

EDITORIAL

Assisted Death in Canada for Persons with Active Psychiatric Disorders

My Clinical World

On March 8th, 2016 one of my patients said to me, “I can kill myself soon...they are making a law to make it legal...and you won't be able to stop me now”. My heart sank. I have worked for years to support this person through suicide attempts and the profound burden of serious mental illness.

Another patient expressed grave concern because she counted on “the system” to pull her back from the precipice when she attempted suicide. She really did not want to be allowed any pathway to certain death despite her persistent suicidal behaviour and professed claim of wanting it badly.

In 20 years as a physician caring for people with mental illness I have rarely met anyone who wants to die; I have commonly met people who are weighing or planning suicide because they can find no other way to relieve the anguish and suffering of severe mental illness. Fortunately, in most of these cases, there were effective treatments that had not yet been tried and the suicide option was relegated to a back-up position. Paradoxically, for many people suicidal thinking helps keep them alive because it gives them a sense of control: “there is a way out if I ever need it.”

That is not to say that mentally ill people should not be allowed access to medical aid in dying because of the possibility of effective treatments being developed in the future (near or otherwise). It is to say that current potentially effective treatments must be tried before even moving to the question of choosing death.

Suicide Prevention

If an “actively suicidal” person comes to me for help, as a psychiatrist, I have the legal option, and moral and professional duty, to commit them to a hospital against their (possibly impaired) will for a psychiatric assessment. Suicide prevention is an undeniably important social good and goal.

Assisting someone to commit suicide continues to be illegal in Canada and is punishable by up to fourteen years in jail. As a society we still seem to want assisted suicide by the general citizenry to be illegal because we can imagine many possible abuses...dare I say, abuses that physicians could of course also commit, under the added cloak of professional mercy.

“At root, the debate is about what mistakes we fear most – the mistake of prolonging suffering or the mistake of shortening valued life. We stop the healthy from committing suicide because we recognize that their psychic suffering is often temporary. We believe that, with help, the remembering self will later see matters differently

than the experiencing self – and indeed only a minority of people saved from suicide make a repeated attempt; the vast majority eventually report being glad to be alive. But for the terminally ill who face suffering that we know will increase, only the stonehearted can be unsympathetic.”¹

Some History

In its earlier form the Hippocratic oath contained these words: “I will give no deadly medicine to anyone if asked, nor suggest any such counsel...”

In one of the later versions it was modified as follows: “Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.” (attributed to Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, 1964).

One can't help but wonder if the values that motivated the change in the oath reflect the undercurrent of liberal eugenics that marked so much of medicine (and psychiatry in particular) in the first half of the 20th century.

The early euthanasia debates in the 1970's and 80's centred on two groups. Those who were in a coma and brain dead, and those who were terminally ill (having a progressive physical illness with uncontrollable pain) who were lacking the physical wherewithal to literally kill themselves.

With the former, the debates centred on notions of brain death, personhood, wrongful life, thwarted autonomy, a life no longer worth living, and the right to die. The latter considered futility of treatment, the right to refuse treatment, and the question of a harmful life. Elements of both these debates still swirl at the centre of the current legislative storm.

To be clear, active voluntary euthanasia was intended to address the wrong or harm of citizens enduring suffering they cannot stop themselves. The involvement of physicians reflected the fact that a brain dead person was *artificially or medically sustained* and could never recover; or there was a *medically treated physical illness* that was now terminal, and the end was in some obvious sense, near.

Why did the social discussion make the leap from the much narrower goal of helping someone who is already brain dead die, or helping someone of sound mind act on a desire (expressed

in the present or through prior wishes) to kill themselves when the disease has progressed to the point that suffering (however defined) is unbearable and they can't physically do it themselves (e.g. endstage ALS, cancer, dementia, AIDS)?

In Canada we have now moved to the much larger question of helping persons stop "intolerable suffering" from all "grievous, irremediable conditions" even when they can do so themselves and death is not necessarily imminent.

In the pro-euthanasia culture that has devolved in the Netherlands, physicians (including psychiatrists) have for many years been assessing the requests of persons with active mental illness for assisted death and they are writing the lethal drug prescriptions². In my opinion, the eligibility criteria there are too broad and subject to abuse. This is not the Canada I want.

The Carter Decision

In the *Carter* decision the Supreme Court of Canada ordered our federal parliament to develop and enact assisted death legislation by June 6th of 2016. So as a country, or more specifically, a community of citizens with constitutionally protected rights, we are trying to figure out how to regulate the process of having an assisted or hastened death.

Of note:

"The Supreme Court of Canada stated that "persons with psychiatric disorders" "would not fall within the parameters" suggested by the reasons in *Carter*.

Despite that comment in the *Carter* decision and given its focus on grievous, irremediable conditions and intolerable suffering, the test formulated by the Supreme Court of Canada in *Carter* leaves open the possibility that it would be unconstitutional to bar a capable adult from making the fundamentally important and personal medical decision that he or she can no longer tolerate the irremediable suffering of a treatment-resistant, severe mental illness."³

The court is making a rights based argument that citizens must not be forced to endure certain kinds of suffering longer than they wish. But they are also speaking of "irremediable conditions" which shifts the matter to the domain of clinical ethics as well.

The rights based argument (the right not to endure unnecessary harm) and the clinical ethics based argument (the right to have suffering relieved) are deeply entwined in this debate.

We must not downplay the fact we also have a broad constitutional obligation to protect the vulnerable. At the very least, some arguments rooted in a rights based perspective seem to evidence some willful blindness to (or limited clinical appreciation of) just how vulnerable you can become when your brain isn't working as it usually does (and should again before making an irreversible decision like this.)

The provincial legislation on assisted death in Quebec, which recently came into force, specifically (and rightfully) excluded

persons with mental illness. But we now have a federal parliamentary committee, along with some very concerned citizens and consumer groups, arguing that the new federal law must not exclude persons with mental illness. Even if the new law (as it seems the Liberal government intends) excludes persons with mental illness, it is certain there will be court challenges.

If persons with mental illness are excluded, do we mean by that:

1. everyone with a past history of mental illness;
2. persons with active symptoms of mental illness,
3. persons with mental illness who endure progressive, episodic or cyclic deterioration in mental function;
4. or persons with mental illness of the sort that affects cognition, judgment or mood to the point that decisional capacity is impaired around the time that assisted death is being sought?

Presumably it is this last group that is of greatest concern [and which will from time to time subsume members of both groups (2) and (3)].

The *Carter* decision supports helping someone who is physically unable to commit suicide (and would therefore have to do it earlier than desired). Insofar as persons with mental illness can literally kill themselves it is hard to see how the rights based argument for assistance due to physical incapacity could even apply. How can one be deprived of a right one can accomplish on one's own?

Assisted Death vs Physician Assisted Death

There is a clinical ethics argument to be made that we ought not to let people who have suffered terribly for a long time end their lives alone and in a stigmatizing manner but that in those cases where there is nothing left to offer, that we owe it to people to at least accompany them to the end of life.

Be that as it may, it is not clear to me that the state (or physicians as directed agents of the state) have to involve themselves in actions that citizens can accomplish on their own, or with the assistance of a variety of other social resources that do not require physician involvement.

I understand full well that many doctors in Canada will feel comfortable (and relieved) when they can legally end the suffering of those enduring horrible physical pain with its attendant emotional burden for the patient and family. In reality this has already been occurring for years [e.g. large morphine ranges sometimes prescribed on palliative care units ("palliative sedation"), prescriptions renewed knowing the terminal patient is stockpiling them, morphine pumps with no dose limit in AIDS hospices].

The Quebec legislation is explicit that medical aid in dying is a healthcare act which means that it results from the usual process of clinical decision-making in cases where a person is suffering

terribly, nothing helps to relieve it, the person is going to die soon anyway, and all that is left ahead of them is suffering. This approach distances the issue from the rights based discourse and brings the problem into a clinical ethics discourse where the question is no longer whether a right is being denied, but rather the question is, “Is this truly a form of treatment or medical care?” If not, how is it distinct from other types of permitted healthcare acts such as palliative sedation?

It is not clear to me that assisted death is a healthcare act or a medical decision except perhaps secondarily, incidentally or just conveniently. It seems primarily to be an existential decision (with some pragmatic help needed for its accomplishment). All treatment has already failed or is inadequately palliative; there are no further treatment decisions to be made...just a decision to supplant life with death.

Insofar as treatment aims at preventing death, hastening death can't logically be treatment. Insofar as treatment aims at reducing suffering, hastening death is the treatment par excellence. But isn't the primary goal of all treatment to help people live their lives well despite maladies? (With the emphasis on “live”.)

Within the therapeutic relationship we have privileged knowledge and a privileged opportunity to relieve suffering when all else has failed. If continued meaningful living is not possible, then a doctor could certainly try to help someone live life as well as possible right to the end. In fact isn't this what the stereotypical GP did in the days of house calls before we shifted to this new way of resisting death and fighting dying at all medical costs (often with limited success and poor quality of life)? And isn't this the cardinal philosophy of palliative care? There can be no doubt that palliative ministrations are rightly a doctor's duty, but accompanying someone at the very end of the journey is primarily an act of human kindness that falls to many (family, friends, and possibly but not necessarily your doctor).

Perhaps I am conditioned by my modern medical training, but I also worked on palliative care units for years. Holding someone's hand while they die is not the same thing as sticking a needle into someone's arm and killing them. Perhaps my reticence reflects deeply held but indefensible values; or perhaps there is something critically important about keeping the roles of ‘bringer of comfort’ and ‘bringer of death’ practically separate even if they are arguably on a conceptual continuum.

Decisional Capacity

I am told doctors have to be part of the process no matter what because they have to assess capacity for decision making. Fair enough; as a physician I can be involved with an assessment of capacity that offers an opinion that a person is of sound mind for whatever life or death decisions they wish to make (point in time and decision specific).

But each physician must be allowed the option of conscientious objection (which is supported in the *Carter* decision) and supportively refer on to others more willing as conscience dictates. Note that this option would vitiate the earlier point about the

value of a uniquely privileged therapeutic relationship (and make another doctor's capacity assessment more challenging and suspect in the absence of some prior knowledge of the person's values gleaned over time through a continuing therapeutic relationship).

Some physicians (and some psychologists and nurse practitioners) are uniquely trained and experienced in decisional capacity assessments. But make no mistake; this is a sophisticated skillset and much conceptual work and training is still needed before this becomes a tool wielded with universal aplomb.

The proposed legislation is expected to call for an evaluation or supporting opinion by two health professionals (doctor or nurse practitioner). These are important safeguards. But if the law ever allows a person with active mental illness to seek an assisted death, then at the very least there should be an additional requirement for a mandatory psychiatric evaluation (including a decisional capacity assessment) before the person is allowed to avail themselves of next steps.

In my opinion, decisional capacity assessments are one of the greatest areas of potential abuse or inadequacy in any assisted death protocol.

Death Prescriptions

Some have cogently argued that asking physicians to write the death prescription is simply an extension of their extant responsibility to relieve suffering. Others respond that this is an untenable position of dual agency; “don't make me the judge and executioner”.

Tragically, people living with mental illness kill themselves in large numbers despite best prevention and mental health treatment efforts. And they do so without getting a death prescription. A Google search instantly yields over 5 million results with very simple and specific instructions for painless suicide.

There are alternatives to physicians writing these prescriptions.

Alternatives

After getting however many such capacity opinions as we feel are required procedural safeguards, then a person could choose whether to go with the signed documents in hand to get the death concoction at a death assistance centre or pharmacy. Splitting a hair? Artificially trying to limit the burden of unclear dual agency and allowing a working form of conscientious objection to involvement in the process? Maybe, but if it helps me be the physician I swore to be, then I'll take it.

Do doctors have to help because people commonly “botch” suicide attempts, use up emergency response resources, and traumatize family members and others involved in the aftermath? I am not sure how these points serve an argument for physician involvement. They direct us equally to other solutions that do not involve doctors but still solve the social problems.

Why not develop specific support services for those who have completed the necessary legislated steps? For example, what about

government funded death assistance centres (or mobile vans like Belgium) with sensitive death counsellors/technicians who provide advice on means, location, body pick-up, and getting a death certificate after the fact? They could also make house calls and assist with IV placement if a person is physically unable to swallow the death-causing pills, and help with other practical follow-up details with minimal fuss or complication. Experience from other countries and reports from suicide assistance groups show clearly that doctors are simply not needed in the process.

Will hospice groups want to take this on as a natural extension of their mandate? Are hastening death and providing comfort while dying two sides of the same coin? Perhaps, but in that toss, heads you comfort and tails you die. Do we really want hospice services being able to hasten death as a primary goal rather than a secondary double effect? Presumably this would make them more welcome to some and inordinately threatening to others.

Exceptions

I am not disingenuously saying that there are no mental conditions or burdens that make life subjectively unbearable (e.g prolonged severe chronic pain, extremely treatment resistant depression, unremitting and terrifying paranoia). I am saying that most persons in such circumstances can choose to kill themselves without physician or state involvement.

But what about those people who are so disorganized in thought, catatonic, or so affectively or cognitively impaired that they can't plan or manage to kill themselves? Are these the people we want to clearly exclude from an assisted death option because of obvious decisional incapacity? What if prior wishes are known? What if the profoundly debilitating psychiatric illness is permanent or progressive? What if the person is obviously suffering intense emotional pain? What if the 'person who was' is likely to never return? Are the considerations here not analogous in some important sense to the brain death discussions? The person is gone, the person is suffering, "no human being should have to endure this..."

Some find spiritual meaning in extreme suffering. Who are we to judge the quality of someone's life? Who do we have to be? My child, my spouse, my mom? If death is chosen for me not because of what they can't stand to watch, but rather because of what they believe the "me" they knew would want, then our society has some right to attempt safeguards against deceit or abuse, but no clear legal right to prohibit the potentially hardest and most loving act of all... born of heart wrenching compassion.

These exceptional cases demand our best attempts to conceptually define the legislative limits and risks. And it may well be that wisdom will call us to protecting a gray area that requires a judge's nuanced evaluation of the human particulars and frailties involved at a unique moment in someone's life. Let's not make legislation that is too broad or blunt an instrument.

Conclusion

With the advent of this legislation it behooves all of us to complete advance directives and to do our best to imagine ourselves in a

variety of life predicaments. Notwithstanding the experiential gap we each have with our future selves, this exercise could turn out to be the key to safeguarding some of your most important life decisions.

I can't help but feel that some of the arguments presented in support of people with active mental illness getting "medical approval" and then help to kill themselves is in part stigmatization masquerading as a defence of constitutional rights.

What responsibility does society bear when the circumstances of someone's life cause intolerable suffering? Especially when this is due to the many failures of our society to make meaningful places for mentally ill people. The fact is many mentally ill people live in terrible conditions of poverty and social exclusion. Will I see gracious and unselfconscious offering of full community membership in my lifetime? Should society's failure be a legitimate source of intolerable suffering? Are we pushing people towards wanting death and then perversely offering a legal path to that end? Shame on us if we are.

As a physician, I am not an agent of death. By virtue of vocation and oath I am an agent of hope. I have promised to do my best to relieve physical and emotional suffering, and when my art, skills and tools are believed by my patient to be inadequate, and life is felt to be no longer worth living, then each person can signal their answer to the question, "to be or not to be", through their respective literal action. But when they do so, the decision must not be unduly conditioned or determined by an active psychiatric disorder that is affecting cognition, judgment or mood. As the old moral maxim goes, "when in doubt don't do it"...a proscription for patient and physician alike.

I was taught long ago that the "slippery slope" argument is a fallacy. My ethics professor made it clear that, "the possibility of abuse is no argument against proper use". Even so, I have a deeply held intuition that if a dam is never opened in the first place, that downstream flooding is less likely. More to the point, many social horrors and atrocities started with seemingly reasonable ideologies that were then perverted and collectively supported. Let's proceed cautiously.

References

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These opinions are entirely my own and do not represent a position taken by the Editorial Committee or Board of the JEMH.

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