COMMENTARY

A Response to "Assisted Death in Canada for Persons with Active Psychiatric Disorders"

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I am grateful to the *Journal of Ethics in Mental Health* for the opportunity to respond to John Maher's editorial, "Assisted Death in Canada for Persons with Active Psychiatric Disorders" (2016). Psychiatrists have felt tremendous ambivalence about being involved in the practice and in extending it to their patients given their traditional role in the care of suicidal persons. Maher is right to highlight the concerns shared by many in the field. At its heart, his editorial expresses three main issues:

1. medical aid in dying[1] and assisted suicide should not be considered medical acts in light of the physician's traditional role as healer;

2. the Supreme Court of Canada's argument that certain suffering patients have a right to medical aid in dying because they might become too ill to end their lives at a time of their choosing does not apply to patients with psychiatric disorders who can commit suicide on their own;[2] and

3. because of the very nature of their disorders, patients with psychiatric problems are vulnerable and their eligibility for medical aid in dying should be subject to extra scrutiny, particularly as it concerns decision-making capacity.

The first I take to be a general concern about medical aid in dying while the latter two refer specifically to the eligibility of mentally ill persons for medical aid in dying. In this editorial, I will argue that these issues become more tractable if we initiate the analysis from a clinical and ethical standpoint (i.e. what constitutes appropriate care in situations where the therapeutic options to treat a medical problem have been exhausted yet suffering due to that problem continues?) rather than a legal one (i.e. what rights does one have in such situations?). Practically speaking, the norms of good clinical practice can guide us in working through the issues Maher raises. Further, in applying these norms, the sharp lines he draws between psychiatric and non-psychiatric problems become less distinct illustrating that the key challenges in implementing medical aid in dying are common to both groups.

The clinical starting point of the Québec's Act concerning End of Life Care, presently the only legislation in Canada permitting medical aid in dying, and the clinical circumstances of Gloria Taylor and Kay Carter, whose situations were the subject of the *Carter v. Canada* case, is a factual observation. There are times in the course of clinical care of a medical problem or set of problems when there is nothing left to offer to alleviate a patient's suffering from that very problem. This is as true in psychiatry as it is in any other area of medical practice. Wanting to die in such circumstances may have many facets depending on the patient: social, existential, and even financial. But such a desire also reflects something about the facts of a *medical* problem. Doctors may not have a treatment to offer but why would they suddenly stop playing a part in helping patients to address their suffering? And if they use medical knowledge and skills to do the only thing left to relieve suffering in a safe manner, why would this not constitute a medical act?

At present the Québec legislation and the proposed federal legislation limit medical aid in dying to patients who are already at or approaching the end of life, creating a context where in those cases that it is an option, the physician can be reasonably sure that all that awaits the person for the remainder of his life is relentless suffering. The majority of Canadians favour allowing the practice in these specific circumstances (Schuklenk et al., 2011). In fact, the Québec legislation goes one step further by *dis*allowing assisted suicide making it clear that medical aid in dying is a final act between doctor (and treating team) and patient and highlighting the importance of accompaniment, rather than withdrawal, in the face of therapeutic failure. Maher wonders why medical aid in dying *should be* considered a medical act. The Québec law provides one possible answer: because in those exceptional cases where there are no therapeutic options, medical aid in dying stems from a physician's duty towards her patient to relieve suffering and to ensure that she dies in dignity, a notion enshrined in the Québec profession's code of ethics even prior to the legislation.

Once we step outside the clinical contexts of end of life or progressive degeneration, what awaits a patient become much more difficult to predict in terms of future medical options and in terms of changes to the person's life and social circumstances. Mental illnesses may take a relapsing-remitting or chronic course but are neither degenerative nor terminal.[3] Maher asks why we should help someone to die if he is capable of committing suicide himself. Situating ourselves within the clinical relationship offers a useful perspective. Many psychiatrists develop long-term, professionally intimate relationships with their patients and often have privileged access to their suffering. If a specific patient with whom one has a close relationship experiences overwhelming suffering over an

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extended period of time, has no real therapeutic options left, and is determined to kill himself asks his trusted, long-term psychiatrist to accompany him to his death by providing medical aid in dying, it might become harder to argue that it is ethically better to leave this person to end his life alone, in potentially violent and stigmatizing circumstances. Neither option seems ideal because the real problem here is not whether certain categories of patients should be excluded, but whether medical aid in dying is an ethically appropriate practice outside the clinical contexts of progressive degeneration or end of life care. And if it is not, what constitutes a humane response? Psychiatrists may argue that this type of case is rare. I think they are right. Indeed, the Collège des Médecins du Québec (2008, p. 8) reminds us that the kinds of clinical circumstances in which requests for medical aid in dying should arise are exceptional. But just as the rarity of certain diseases does not remove our responsibility to acknowledge and address them, neither do the rarity of therapeutic and palliative failures absolve us from the same responsibility.

Finally, Maher raises the issue of the vulnerability of psychiatric patients and the need for extra scrutiny of their requests for medical aid in dying. It is probably the case that a request for medical aid in dying reflects an array of noxious feelings and experiences – pain and other bodily discomforts, fear, exhaustion, etc. – in the person making the request. From a clinical point of view, it is consistent with good practice to interpret such requests as a distress call first, and an expression of Charter rights second. Understood this way, the ethical question is not whether psychiatric patients should be in or out, but whether we have done right by any patient who sees no other option but medical aid in dying. Every patient's vulnerability – whether it concerns decision-making capacity or otherwise – ought to be explored and addressed by the appropriate methods and personnel. Should this be spelled out in the law? Perhaps. But the norms of clinical practice already tell us that specific tasks ought to be undertaken by those clinicians who have been properly trained to do so.

I have argued that the concerns Maher raises, while legitimate, do not only apply to patients with psychiatric conditions and therefore, asking whether to include or exclude this category of patients is the wrong question. Instead, his objections relate to the real limitations of existing concepts, practices, and resources needed to implement this practice for all patients. For example: decision-making capacity may simply be too restricted a concept to capture the complexity of decision-making (Charland, Lemmens, & Wada, 2016). Provisions for conscientious objection mean that patients requesting medical aid in dying may not be evaluated by clinicians who know them, limiting the quality of the assessment. Existing social structures may not be able to prevent the loss of meaning and isolation that can accompany serious illness.

By situating medical aid in dying as a response to exceptional clinical circumstances the norms of ethical practice can guide us. However, I recognize that even in experienced jurisdictions such as the Netherlands and Belgium, new controversial cases continue to arise, old controversies are reawakened, and ethical norms are challenged anew (Cowley, 2013; Lamme, 2016; Wijsbek, 2012). Whatever good arguments and landmark court decisions are marshalled to support it, medical aid in dying may be just one of those practices that resists straightforward practical implementation whether for mentally ill persons or otherwise. The fact that the majority of cases of patients receiving medical aid in dying in countries such as the Netherlands (Onwuteaka-Philipsen, Rurup, Pasman, & van der Heide, 2010; van der Heide et al., 2007), are patients with end stage disease and intractable physical symptoms suggests that there is a high degree of consensus about the practice in these circumstances – particularly amongst the physicians who agree to undertake this type of work. With that in mind, it seems reasonable that this controversial practice be initiated in those circumstances where we feel most confident in its ethics, as Québec and the proposed federal legislation do. This leaves the discussion of the thornier issues that Maher raises for the debates to come.

Footnotes:

1. Existing terminology varies in meaning. In Québec, medical aid in dying refers only to voluntary euthanasia, not assisted suicide. In the proposed federal legislation, Bill C-14, medical aid (or 'assistance' as it is named therein) in dying refers to both practices. In this paper, I will use medical aid in dying as it is used in both contexts. When I write about Québec, the phrase refers only to voluntary euthanasia. When I refer to the Bill C-14, the phrase includes both.

2. In its November 2015 position paper presented to the External Panel on Options for a Legislative Response to *Carter v. Canada*, the Canadian Psychiatric Association also makes this point.

3. It could be argued that a patient who makes repeated, serious suicide attempts due to a mental illness is in a terminal phase of this illness because the chances that this person will eventually succeed in ending his life, on an actuarial basis, are quite elevated.

References

Charland, L. C., Lemmens, T., & Wada, K. (2016). Decision-making capacity to consent to medical assistance in dying for persons with mental disorders. *Journal of Ethics in Mental Health, open volume.*

Collège des Medécins du Québec. (2008). *Pour des soins appropriés au début, tout au long et en fin de vie: Rapport du groupe de travail en éthique clinique* (pp. 8). Quebec, Canada: Author.

Cowley, C. (2013). Euthanasia in psychiatry can never be justified: A reply to Wijsbek. *Theoretical Medicine and Bioethics, 34*(3), 227–238.

Lamme, V. (2016, February 16). Euthanasie Praktijk Bevindt Zich op Hellend Vlak. Huppakee Weg [The Practice of Euthanasia Has Landed on A Slippery Slope. Huppakee Gone!]. *De Volkskrant*. (Available in translation from: https://trudolemmens.wordpress.com/2016/02/28/victor-lamme-the-practice-of-euthanasia-has-landed-on-a-slippery-slope-huppakee-gone-transl-op-ed-volkskrant/). Accessed June 1, 2016.

Maher, J. (2016). Assisted Death in Canada for Persons with Active Psychiatric Disorders, *Journal of Ethics in Mental Health*, open volume.

Onwuteaka-Philipsen, B. D., Rurup, M. L., Pasman, H. R. W., & van der Heide, A. (2010). The last phase of life: Who requests and who receives euthanasia or physician-assisted suicide? *Medical Care, 48*(7), 596-603.

Schuklenk, U., van Delden, J. J. M., Downie, J., McLean, S., Upshur, R., & Weinstock, D. (2011). *Royal Society of Canada Expert Panel Report: End-of-Life Decision-Making* (pp. 23-28). Ottawa, Canada: The Royal Society of Canada.

van der Heide, A., Onwuteaka-Philipsen, B. D., Rurup, M. L., Buiting, H. M., van Delden, J. J. M., Hanssen-de Wolf, J. E., …van der Wal, G. (2007). End-of-life practices in the Netherlands under the Euthanasia Act. *New England Journal of Medicine. 356*(19), 1957-1965.

Wijsbek, H. (2012). To thine own self be true: On the loss of integrity as a kind of suffering. *Bioethics, 26*(1), 1–7.

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