. Since 2019, the number of deaths has increased by 135%, from 5,631 cases to 13,241 cases. We can debate why Canada's numbers are rising so rapidly but it seems that the this is due to the manner in which Canada has set up its MAID regime. In particular, Canada has treated MAID as a form of care, helping to destigmatize and encourage MAID to be seen as integrated into a normal continuum of treatment. Moreover, Canada has adopted a highly subjectivized approach, placing a high value on autonomy versus protection of the vulnerable and respect for life (62).

The ground has, I argue, been laid for this same dynamic to play out in cases of MAID for mental illness. As MAID has been integrated into healthcare, so too will it be integrated into care for the mentally ill. And we have seen that the criteria to govern MAID for mental illness have been established in a way that emphasizes the subjective aspect, the principle of autonomy, putting a premium on the patient's own determination about what they purportedly want. I suggest that we see this subjective emphasis in two major ways. First, in the Netherlands and Belgium there is a requirement that patients pursue other treatment options before they can be given access to MAID. This requirement contributes to the high number of rejected requests. However, in Canada we have no such requirement; all that is required is that the patient be informed of other treatment options and that they have seriously considered them. So, a key requirement set up in the Netherlands and Belgium and which has led to a low number of cases is not present in Canada's system. Second, there is a strong move, even an official one, for interpreting what would ordinarily be objective criteria as subjective criteria in order to allow people to choose MAID. As we saw, there is a big push to interpret irremediability in terms of the patient's decision, along with their doctor, not to pursue other treatment options.

We must remember that this so-called autonomy is meant to be exercised by patients who have *grievous* mental health conditions, and conditions that are often closely linked with a desire for death. This is a population in highly vulnerable situations, and vulnerable precisely with respect to the decision they are expected to make autonomously. So, let us be clear: If Canada goes down this path, many vulnerable people will be given MAID at the hands of psychiatric caregivers who are sworn to protect and care for them.

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[11] Recent studies estimate that 95% of requests are rejected in the Netherlands (9).

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REFERENCES

1. Health Canada. Fourth Annual Report on Medical Assistance in Dying in Canada 2021. Oct 2023.
2. Favaro A. Woman with disabilities nears medically assisted death after futile bid for affordable housing. CTV News. 30 Apr 2022.
3. Favaro A. Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing. CTV News. 13 April 2022.
4. Cribb R, Buckley C, Gribilas T. Michael's choice. Toronto Star. 10 Nov 2022.
5. Is it too easy to die in Canada? Surprising approvals for medically assisted death. The Fifth Estate. CBC. 17 Jan 2023. (Starting at 18:49.)
6. Collège des médecins du Québec. BRIEF— Recommendations on Expanded Access to Medical Assistance in Dying. Submitted to Special Joint Committee on Medical Assistance in Dying. 24 May 2022.
7. Parliament of Canada. Special Joint Committee on Medical Assistance in Dying. Medical Assistance in Dying in Canada: Choices for Canadians. 1st session. 44th Parliament. 15 February 2023. Committee Report No. 2.
8. Bill 11. An Act to Increase the Supply of Primary Care Services and to Improve the Management of that Supply. 2nd sess. 42nd Legislature. 2022.
9. van Veen S, Widdershoven G, Beekman A, Evans N. Physician assisted death for psychiatric suffering: experiences in the Netherlands. Frontiers in Psychiatry. 2022;13:895387.
10. Dutch Regional Euthanasia Review Committees. Annual Report 2021. 27 Mar 2022.
11. Dutch Regional Euthanasia Review Committees. Annual Report 2022. 27 Mar 2023.
12. Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie. Dixième rapport aux Chambres législatives (années 2020-2021). 8 Dec 2022.
13. Truchon c. Procureur général du Canada, QCCS 3792 (2019).
14. Department of Justice. Legislative Background: Medical Assistance in Dying (Bill C-14). 2016.
15. Quebec National Assembly. Report of the Select Committee on the Evolution of the Act Respecting End-of-Life Care. Dec 2021.
16. Bill C-7. An Act to Amend the Criminal Code (Medical Assistance in Dying). 2d sess. 43rd Parliament. 2021. SC 2021.
17. Bill C-39. An Act to Amend an Act to Amend the Criminal Code (Medical Assistance in Dying). 1st sess. 44th Parliament. 2023. SC 2023.
18. Council of Canadian Academies. The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition. Ottawa: The Expert Panel Working Group on MAID Where a Mental Disorder is the Sole Underlying Medical Condition; 2018.
19. Expert Advisory Group on Medical Assistance in Dying. Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Person with a Mental Disorder. 13 Feb 2020.
20. Nicolini ME, Jardas EJ, Zarate CA, Gastmans C, Kim SYH. Irremediability in psychiatric euthanasia: Examining the objective standard. Psychological Medicine. 2022;53(12):5729-47
21. Gaind KS. What does "irremediability" in mental illness mean? Canadian Journal of Psychiatry. 2020;65(9):604-6.
22. Sinyor M, Schaffer A. The lack of adequate scientific evidence regarding physician-assisted death for people with psychiatric disorders is a danger to patients. Canadian Journal of Psychiatry. 2020;65(9):607-9.
23. Schuklenk U. Certainty is not a morally defensible threshold to determine eligibility for assisted dying. Bioethics. 2019;33(2):219-20.
24. Schuklenk U, van de Vathorst S. Treatment-resistant major depressive disorder and assisted dying. Journal of Medical Ethics. 2015;41(8):577-83.
25. Cowley C. Euthanasia in psychiatry can never be justified: a reply to Wijsbek. Theoretical Medicine and Bioethics. 2013;34(3):227-38.
26. Sinyor M. Parliament of Canada. Special Joint Committee. Statutory Review. 26 May 2022.

27. Expert Advisory Group on Medical Assistance in Dying. Brief to Parliamentary Committee. Submitted to Special Joint Committee on Medical Assistance in Dying. 30 May 2022.
28. van Veen SMP, Ruissen AM, Beekman ATF, Evans N, Widdershoven GAM. Establishing irremediable psychiatric suffering in the context of medical assistance in dying in the Netherlands: a qualitative study. Canadian Medical Association Journal. 2022;194(13):E485-91.
29. Centre for Addiction and Mental Health. Policy Advice on Medical Assistance in Dying for Mental Illness. Toronto. Oct 2017.
30. Canadian Association for Suicide Prevention. MAID for Mental Illness: Matters for Consideration. Submitted to Special Joint Committee on Medical Assistance in Dying. 26 May 2022.
31. Gaind KS. Canadian Psychiatric Association interim response to Report of the Special Joint Committee on physician assisted dying. 11 Apr 2016.
32. Chaimowitz G, Freeland A, Neilson GE, et al.Position Statement: Medical Assistance in Dying. Canadian Psychiatric Association. 10 Feb 2020.
33. Chaimowitz G, Freeland A, Neilson GE, Mathew N, Snelgrove N, Wong MR. Position Statement: Medical Assistance in Dying: An Update. Canadian Psychiatric Association. 18 Oct 2021.
34. Maung HH. Externalist argument against medical assistance in dying for psychiatric illness. Journal of Medical Ethics. 2022;49(8):553-57.
35. 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. 2018;63(7):451-56.
36. Dembo JS, Clemens NA. The ethics of providing hope in psychotherapy. Journal of Psychiatric Practice. 2013;19(4):316-22.
37. Health Canada. Final Report of the Expert Panel on MAiD and Mental Illness. The Expert Panel on MAID and Mental Illness. 13 May 2022.
38. Association des médecins psychiatres du Québec. Access to medical assistance in dying for people with mental disorders: Discussion Paper. Nov 2020.
39. Gupta M. Parliament of Canada. Special Joint Committee. Statutory Review. 26 May 2022.
40. Smith D. Parliament of Canada. Special Joint Committee. Statutory Review. 25 May 2022.
41. Van Veen SMP, Ruissen AM, Widdershoven GAM. Irremediable psychiatric suffering in the context of physician-assisted death: a scoping review of arguments. Canadian Journal of Psychiatry. 2020;65(9):593-603.
42. Department of Justice. Glossary - Medical Assistance in Dying. 2016.
43. Ontario, Health Care Consent Act, 1996, c. 2.
44. Wildeman S. Consent to psychiatric treatment: from insight (into illness) to incite (a riot). In: Chandler J, Flood C, editors. Law and Mind: Mental Health Law and Policy in Canada. Toronto: LexisNexis; 2016.
45. Kidd IJ, Spencer L, Carel H. Epistemic injustice and psychiatric research and practice. Philosophical Psychology. 2022.
46. Blikshavn T, Husum TL, Magelssen M. Four reasons why assisted dying should not be offered for depression. Journal of Bioethical Inquiry. 2017;14(1):151-57.
47. Appelbaum PS. Physician-assisted death in psychiatry. World Psychiatry. 2018;17(2):145-46.
48. Charland L. Passion and decision-making capacity in anorexia nervosa. American Journal of Bioethics Neuroscience. 2015;6(4):66-68.
49. Ontario, Mental Health Act, 1990, section 20.
50. Van Staden CW, Kruger C. Incapacity to give informed consent owing to mental disorder. Journal of Medical Ethics. 2003;29(1):41-43.
51. 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 Analysis. 2018;26(4):326-43.
52. Charland L, Lemmens T, Wada K. Decision-making capacity to consent to medical assistance in dying for persons with mental disorders. Journal of Ethics in Mental Health. 2016:1-14.
53. Kim SYH. Evaluation of Capacity to Consent to Treatment and Research. New York: Oxford University Press; 2010.
54. Kim SYH. Do clinicians follow a risk-sensitive model of capacity determination? Psychosomatics Journal. 2006;47(4):325-29.
55. Marson DC, McInturff B, Hawkins L, Bartolucci A, Harrell L. Consistency of physician judgments of capacity to consent in mild Alzheimer’s disease. American Geriatrics Society. 1997;45(4):453-57.
56. Appelbaum P, Grisso T. Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. New York: Oxford University Press; 1998.
57. Harris K. The next frontier in the ‘right to die’: advance requests, minors and the mentally ill. CBC News. 3 Jan 2019.
58. Freyenhagen F, O’Shea T. Hidden substance: mental disorder as a challenge to normatively neutral accounts of autonomy. International Journal of Law in Context 9. 2013;9(1):53-70.
59. Maung HH. Psychiatric euthanasia and the ontology of mental disorder. Journal of Applied Philosophy. 2020;38(1):136-54.
60. Owen GS, Freyenhagen F, Richardson G, Hotopf M. Mental capacity and decisional autonomy: an interdisciplinary challenge. Inquiry. 2009;52(1):79-107.

61. Tan JOA, Stewart A, Hope T. Decision-making as a broader concept. Philosophy, Psychiatry, and Psychology. 2009;16:(4):341-44.
62. Lemmens T. When death becomes therapy: canada's troubling normalization of health care provider ending of life. American Journal of Bioethics. 2023;23(11):79-84.
63. Bill C-14. An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying).1st sess. 42nd Parliament. 2016. SC 2016.
64. Bill C-300. An Act Respecting a Federal Framework for Suicide Prevention. 1st sess. 41st Parliament. SC 2012.
65. World Health Organization. Preventing Suicide: A Global Imperative. 17 Aug 2014.
66. Maher J. Parliament of Canada. Special Joint Committee. Statutory Review. 26 May 2022.
67. Maher J. Parliament of Canada. Special Joint Committee. Statutory Review. 26 May 2022.
68. Wiebe E. Parliament of Canada. Special Joint Committee. Statutory Review. 26 May 2022.
69. Janz H. MAID to die by medical and systemic ableism. In: Kotalik J, Shannon DW, editors. Medically Assistance in Dying (MAID) in Canada. The International Library of Bioethics 104. Cham, Switzerland: Springer; 2023. p. 299-308.
70. Coelho R, Maher J, Gaind KS, Lemmens T. The realities of medical assistance in dying in Canada. Palliative & Supportive Care. 2023;21(5):871-78.
71. Leffler B, Dimain M. How poverty, not pain, is driving Canadians with disabilities to consider medically-assisted death. Global News. 8 Oct 2022.
72. Raikin A. No other options. The New Atlantis. 2022;71(Winter 2023):3-24.
73. Favaro A. Woman with disabilities approved for medically assisted death relocated thanks to 'inspiring' support. CTV News. 28 May 2022.
74. Hopper T. Disability groups now assuring members they won't recommend euthanasia. National Post. 5 Jan 2023.
75. Quebec National Assembly. Select Committee on Dying with Dignity Report. Mar 2012.