

Medical Assistance in Dying for Suffering Arising from Mental Health Disorders: Could augmented safeguards enhance its ethical acceptability?

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Abstract

The controversial topic of medical assistance in dying for suffering arising from mental health disorders has resurfaced since the 2015 Supreme Court of Canada decision that recognized psychological suffering as a legitimate, qualifying condition for medically-assisted deaths, and did not restrict such legal acceptability to near-death paradigm circumstances. This subject area is explored and analyzed through the use of four ethics lenses: individual autonomy and informed choice, patient welfare considerations, social/feminist accounts of justice, and formal Aristotelian justice. It is concluded that medical assistance in dying for suffering arising from mental health disorders (MHDb-MAiD) should be considered ethically acceptable in non-paradigm circumstances in Canada, and that morally-relevant and pragmatic distinctions between these circumstances and the most common circumstances of medical assistance in dying for suffering arising from physical health disorders support the potential inclusion of a set of five augmented safeguards in possible, future North American MHDb-MAiD regulations and policies.

Key Words: mental-health-disorder-based-suffering, medical assistance in dying, augmented regulatory and policy safeguards

Introduction

There has been a renewed interest within North America in the controversial topic of medical assistance in dying (MAiD) for suffering that arises from the experience of mental health disorders since the Carter v. Canada Supreme Court of Canada (SCC) decision which

recognized psychological suffering as a legitimate basis for requesting a medically-assisted death (Carter v. Canada 2015). The subsequent 2016 political decision in Canada to legally restrict accessibility to MAiD to persons who are in an “advanced state of functional deterioration in capability” (wording of both Quebec’s *Bill 52* and federal *Bill C-14*) and whose death “is reasonably foreseeable” (*Bill C-14* wording), which essentially eliminates psychiatric disorders as potential stand-alone, qualifying conditions for MAiD, came as a surprise to many informed observers, given its discordance with the SCC decision (*Bill C14* 2016; *Bill 52* 2014). This legislative restriction also went against the recommendations of the Special [Parliamentary] Joint [House of Commons & Senate] Committee on Physician-Assisted Dying which was appointed by the Canadian government.

The incidence of medically-assisted dying based on suffering arising from mental health disorders (MHDb-MAiD) has gradually increased in international jurisdictions such as Belgium and the Netherlands where mental health disorders can be stand-alone, qualifying conditions for MAiD. There were 56 reported cases in the Netherlands in 2015 (up from 43 cases in 2013) (Kim et al. 2016). To date, the potential provision of assisted dying services for mental-health-disorder-based (MHDb) suffering has not been well accepted by the North American professional psychiatric community and the public-at-large (American Psychiatric Association 2016; McCormack & Fléchais 2012; Nanos Research / Globe & Mail Survey 2016). In international jurisdictions where MHDb-MAiD is legal, the practice exists in clinical tension with the well-entrenched, psychiatric care and psychiatric residency-training traditions of: 1) intentional provision of therapeutic benefits to patients through the sequentially-augmented use of multiple treatment modalities (beneficence-related duty-of-care), and 2) prevention of the serious harms of self-injury and suicide (nonmaleficence-related obligation).

In the relevant literature, a mental health disorder that is often referenced as a stand-alone, qualifying condition for MHDb-MAiD is severe, treatment-resistant depression. Although it is possible to imagine stand-alone, mental health disorders that could meet the *Bill C-14* criterion of a reasonably foreseeable death such as terminal anorexia nervosa or compulsive suicidal behaviour with strong intent to complete, the vast majority of serious mental health conditions are not typically associated, in and of themselves, with a terminal prognosis.

I use the terms near-death paradigm and non-paradigm circumstances in a particular way in the paper. Paradigm circumstances refer to those MAiD scenarios where the individual is experiencing refractory, profound suffering in the context of an anticipated death from the underlying health condition(s) in the near future, i.e., within weeks to a few months. In contrast, non-paradigm circumstances refer to those MAiD scenarios where the individual’s death is not expected to occur within the next few months (Kirby 2015). Given these definitional descriptions, most near-death paradigm MAiD circumstances involve patients with a terminal physical illness, e.g., cancer, a progressive cardiovascular or respiratory disorder, while non-paradigm MAiD circumstances typically involve patients with a chronic medical or psychiatric illness, e.g. a progressive neurodegenerative condition or treatment-resistant psychiatric disorder.

I begin with a brief description of what is currently known about the practice of MHDb-MAiD in Belgium and the Netherlands. Subsequently, MHDb-MAiD is explored and analyzed through a set of four ethics lenses: 1) individual autonomy and informed choice, 2) patient welfare considerations, 3) social/feminist accounts of justice, and 4) formal Aristotelian justice. I conclude on the basis of a synthesis of the analytical outcomes of these lens-based considerations that: 1) significant, morally-relevant similarities between MHDb suffering and physical-health-disorder-based (PHDb) suffering, and the impossibility of demonstrating a morally-relevant difference between these two forms of suffering, support the consideration of both types of suffering as ethically acceptable, qualifying conditions for MAiD in non-paradigm circumstances in the (post 2015 SCC decision) Canadian context, and 2) morally-relevant distinctions and pragmatic differences between the usual circumstances of MHDb-MAiD and the most common circumstances of PHDb-MAiD justify the development, and practical implementation, of a few additional safeguards for the former in North American jurisdictions where MHDb-MAiD may become legal in the future. I finish with a suggested set of five augmented safeguards for the consideration of developers of MHDb-MAiD regulations and policies.

For the purposes of the paper's analyses, I define three distinct types of health-related suffering/distress. Although I consider these three types of suffering/distress to be conceptually distinct, I recognize that they are frequently comingled in the lived experiences of persons who request, and go on to have, medically-assisted deaths (Dees et al. 2011).

MHDb suffering is the experience of suffering on the basis of active symptomatology that directly arises from the person's confirmed DSM-V mental health disorder(s), e.g., symptoms of anxiety/panic, agitation, intense sadness, disturbing delusions/hallucinations, and any concurrent, negatively-experienced side effects of treatment(s) for the mental health disorder(s).

PHDb suffering is the experience of suffering on the basis of active symptomatology that directly arises from the person's physical health disorder(s), e.g., symptoms of pain, nausea, dyspnea (shortness of breath), delirium, and any concurrent, negatively-experienced side effects of treatment(s) for the physical health disorder(s).

Psychoexistential distress is the experience of psychosocial distress that is based on the person's determination that her/his quality of life has been significantly degraded by a health condition(s) so as to render his/her life no longer worth living; persons experiencing psychoexistential distress may recognize accurately, or perceive, that they are no longer capable of participating in activities that formerly made their life meaningful and/or enjoyable; they could also be experiencing a demoralizing, perceived, progressive loss of 'self', dignity, integrity, independence and/or social significance; psychoexistential distress may be experienced by individuals who have a strong desire to remain in control of their destiny and who wish to avoid becoming, or continuing to be, a burden to loved ones (Dees et al. 2011; Rietjens et al. 2009; Ganzini et al. 2007).

I make the assumption for the purposes of the paper that profound suffering arising directly

from DSM-V psychiatric disorders is a real, experiential phenomenon. The content of many direct accounts of the lived experiences of persons with severe and persistent mental illness, and the descriptive reports of their attending health care providers, suggest that this statement is more fact than assumption (Styron 1990; Nemeroff 2007).

I make an additional assumption that I do not argue for here, i.e., that MAiD for profound PHDb suffering is ethically acceptable in non-paradigm circumstances where it is anticipated that a person's natural death from the underlying health condition(s) will not occur in the near future. This assumption is consistent with the ethically- and legally-based findings of the 2015 SCC *Carter v. Canada* decision, and with over-a-decade of implemented assisted dying practices in the Benelux countries. In making this assumption, I recognize that, at least until such time as the outcomes of constitutionally-based SCC challenges to the legitimacy of *Bill C-14* are known, only MAiD for PHDb suffering or mixed PHDb/MHBd suffering in near-death paradigm circumstances is legal in Canada.

Experience with MHDb-MAiD in Europe

MAiD for stand-alone, qualifying mental health disorders has been possible in Belgium and the Netherlands since the early 2000s. Established medical guidelines in both countries advise that a psychiatrist(s) be consulted as part of the request-application process, and this is a mandated requirement in Belgium. Although the academic literature on MHDb-MAiD is scant, two retrospective, case-based studies have recently been reported.

Lieve Thienpont and colleagues (2015) reported on the details of 100 consecutive patients who requested MAiD on mental health grounds from 2007 to 2011 in a single psychiatric outpatient clinic located in a Dutch-speaking region of Belgium. A retrospective, non-interventional analysis of patients' health records revealed the following: 23 of the requestors were men and 77 were women; 48 of the requests for MAiD were approved and 35 assisted deaths were carried out; 90% of the requestors had more than 1 psychiatric diagnosis; and the most common presenting conditions were: 1) treatment-resistant depressive disorder (48 of the unipolar type and 10 of the bipolar type), and 2) a variety of personality disorders of single and mixed types. Twelve of the requestors had a diagnosis of autism spectrum disorder. Other less frequent psychiatric diagnoses among the requestors included post-traumatic stress disorder, schizophrenia, delusional disorder, schizoaffective disorder, eating disorder, somatic symptom disorder and complicated grief.

Scott Kim and colleagues (2016) reviewed 66 clinical summaries of completed MAiD cases from 2011 to 2014 across the Netherlands. The outcomes were similar to those of the Thienpont et al. study in that 70% of the cases were women and many of the studied individuals had more than one psychiatric diagnosis. A diagnostic break-down of the cases revealed a mix of depressive disorders, anxiety disorders (including PTSD and obsessive compulsive disorder), and personality disorders (predominantly of borderline and mixed types). Elements of social isolation and loneliness were noted in 56% of the cases and 52% of the studied individuals were reported to have personality-related problems/issues.

Application of Four Relevant Ethics Lenses

Lens I. Individual Autonomy and Informed Choice

Respect for persons, and related promotion of the self-determination interests of individuals, is the key/primary ethical principle undergirding support for MAiD (Dees et al. 2012). It is generally accepted in Canada and the US that persons have the right, and should have the opportunity, to make meaningful decisions about their health care and treatment. In the MAiD context, proponents extend this concept to include, under the umbrella of health care and treatment, the opportunity to choose how and when to die in circumstances where a specified set of qualifying criteria are met. Importantly, individual autonomy is actualized in all health domains through adherence to the core elements of informed choice/consent, i.e., evaluation/assessment of decision-making capacity, disclosure, understanding, voluntariness and authorization or refusal.

With regard to the first element of informed consent/choice, i.e., decision making capacity, Thomas Grisso and Paul Appelbaum (1995) developed a useful, structured capacity/competence assessment tool to assist in the evaluation of a patient's capacity to make health-related decisions. The four, simplified assessment criteria of the MacArthur Competence Assessment Tool are the patient's abilities to: 1) "understand the relevant information", 2) "appreciate the situation and its consequences", 3) "reason about treatment options", and 4) "communicate a choice" (Appelbaum 2007, 1836).

It is well known that some, severe DSM-V mental health disorders can have degrading effects on a person's decision-making capacity which render the making of an informed choice about a health-related, legal option impossible (Kim et al. 2016). This is particularly so when the experience of symptomatology from a mental health disorder leads to significant impairments in the patient's understanding, insight and/or judgment. For example, individuals who have active, florid psychotic symptomatology, including disturbances of thought and conceptual disorganization, typically have obvious problems with the understanding of relevant features of their life circumstances and the appreciation of the reasonably foreseeable consequences of making or not making health-related decisions. Lack-of-insight is considered to be one of the strongest predictors of incapacity among psychiatric patients. In this regard, lack of recognition of the manifestations and implications of the individual's mental health disorder may be more important than her/his acceptance or non-acceptance of the psychiatric diagnosis(es) provided by his/her attending mental health providers (Neilson and Chaimowitz 2015). Given the potential variability of a patient's mental health status and its dependency in many circumstances on the degree of adherence to recommended treatment, it is usually helpful for mental health providers who are tasked with making determinations of a patient's decision-making capacity to have had some longitudinal experience with providing psychiatric care to the patient over time.

Despite the potential for incapacity in some individuals with mental disorders, "no diagnosis in which consciousness is retained is invariably predictive of incapacity", and most individuals

with DSM-V psychiatric disorders retain the capacity to make informed health-related decisions of an important nature (Appelbaum 2007, 1835). The majority of persons with major depressive disorder, including those diagnosed with severe, treatment-resistant depression, meet the four decision-making capacity criteria of the MacArthur Competence Assessment Tool (Kim et al. 2016; Rudnick 2002). As Laura Dunn and colleagues (2011) have indicated, “depressed patients in general do not ... have significantly impaired decision-making capacity” (33). Interestingly, a study of patients’ decision making with respect to consent for electroconvulsive therapy did not demonstrate a positive correlation between the severity of the patient’s depressive symptoms and her/his degree of incapacity (Lapid et al. 2003).

Based on the foregoing considerations, it cannot be concluded that the having a DSM-V mental health disorder diagnosis precludes the meeting of the requirements set out in standard informed consent/choice processes related to requests for the legal option of an assisted death. However, the possibility of degradation of certain elements of informed choice/consent on the basis of psychiatric illness supports a requirement that the effects of the patient’s mental health disorder on his/her decision making capacity be comprehensively assessed at the time of a request for an assisted death (Ganzini 2008).

One objection to the claim that the experience of a significant mental health disorder does not necessarily disqualify a patient from making an informed decision about a medically-assisted death is that the dire circumstances and emotional desperation of persons who are experiencing profound MHDB suffering can significantly jeopardize informed consent/choice from a voluntariness perspective (Finlay and George 2011; Grisso & Appelbaum 1995). Margaret Battin (2008) has questioned whether informed consent/choice is a useful conception in the typical clinical scenarios in which end-of-life practices such as continuous deep sedation until death and voluntary euthanasia are considered, because reflective, meta-level decision making may not be possible in such circumstances. Essentially, the concern here is that the experience of unbearable suffering acts in the MAiD context as an internally coercive influence/factor. While being a valid consideration regarding the possible degradation of an element of informed consent/choice, this concern applies equally to the experience of profound suffering arising from mental health and physical health disorders (and it did not pose an insurmountable challenge to the SCC’s 2014 position on the ethical and legal acceptability of MAiD).

One of the autonomy-related challenges for the health care provider who is assessing the decision-making capacity of a MHDB-MAiD requestor is to accurately ascertain whether the circumstances under consideration constitute a finding of what has been called rational suicidality (Campo-Engelstein et al. 2016; Conwell and Caine 1991). According to Ron Berghmans and colleagues (2013), a rational decision to end one’s life because of the experience of profound MHDB suffering takes the form of an enduring, well considered and reasoned judgment to forgo further possible treatments if the prospects for symptomatic improvement are low and the anticipated burdens are high. In other words, the choice to request a medically-assisted death is reasonable and rational if there is a high probability of

continued, profound suffering in the future. This description of the mindset of persons requesting MAiD on rational suicidality grounds is quite unlike the potentially reversible suicidal symptomatology that is experienced by psychiatric patients on the basis of their first onset, or crisis-related exacerbation, of a significant mental health disorder (Campo-Engelstein et al. 2016).

Lens II. Patient Welfare Considerations

The ethical principle of nonmaleficence directs health care providers and organizations to do as little as possible harm to patients. In the assisted dying domain, how one defines harm depends on where one is ideologically situated. Proponents of MAiD typically interpret the harm as prolonged, profound suffering while opponents of MAiD often characterize the harm as a hastened death or foreshortened life. In addition to nonmaleficence-related obligations, health care providers and organizations have a duty to provide therapeutic benefits to patients. Opponents of MAiD often argue that, during the theoretical time interval between an assisted death and the (anticipated) timing of a natural death, the MAiD requestor will have lost the opportunity to potentially benefit from a newly-developed treatment or intervention that could have eliminated or adequately mitigated her/his suffering. From the perspective of attending health care providers, this translates to a loss of the opportunity for them to provide a possible, significant therapeutic benefit(s) to patients. This concern is heightened when there is expected to be a lengthy period of time between the implementation of MAiD and the anticipated natural death in circumstances of both MHDb and PHDb suffering, e.g., secondary to some cases of severe, treatment-resistant depression for the former and some cases of mid-stage Huntington disease for the latter. Some proponents of MAiD question whether opposition to medically-assisted dying can be supported on this basis when the relevant hope for therapeutic benefits essentially amounts to either introduction to the market and timely government approval of a new wonder drug or spontaneous recovery of the health condition(s), the latter of which rarely occurs in the health conditions that typically qualify persons for medically-assisted deaths (Berghmans et al. 2013). These MAiD proponents contend that, if the patient with a mental or physical health disorder has decision making capacity, the potential harm of continued profound suffering and the theoretical probability of a prospective therapeutic benefit(s) can be considered and weighed as trade-offs by the person through a well-constructed and supported, informed choice/consent process (Schuklenk and van de Vathorst 2015; Berghmans et al. 2013).

Lens III. Social/Feminist Accounts of Justice

From the perspective of critical feminist theory, a claim can be made that persons with severe and persistent mental health disorders that result in profound suffering are members of an oppressed social group. Many persons with significant, treatment-resistant psychiatric conditions have life experiences that are consistent with the meeting of one or more of Iris Marion Young's five faces of oppression, i.e., marginalization, powerlessness, violence,

exploitation and cultural imperialism (1990). For Young, each of these faces is a sufficient condition for social group oppression in her model of democratic cultural pluralism. The first three of these experiential conditions, marginalization, powerlessness and violence, are particularly applicable to the life circumstances of many individuals with severe and persistent mental illness. If we recognize that individuals fall into the category of an oppressed social group on the basis of their health-related experiences, there is a corresponding social justice obligation on the part of health care providers and organizations to pay particular attention to their interests, needs and perspectives, which includes ensuring that they are meaningfully included in the health-related decision making that affects them. As a way of actualizing this responsibility, it could be argued that privileged attention should be paid to meeting the needs, and non-directionally supporting the capable decisions, of MAiD requestors who have qualifying mental health conditions.

From another social justice perspective, opponents of assisted dying argue that there is an obligation on the part of government to eliminate or mitigate the possibility of discrimination against persons who are members of disadvantaged social groups. In their view, the best way to achieve this objective in jurisdictions where MAiD is not yet legal is to advocate for continued criminalization of the practice. When MAiD is legalized within a jurisdiction, these opponents turn their efforts to limiting the practice to near-death clinical circumstances, which excludes that access of some members of disadvantaged social groups to MAiD, including those with severe and persistent mental illness. Responding on the basis of some limited empirical evidence from the Netherlands and Oregon on assisted suicide dating from the early to mid-2000s, proponents of MAiD contend that there is no evidence that “patients with psychiatric illness including depression” have been over-represented in assisted dying practices in these two jurisdictions (Battin et al. 2007, 596; Finlay and George 2011). Despite the current lack of demonstration of a disproportionate impact in an under-explored health research domain, the possibility of discrimination against, and abuse of, relatively powerless members of disadvantaged social groups, such as persons with significant mental illness, supports the inclusion of carefully thought-out safeguards in assisted dying regulatory and policy regimes that permit MAiD on the (sole) qualifying basis of MHD_b- suffering.

Another important dimension of relevance to social justice is the influence of gender on the initiation of requests for medically-assisted deaths. In both of the aforementioned studies performed in the Netherlands and Belgium, the ratio of women to men was approximately 70% to 30%. Although this is reflective of the relative, gender-specific incidence and prevalence of some qualifying mental health disorders in high- to medium-income countries, this large differential should be considered as a factor/element in the comparative analyses of the burdens and benefits of medically-assisted dying practices for persons with profound suffering arising from mental health disorders. In effect, both the benefit of eliminated profound suffering (from the perspective of MAiD proponents) and the harm of hastened death (from the perspective of MAiD opponents) differentially affect gender-based social groups.

One pragmatic way to meaningfully attend to the particular interests and needs of members

of disadvantaged social groups, including respect for their autonomous health-related wishes and the addressing of the possible discrimination directed against them, would be to provide a workable mechanism to appropriately support their health-related decision making. In the MHDb-MAiD context, this could involve the creation of the option for persons in these circumstances to be provided with the services of a MAiD advocate-navigator who has a general knowledge of mental health disorders and specific training in: 1) diversity, inclusion, cultural responsiveness, and constructive responses to discrimination, 2) non-directional advocacy, and 3) supported health-related decision making (Kirby 2014). To ensure independence in the Canadian context, the responsibility for funding the hours of service of these advocate-navigators should, in my view, be that of the publicly-funded provincial/territorial health system. The provision of such advocacy services would provide a pragmatic form of the privileged support for members of oppressed social groups that is called for by critical feminist accounts of justice (Sherwin 1998).

Lens IV: Formal Aristotelian Justice

A useful and underappreciated tool in the analysis of complex health care practices is Aristotelian formal justice. Essentially, the application of this principle requires that individuals and groups of persons be treated the same unless it can be demonstrated that there is a *relevant* difference between/among which justifies their different treatment. Relevant theoretical questions in the MAiD context include: 1) whether there are morally-relevant similarities and differences in the profound suffering experiences of persons with MHDb-suffering and those with PHDb-suffering, and 2) whether there are morally-relevant distinctions between the usual MHDb-MAiD circumstances and the most common PHDb-MAiD circumstances.

With regard to the first of these questions, when considered in the context of non-paradigm circumstances where a natural death is not anticipated to be near, MHDb-suffering and PHDb-suffering share a variety of features and characteristics. They both frequently have a prospective component, i.e., there is a realistic awareness, reasonable anticipation and/or perception that the suffering will continue indefinitely into the future (Berghmans et al. 2013). Both are commonly associated, and comingled, with elements of psychoexistential distress (Kissane 2012; Wijsbek 2010). Prognostic uncertainty is associated with many of the physical and mental health conditions that give rise to profound suffering in non-paradigm circumstances. Both forms of suffering can occur in persons who do not have terminal health conditions, e.g., the experience of PHDb-suffering by some persons with intractable seizure disorder and the experience of MHDb-suffering by some individuals with severe borderline personality disorder.

Both MHDb-suffering and PHDb-suffering are significantly influenced and shaped by sociorelational context (McCormack & Flechais 2012; Dees et al. 2011). Arguing against the access of patients with psychiatric disorders to medically assisted dying services, Dr. Sonu Gaiand, former President of the Canadian Psychiatric Association, commented that “social isolation, underemployment, poverty and lack of housing all have an impact on the suffering

from mental illness” (Gaiend 2016, 2). However, this is also a truthful statement about the impact of these prevalent socioeconomic conditions on the suffering arising from physical health disorders, in particular when this is being experienced by members of disadvantaged social groups such as the elderly and persons with physical disabilities. For patients with significant psychiatric disorders and for those with serious physical health conditions, the modification of such social determinants of health so as to concretely improve the health and life statuses of affected persons has proven challenging at the micro, meso and macro levels. The existing paucity of community-based and in-patient mental health services is similar in kind to the lack of access of many terminal patients to community-based and in-patient integrated palliative care, and it is difficult to support a claim that legal MAiD should not be made available for both types of profound suffering on the basis that the socioeconomic determinants that underlie both of them should be optimally addressed first.

Moving from similarities to differences, the question of whether there are significant morally-relevant differences between MHDb-suffering and PHDb-suffering is essentially unanswerable. Suffering is widely understood to be a person-specific, subjective experience (McCormick & Flechais 2012; Cassell 1998). As such, in terms of both the quality and magnitude of patients’ lived experiences, profound suffering arising from physical health disorders cannot be adequately compared to profound suffering arising from mental health disorders. The nature of the health condition from which it arises cannot provide a basis for the lexical ordering of types/forms of suffering.

With the identified, multiple similarities of the two types of suffering and the impossibility of demonstrating a morally-relevant difference between them, it cannot be concluded that the two types of profound suffering experienced by persons should be treated differently on a formal justice account. Given the paper’s assumption that PHDb-MAiD in non-paradigm circumstances is ethically and legally acceptable in the (post 2015 SSC decision) Canadian context, an Aristotelian account supports the claim that MAiD for profound suffering that arises from the experience of mental health disorders should be considered ethically acceptable in the same circumstances.

However, in my view, two morally-relevant differences can be demonstrated between the most common near-death paradigm circumstances of PHDb-MAiD and the usual non-paradigm circumstances of MHDb-MAiD in the ethical domain of consequences. In the former circumstances, the amount of foreshortened life is short, i.e., death from natural causes is anticipated to be in the near future, e.g., days to weeks, while in the latter circumstances, the expected foreshortening of life is typically longer, e.g., months to years. While I believe that this constitutes a morally-relevant distinction between these two types of MAiD circumstances, an interesting objection could be raised. The theoretical difference in time between assisted death and the projected natural death between the two sets of circumstances makes it likely, given the improbability of spontaneous recovery and the emergence of a wonder drug/treatment, that the prospective profound suffering to prevent as a harm is greater in quantity/magnitude measured in terms of days of experienced suffering in the usual circumstances of MHDb-MAiD than in most common, near-death

circumstances of PHDb-MAiD. These differentials in foreshortening of life and the anticipated length of prospective suffering disappear when the comparison is made between non-paradigm PHDb-MAiD circumstances and the usual MHDb-MAiD circumstances.

It is possible to claim that there is a second morally-relevant difference between the most common circumstances of PHDb-MAiD and the usual circumstances of MHDb-MAiD on the basis of a potential consequence to the general public. Whereas many members of the North American public support MAiD for near-death paradigm circumstances based on a physical health disorder, favourable majority opinion does not exist for MAiD in non-paradigm circumstances including circumstances where the suffering arises from mental health disorders. This is, in part, because of media reports of uses of MAiD in non-paradigm circumstances in Belgium and the Netherlands that have had an unsettling effect on international public opinion about assisted dying and opened-up an imaginative public space for doubt and fear. In recent years, there has been sensationalized reporting of a number of provocative MAiD cases, including, in the Netherlands, the case of a 63 year old man who was fearful of prospective loneliness when he retired in the future, and a woman with tinnitus (ringing in the ears) who had not been treated with standard modalities for this common health condition (Hoflinger 2015). The resultant, international engenderment of collective uncertainty and anxiety about assisted dying practices has, in my view, had negative impacts on the social acceptability of MAiD in non-paradigm circumstances in a morally-relevant way. Given these two morally-relevant distinctions between the usual circumstances of MHDb-MAiD and the most common circumstances of PHDb-MAiD, an argument based on formal justice supports their different treatment with regard to the development of MAiD regulations and policies.

Pragmatic Considerations

In addition to the morally-relevant differences between the most common PHDb-MAiD circumstances and the usual MHDb-MAiD circumstances, there are some pragmatic challenges that could also support the development and implementation of augmented policy and regulatory safeguards for the latter. The assessment of a person's capacity can be more challenging in the clinical context of a psychiatric disorder than in that of a physical health disorder because lack of insight is often more of a limiting factor in the former, and there tends to be less variability/fluctuation in symptom intensity over time in the latter. Given its complexity, the formal capacity assessment of persons with severe and persistent mental health disorders has typically fallen within the exclusive domain of psychiatry, while most capacity assessments of persons with physical health disorders are performed by generalists. Further, assessing whether a psychiatric condition should be considered irremediable is often more difficult than a similar evaluation in the context of a physical health disorder, given the wide variety of possible psychiatric medications and psychotherapeutic approaches for psychiatric disorders including, in the case of treatment-resistant depression, the option of electroconvulsive treatment, transcranial magnetic stimulation and invasive deep brain stimulation. Only a mental health specialist with the

capacity to prescribe/order treatments can be expected to have adequate knowledge of the full spectrum of psychiatric treatment modalities for serious, intractable mental health conditions while, in scenarios where profound suffering arises from a physical health disorder, many of the treatment options remaining to patients fall within the spectrum of palliative care, which is better known by generalists. With regard to assessment of degree/extent, suffering arising from physical health disorders is typically associated with measurable, objective behaviours and physical responses, while suffering arising from mental health disorders may not be manifested in an externally measurable way.

In addition to the paucity of external manifestations of psychiatric-based suffering, the assessment of decision-making capacity is often more challenging in persons with mental illness than when the suffering arises from a physical health condition. Speaking of the difficulty of evaluating requests for MAiD where the suffering arises from a mental health disorder, Gaiend (2016) comments that “teasing apart how illness-based cognitive distortions can influence decision making is a formidable challenge.” Further and importantly, the nature of therapeutic relationships between patients with mental health disorders and their longstanding, attending health care providers is often deeper, in terms of the affective/emotional engagement on both sides, than the often fragmentary, therapeutic relationships between patients with serious physical health disorders and their mixed (generalist and specialist) attending health care providers. Therapeutic relationships of the former type are more likely to involve complicating, dynamic features such as transference and countertransference. In the development of relevant regulations and policies, these differentials in the complexity of capacity assessment and in therapeutic relational-depth help justify a requirement for assessment of the requestor by an independent psychiatrist for MHDb-MAiD.

In the particular context of future consideration for MAiD for adolescents with profound MHDb-suffering, it is known that evolving brain development and complex neuroendocrine influences on neural pathways in this age group can impair decision-making capacity and affect the clinical presentation of psychiatric disorders (Arain et al. 2013; Thapar 2012). This is likely to make the assessment of illness prognosis, irremediability, and other MAiD qualifying criteria very challenging for adolescents who are experiencing suffering on the basis of a mental health disorder(s). It is probable that the difficulties faced by MHDb-MAiD criteria-evaluators would be of greater magnitude than those related to the assessment of adolescent mature minors who are requesting an assisted death because of their experience of profound, physical-based distress, such as the suffering that can be associated with terminal cancer.

Suggested Augmented Regulatory and Policy Safeguards for MHDb-MAiD

Persons with MHDb-suffering may become candidates for MAiD in Canada if the current SCC challenges to *Bill C-14* are successful and the restrictive criterion of a reasonably foreseeable (natural) death is found to be non-constitutional. In my view, should MHDb-MAiD become legal in Canada and/or the US in the future, the following five augmented, regulatory and

policy safeguards could be justified and supported on the basis of outcomes of the paper's multi-lens analysis:

1. Ex ante (pre-MAiD) engagement of an independent psychiatrist (as a formal assessor) in: 1) the evaluation of the eligibility criteria for MAiD, and 2) the informed choice/consent process for MAiD.

*Where there is limited access to independent psychiatrists, e.g., in rural and remote geographical areas, the psychiatric assessment could be performed using telehealth services, where available, or relatively low-tech alternatives such as Skype.

2. Involvement of the requestor's attending mental health care provider in MAiD assessments through an in-person or virtual interview with the independent psychiatrist assessor and, as possible, with the second formal assessor, if this arrangement is not precluded by conscientious objection or other provider-specific constraints.
3. The requestor is provided with the option of facilitated access to the publicly-funded services of an independent MAiD advocate-navigator who has a general knowledge of mental health disorders and specific training in diversity, inclusion, cultural responsiveness, constructive responses to discrimination, non-directional advocacy, and supported health-related decision making.
4. Exclusion of consideration of requests for MAiD services from children and adolescents where the experienced suffering arises solely from a stand-alone mental health disorder.
5. Ex post (post-MAiD) review of MHDb-MAiD occurrences by an independent* psychiatrist who is a regular or ad hoc member of the formal MAiD review committee/panel in the relevant health care jurisdiction, e.g., a Canadian province/territory.

*Requirement of non-engagement of this psychiatrist in #1 and/or #2 for the individual cases under review

An anticipated, critical response from MAiD proponents to these suggested safeguard augmentations is the claim that they could unfairly interfere with access to MAiD for persons with MHDb-suffering. An awareness of this legitimate, equity-related concern and the related anticipation of such an objection informed the development of the suggested, augmented safeguards. The list intentionally does not include such potentially access-degrading elements as mandatory requirements for: 1) formal preapproval for MAiD by a health organization or quasi-judicial committee, 2) mandatory assessment of requestors by a multidisciplinary

mental health care team, and 3) formal reporting beyond what is required for near-death paradigm circumstances of PHDb-MAiD. A time-extension of the usual post MAiD-decision mandatory reflection period was not included as a safeguard as this does not appear to be necessary. Research in the Netherlands and Belgium has shown that there is typically a prolonged period of time between a request for MAiD in non-paradigm circumstances and its implementation, e.g., an average of 8.66 months in the aforementioned 2015 study by Thienpont and colleagues in Belgium, during which there appears to be adequate time for reflection on the decision to request MAiD. The possibility of assessment by distributed means, e.g., through telehealth or low tech communication alternatives, also mitigates a potential concern related to inadequate specialist resources in some geographical areas and the possible, relative immobility of persons with MHDb-suffering due to the nature of their significant mental health disorder and related aspects of their socioeconomic environment. Safeguard #4 regarding the exclusion of mature minors with stand-alone MHDb-suffering could be eliminated or revised in the future should adequate health knowledge emerge regarding the influences that evolving brain development and neuroendocrine factors have on the presentation of psychiatric symptomatology and the decision-making capacities of children and adolescents.

Although, in my view, ex post reporting and review procedures relating to (potentially future) legalized MHDb-MAiD in Canada should be the same as the reporting and review procedures for PHDb-MAiD, I think that there would be significant value in the creation of a government-appointed, national MAiD Commission to facilitate relevant data collection and to enable the (quantitative, qualitative and mixed) analyses of such important research questions as: 1) who is requesting MAiD across Canada?, 2) what elements/dimensions of their health statuses and life circumstances led to the meeting of the relevant criteria for those who qualified?, and 3) what were the initial attitudes of generalists and mental health care specialists toward MAiD and how have these evolved over time? I think that the establishment of such a national commission will be particularly important if the current challenges to *Bill C-14* (particularly regarding the *reasonably foreseeable death* and *advanced state of functional deterioration in capability* criteria) are successful, which would likely result in legalization of MAiD in non-paradigm circumstances for refractory, profound suffering that is based on physical and/or mental health disorders (commonly associated with a comingled element of psychoexistential distress). One of the key responsibilities of such a commission would be to report to the government and the public in a transparent manner regarding the operational specifics and multidimensional outcomes of assisted dying practices in Canada. This research-generated knowledge would also meaningfully inform periodic regulatory and policy review/revision.

A related, interesting research question has not been addressed in the paper, i.e., are there morally-relevant differences between near-death paradigm PHDb-MAiD circumstances and non-paradigm PHDb-MAiD circumstances that would warrant the development of augmented safeguards for the latter. I can only speculate that safeguards #s 1, 2, 4 and 5 may not be adequately justified by such a comparative analysis, and that safeguard # 3, i.e., the

option for requestors to be supported by a publicly-funded, independent MAiD advocate-navigator, could prove helpful/constructive in non-paradigm PHDb-MAiD circumstances and not necessary in near-death paradigm PHDb-MAiD circumstances.

Another speculative consideration relates to the possibility of a utilitarian-dividend of legalizing MHDb-MAiD in North America. Requestors in the usual circumstances of MHDb-MAiD and in non-paradigm PHDb-MAiD circumstances have the potential to be good candidates for organ donation. I have argued elsewhere that organ donation after an assisted death is less ethically problematic than one of the two existing ways of securing transplantable organs in Canada and the US, i.e., organ donation after circulatory determination of death (Kirby 2016).

Summary Comments

The controversial topic of MAiD for persons whose profound suffering arises from mental health disorders was explored through the application of four ethics lenses: individual autonomy and informed choice, patient welfare considerations, social/feminist accounts of justice, and formal Aristotelian justice. A synthesis of these lens-based analyses led to conclusions that: 1) MHDb-MAiD should be considered an ethically acceptable practice in non-paradigm circumstances in the (post 2015 SCC decision) Canadian context, and 2) there are morally-relevant and pragmatic differences between the usual MHDb-MAiD circumstances and the most common PHDb-MAiD circumstances that support the inclusion of a suggested set of five augmented safeguards in possible, future North American MHDb-MAiD regulations and policies.

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