

MAiD Legislation at a Crossroads: Persons with Mental Disorders as Their Sole Underlying Medical Condition

The Halifax Group



ABOUT THE REPORT

The Halifax Group is composed of eight of the members of the Council of Canadian Academies (CCA) expert panel working group charged with reviewing the state of knowledge on medical assistance in dying (MAiD) as it relates to cases where a mental disorder is the sole underlying medical condition (MD-SUMC). The CCA report was issued in December, 2018. In May 2019, Jocelyn Downie convened the Halifax Group to explore whether they could make any recommendations to governments in regard to MAiD for persons with MD-SUMC. This IRPP report is the result of the in-person meeting and subsequent deliberations regarding the federal and Quebec governments' plans to make changes to their respective MAiD laws and potential reforms.

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This report represents the thinking of only the individuals involved in their individual capacities – that is, it in no way reflects the views of the CCA, the CCA Expert Panel Working Group on MD-SUMC or any individual's employer or boards, panels, councils, or committees on which they serve. Further, it does not purport to represent the range of views of individuals with lived experience with mental disorders.

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EXECUTIVE SUMMARY

Legislation permitting medical assistance in dying (MAiD) came into force in Quebec in December 2015, and in the rest of Canada in June 2016. The Quebec and federal MAiD laws contain detailed eligibility criteria as well as procedural safeguards. In particular, Quebec's MAiD legislation requires that to be eligible for MAiD, a person must be "at the end of life," whereas the federal legislation requires that a person's "natural death" must have become "reasonably foreseeable." At the time the two laws were introduced, legal experts warned that some eligibility criteria would require further clarification and could even face Charter of Rights and Freedoms (Charter) challenges.

The federal legislation also required that the ministers of health and justice initiate an independent review of issues relating to requests for MAiD by mature minors, advance requests, and requests where a mental disorder is the sole underlying medical condition (MD-SUMC). Tasked with conducting this review, the Council of Canadian Academies appointed an expert panel, which submitted its reports to Parliament in December 2018.

As predicted, in 2017, the "reasonably foreseeable" natural death and "end of life" eligibility criteria were challenged by Jean Truchon and Nicole Gladu – two individuals seeking access to MAiD who were experiencing enduring, intolerable and irremediable suffering (from physical conditions) but whose natural deaths were not yet reasonably foreseeable and who were not at the end of life. In her 2019 decision, Quebec Superior Court Justice Baudouin concluded that both the federal and Quebec criteria violated the Charter. She struck these provisions from both laws for Quebec, in a decision that will take effect in March 2020. The federal and Quebec governments chose not to appeal the decision. Despite the fact that the ruling only applies to Quebec, the federal government committed to changing its MAiD law for all Canadians.

As a result, persons with physical disabilities and chronic conditions like Jean Truchon and Nicole Gladu will have access to MAiD. But the implications of these changes will extend to many others, including persons with MD-SUMC who were unlikely to meet the "end of life" and the "reasonably foreseeable death" criteria.

In May 2019, eight of the members of the Expert Panel Working Group that examined MAiD for persons with MD-SUMC for the Council of Canadian Academies gathered in Halifax to explore whether they could make recommendations to governments in regard to MAiD for persons with MD-SUMC. This IRPP report, authored by the Halifax Group, aims to shed light on and offer solutions to the challenges associated with amending the federal and the Quebec legislation, specifically as it relates to cases where mental disorder is the sole underlying medical condition.

The Halifax Group's recommendations address a range of legal and policy issues, such as how to revise the MAiD eligibility criteria and improve professional competencies

and standards for clinical assessments, as well as the need for greater consultation support and a new oversight process for complex cases. More broadly, the report also calls for better access to mental health services and social supports across Canada, particularly for those with chronic, difficult-to-treat mental disorders.

Recommendations

1. The federal and Quebec governments should not amend their laws to exclude all persons with MD-SUMC from accessing MAiD.
2. The federal and Quebec governments should not add an eligibility criterion of a “nonambivalent decision” to their legislation.
3. The federal and Quebec governments should add an eligibility criterion that a person’s decision to request MAiD be “well-considered,” and they should define this criterion explicitly in the legislation to make it clear that it does not require an assessment of the quality of the decision the person is making – that is, whether the assessor believes it to be a good decision – but rather an assessment of the decision-making process to ensure that it is well thought out and not impulsive.
4. Provincial/territorial regulators of physicians and nurse practitioners should establish explicit standards for clinical assessments of MAiD for persons with MD-SUMC.
5. Training programs and continuing education providers should offer training to improve the eligibility-assessment skills of MAiD assessors and providers for cases of persons with MD-SUMC.
6. The federal government should establish a MAiD consultation service for providers, assessors and patients for an initial five-year period.
7. The federal government should establish a *post hoc* peer review process for an initial five-year period for all requests outside Quebec for MAiD in circumstances in which the person did not have a diagnosis of a lethal condition.
8. Federal/provincial/territorial governments should significantly improve and increase access to mental health services (especially in rural, remote, underserved and marginalized communities), particularly for persons with chronic, difficult-to-treat mental disorders.
9. Federal/provincial/territorial governments should improve and increase access to social supports for persons with mental disorders, particularly for persons with chronic difficult-to-treat mental disorders.
10. Provincial/territorial health departments should increase and improve “corridors of service” to facilitate family physicians and nurse practitioners taking on patients with mental disorders.

11. The federal departments of justice and health should work together with provincial/territorial departments of health (as well as with clinicians and experts in health law and ethics) to resolve the potential for overlap in MAiD eligibility criteria and involuntary hospitalization admission criteria.
12. Professional associations should develop clinical practice guidelines to enable physicians and nurses to better respond to cases where voluntary stopping eating and drinking or personal care is used as an alternative to MAiD.

Canadians must now decide under what conditions to permit and how to regulate MAiD for persons with MD-SUMC. The Truchon and Gladu decision has precipitated changes to MAiD eligibility criteria. This report aims to contribute to the imminent public policy debate as federal and Quebec legislators reflect upon how best to respond to the issue of MAiD for persons with MD-SUMC.

1. LEGISLATIVE CONTEXT

Legislation permitting medical assistance in dying (MAiD) came into force in Quebec in December 2015, and in the rest of Canada in June 2016. The Quebec and federal MAiD laws contain eligibility criteria as well as procedural safeguards. For example, the Quebec MAiD legislation requires that to be eligible for MAiD, a person must be “at the end of life.”¹ The federal MAiD legislation requires that to be eligible for MAiD, a person’s “natural death” must have become “reasonably foreseeable.”² To date, over 7,000 people have had a medically assisted death (Health Canada 2018),³ and MAiD is becoming more frequently accessed by Canadians. Nevertheless, it was clear from the time the two laws were passed that some eligibility criteria would require further clarification (Downie and Chandler 2018) and would even face Charter of Rights and Freedoms (Charter) challenges.

The federal legislation required that a review be undertaken concerning issues relating to three specific subgroups: (1) mature minors, (2) those who wish to make an advance request for MAiD in the event of the future loss of decision-making capacity and (3) persons for whom a mental disorder is the sole underlying medical condition (MD-SUMC) motivating the request for MAiD. This review was submitted to Parliament in December 2018 (Council of Academies 2018a).

Meanwhile, in 2017, the “reasonably foreseeable” natural death and “end of life” eligibility criteria were challenged by Jean Truchon and Nicole Gladu – two individuals seeking access to MAiD who were experiencing enduring, intolerable and irremediable suffering (from physical conditions) but whose natural deaths were not yet reasonably foreseeable and who were not at the end of life. In her 2019 decision in *Truchon v. Attorney General of Canada*,⁴ Quebec Superior Court Justice Baudouin concluded that the federal eligibility criterion (restricting access to MAiD to those whose natural death has become reasonably foreseeable) and the Quebec eligibility criterion (restricting access to MAiD to those at the end of life) violated the Charter. She struck these eligibility provisions from their respective pieces of legislation for Quebec⁵ in a decision that will take effect in March 2020. The federal and Quebec governments chose not to appeal this decision. Despite the fact that the ruling applies only to Quebec, the federal government has committed to changing its MAiD law for all Canadians.

As a result of this decision, persons with physical disabilities and chronic conditions like Jean Truchon and Nicole Gladu will have access to MAiD. But the implications of

¹ *An Act Respecting End-of-Life Care*, RSQ 2014, c. S-32.0001 s. 26(3).

² *Criminal Code*, RSC 1985, c. C-46, s. 241.2(2)(d).

³ The official Health Canada data report 6,749 MAiD deaths between December 2015 and October 2018. This underreports because it is missing seven months of data from Quebec. It is also reasonable to assume the occurrence of at least 3,000 MAiD deaths since October 2018.

⁴ *Truchon v. Attorney General of Canada*, 2019 QCCS 3792 (CanLII) [*Truchon and Gladu*].

⁵ Because a trial judge in one province/territory cannot bind a judge in another, the judge’s decision in *Truchon and Gladu* striking down the provisions only has effect in Quebec. Only Supreme Court of Canada decisions bind all judges in all provinces/territories.

these changes will extend to many others as well: although *Truchon and Gladu* was not a case directly about MD-SUMC, its effect in striking down “reasonably foreseeable” natural death and “end of life” may allow many more persons with MD-SUMC to be eligible for MAiD.⁶

Under the Quebec and federal laws, persons with MD-SUMC are unlikely to be eligible for MAiD – mainly because they are unlikely to meet the eligibility criteria of “natural death has become reasonably foreseeable” (Canada) and “end of life” (Quebec). Neither of these phrases are defined in the legislation and there has been considerable debate about how they should be interpreted (Downie and Chandler 2018). However, on the narrowest interpretations, most persons with MD-SUMC do not qualify because they are not predicted to die a natural death within, for example, 12 months (see examples of early, variable and narrow interpretations in Quebec [Radio-Canada 2016]). On even broader interpretations, most persons with MD-SUMC still do not qualify because they are not predicted to die a natural death within “a period of time that is not too remote” (even as long as 6 or 10 years) and they do not have a “predictable cause of death” (Downie and Chandler 2018).

With recent developments in *Truchon and Gladu*, the issue of MAiD for persons with MD-SUMC has landed squarely and unavoidably on the desks of Parliament (under its responsibility for the Criminal Code) and the Quebec National Assembly (health care being a provincial jurisdiction).

1.1 Issues and options pertaining to MAiD for persons with MD-SUMC

Both the federal and Quebec governments have said that they would amend their legislation in light of the *Truchon and Gladu* decision.⁷ This report aims to shed light on the challenges associated with doing so, specifically as it relates to MD-SUMC.⁸ In May 2019, eight individuals who had been part of the Council of Canadian Academies’ Expert Panel Working Group on MAiD Where a Mental Disorder is the Sole Underlying Medical Condition gathered in Halifax to explore whether they could make any recommendations in this regard. This report is the result of the in-person meeting and subsequent deliberations.

As legislators prepare to respond to the court’s decision, the question for Parliament with respect to its legislation is therefore which of the following options to take:

⁶ We do not believe this development is evidence of a “slippery slope.” The *Truchon and Gladu* decision restores some of the eligibility for MAiD established by the Supreme Court of Canada in *Carter v. Canada (Attorney General)*, 2015 SCC 5 [Carter SCC].

⁷ Indeed, the leaders of all of the major parties except the Conservative Party committed to do so during the recent election campaign; see comments made during the French debate in direct response to a question from a member of the public (CTVNews.ca 2019).

⁸ For the purposes of this report, and as explained in section 3.3, we stipulate the following definition of “mental disorder”: “health problems that disturb or impair a person’s thoughts, experiences, emotions, behaviour, and/or ability to relate to others.”

- Do nothing (which would leave “reasonably foreseeable” natural death in place throughout Canada except for Quebec and likely result in *Lamb v. Canada*⁹ being reset or another Charter challenge launched).
- Amend the Criminal Code to
 - remove “reasonably foreseeable” to make Quebec and the rest of Canada consistent
 - add Charter-compliant eligibility criteria or procedural safeguards that would apply only to persons with MD-SUMC
 - add Charter-compliant eligibility criteria or procedural safeguards that would apply to persons with MD-SUMC and to others who would also be included (for example, persons with physical conditions such as a permanent stable disability) as a result of the *Truchon and Gladu* decision.

The question for the Quebec National Assembly with respect to MAiD for persons with MD-SUMC was which of the following options to take:

- Do nothing (which would mean that persons with MD-SUMC need to meet the other eligibility criteria but no longer need to be at the end of life).
- Amend the Quebec legislation to add Charter-compliant eligibility criteria or procedural safeguards that would
 - restrict access only for persons with MD-SUMC
 - restrict access for persons with MD-SUMC and others who would also be included (e.g., persons with physical conditions such as quadriplegia-SUMC) as a result of the *Truchon and Gladu* decision.

On January 21, 2019, the Quebec government announced that it would take the first of these options. Rather than amend the legislation, it would leave the *Truchon and Gladu* decision to take effect in March 2020, and ask physician and nurse practitioner regulators to provide guidance about MAiD for persons with MD-SUMC. A week later Quebec announced that it would temporarily suspend access to MAiD for persons with MD-SUMC while it pursues its consultations, in order to achieve broad consensus on how best to reform MAiD legislation for persons with mental illness.

There are tensions in the area of MAiD for persons with MD-SUMC. Some believe that someone who lives with a mental disorder is too vulnerable to be able to freely choose MAiD because of the myriad of social factors that may negatively influence that person’s life, including socio-economic precariousness, discrimination, stigmatization, the

⁹ *Lamb v. Canada (Attorney General)*, 2017 BCSC 1802, [Lamb] was a Charter challenge to Bill C-14 launched just 10 days after the federal legislation came into force (*British Columbia Civil Liberties Association Newsletter*, 2016). The case was adjourned at the request of the plaintiffs and with the consent of the Attorney General after the filing of the Attorney General’s expert’s report indicating that a person who “expresses certain intent” to refuse preventive care (e.g., to stop using a BiPAP machine that helps a person to breathe better while sleeping and thereby to prevent pneumonia that, if untreated, will be lethal) meets the “natural death has become reasonably foreseeable” criterion. However, *Lamb* will not feature in this report because months after the Halifax meeting (see section 3 of this report), *Truchon and Gladu* was decided and the government chose not to appeal it and promised to amend the law to be consistent with the judge’s decision.

elevated risk of incarceration and the historical spectre of eugenics. Others believe that the choice of MAiD for those with a mental disorder can never be free, at least in certain cases, because of the intimate link between the feeling of hopelessness and the wish to die caused by specific mental disorders. And still others believe that it is difficult or impossible to identify whether the wish to die is part of a treatable mental disorder and whether the suffering caused by a mental disorder is truly irremediable.

On the other hand, there are those who believe that excluding all persons with a mental disorder from ever accessing MAiD is stigmatizing and potentially discriminatory because, in specific cases, the eligibility criteria of enduring, intolerable and irremediable suffering, and advanced and irreversible decline in capability could be met. Furthermore, they ask why capable people with mental disorders shouldn't be entitled to make important choices just as they are allowed to do in many other spheres of health care decision-making (e.g., refusing treatment or not eating and drinking), as other capable people are allowed to do.

Some believe the risks of permitting MAiD for persons with MD-SUMC apply to all persons with MD-SUMC, and therefore a blanket exclusion is required. Others believe that these risks do not apply to all persons with MD-SUMC, but that existing clinical methods such as capacity assessment are unable to distinguish those who are vulnerable or impaired from those who are not; therefore a blanket exclusion on accessing MAiD is required. Still others believe that our existing clinical methods are able to identify persons with MD-SUMC who are acting autonomously as compared to those who are not; so a blanket exclusion is not required (and some within this group believe that additional safeguards should be built in, while others do not).

This report recommends that the federal and Quebec governments add the criterion that a person's decision to request MAiD must be "well-considered" (defined in the legislation as requiring an assessment not of the quality of the decision but of the decision-making process). They should not, however, amend their laws to exclude individuals with MD-SUMC from accessing MAiD or require that these individuals' decisions be nonambivalent. The report also calls for improving the professional competencies for clinical assessments of whether persons with MD-SUMC meet the eligibility criteria and a new oversight process (for an initial five-year period), as well as the establishment of a consultation service for difficult cases. Further, the report highlights how current access to mental health services and social supports across Canada needs to be improved in conjunction with the implementation of the post-*Truchon and Gladu* eligibility criteria, particularly for those with chronic, difficult-to-treat mental disorders.

2. THE LEGAL STATUS OF MAiD IN CANADA

This section summarizes the legislation, key court cases and expert reports, which, together with the *Truchon and Gladu* and *Lamb* cases discussed earlier, have led to the point where policy decisions now need to be made about MAiD for persons with MD-SUMC.

2.1 *Carter v. Canada (Attorney General)*

In February 2015, in *Carter v. Canada (Attorney General)*, the Supreme Court of Canada struck down Canada's Criminal Code prohibitions on medical assistance in dying:

The appropriate remedy is therefore a declaration that s. 241 (b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable"... does not require the patient to undertake treatments that are not acceptable to the individual.¹⁰

The rationale offered by the SCC for its declaration would seem to encompass MAiD for persons with MD-SUMC. However, it is important to note that the SCC explicitly limited the scope of its declaration:

The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.¹¹

It also included "persons with psychiatric disorders" in an illustrative list of MAiD cases that "would not fall within the parameters suggested in these [*Carter* SCC] reasons."¹²

This exclusion is not surprising because none of the plaintiffs in the case had MD-SUMC. But it did leave the implications of *Carter* SCC contestable for MAiD for persons with MD-SUMC.

2.2 Federal MAiD legislation: The Criminal Code of Canada

In response to the SCC decision in *Carter* SCC, in June 2016, Parliament passed Bill C-14¹³ to amend the Criminal Code, establishing a federal legal framework for MAiD in Canada. The law includes the following provisions relevant to the analysis presented in this report:

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:

(a) they are eligible—or, but for any applicable minimum period of residence or waiting period, would be eligible—for health services funded by a government in Canada;

¹⁰ *Carter* SCC at paragraph 127.

¹¹ *Carter* SCC at paragraph 127.

¹² *Carter* SCC at paragraph 111.

¹³ Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying)*, SC 2016, c. 3 [Bill C-14].

- (b) they are at least 18 years of age and capable of making decisions with respect to their health;*
- (c) they have a grievous and irremediable medical condition;*
- (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and*
- (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.*

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;*
- (b) they are in an advanced state of irreversible decline in capability;*
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and*
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.*

241.2(3)(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying;

A letter from Jody Wilson-Raybould, the Minister of Justice and Attorney General of Canada at the time, confirms that under the current federal law, having a mental disorder is not an exclusion criterion (Downie and Dembo 2016; Council of Canadian Academies 2018b, 63) and, if they meet the eligibility criteria, persons with mental disorders (even MD-SUMC) can potentially access MAiD. For example, a person with a mental disorder and end-stage cancer may be capable of making a decision about accessing MAiD. At present, there is no requirement that a person be excluded from accessing MAiD even if their reason for wanting MAiD relates primarily to suffering brought about by their mental disorder. Persons with MD-SUMC, on the other hand, are unlikely to meet the eligibility criteria. They may have difficulty with the decision-making capacity criterion, and/or the requirement that their condition is incurable and/or their state of decline in capability is advanced and irreversible, and/or especially the requirement that natural death has become reasonably foreseeable. The challenge is to understand what differences exist, if any, between a person with coexisting psychiatric and physical conditions who is currently eligible for MAiD and someone who has MD-SUMC and is not eligible.

In addition, under the federal legislation, the ministers of justice and health were required to initiate independent review(s) within 180 days of the law receiving royal assent and report back to Parliament no later than two years after initiation (i.e., December 2018) on three outstanding issues: requests for MAiD made in ad-

vance of loss of decision-making capacity; mature minors; and MAiD for persons with MD-SUMC.¹⁴

Finally, under the federal legislation, a review of the legislation and the state of palliative care in Canada must be referred to a committee of the Senate, the House of Commons or both houses of Parliament, and that committee must report back to its referring house(s) of Parliament.¹⁵ This review, which will also consider the impact of the legislation on persons with MD-SUMC, must be commenced shortly after June 17, 2020.

2.3 Quebec legislation

In June 2014, using its constitutional powers in the area of health, the Quebec National Assembly passed *An Act Respecting End-of-Life Care*. The goal of the legislation was to ensure that all Quebecers had access to a full range of health care options at the end of life, including palliative care, palliative sedation and MAiD. The Act contains the following provisions relevant to the analysis presented in this report:

26. Only a patient who meets all of the following criteria may obtain medical aid in dying:

- (1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);*
- (2) be of full age and capable of giving consent to care;*
- (3) be at the end of life;*
- (4) suffer from a serious and incurable illness;*
- (5) be in an advanced state of irreversible decline in capability; and*
- (6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.*

Under the Quebec legislation, having a mental disorder is not an explicit exclusion criterion but, as with the federal legislation described above, access to MAiD by those with MD-SUMC is very limited because almost all persons with MD-SUMC will not meet the eligibility criteria, especially “at the end of life” and “advanced state of irreversible decline in capability.” More commonly a person who fulfills the criteria as a result of a coexisting disease (e.g., cancer) and who also has a mental disorder will be able to access MAiD.

¹⁴ Bill C-14 s. 9.1 says: “(1) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition. (2) The Minister of Justice and the Minister of Health must, no later than two years after the day on which a review is initiated, cause one or more reports on the review, including any findings or recommendations resulting from it, to be laid before each House of Parliament.”

¹⁵ Bill C-14, s. 10 says: “(1) At the start of the fifth year after the day on which this Act receives royal assent, the provisions enacted by this Act are to be referred to the committee of the Senate, of the House of Commons, or of both Houses of Parliament that may be designated or established for the purpose of reviewing the provisions. (2) The committee to which the provisions are referred is to review them and the state of palliative care in Canada and submit a report to the House or Houses of Parliament of which it is a committee, including a statement setting out any changes to the provisions that the committee recommends.”

It is also important to note that people in Quebec must abide by both the federal Criminal Code and the Quebec MAiD legislation. Insofar as one is more restrictive than the other, the more restrictive provisions must be followed.

2.4 Provincial/territorial laws, rules or standards

The Criminal Code's MAiD provisions establish that "[m]edical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards" (section 241.2(7)). This places further guidance about the practice of MAiD in the hands of provincial/territorial bodies (governments and professional regulators).

The medical regulators of each province (except New Brunswick) and the governments of the territories (except Nunavut) have produced guidance documents concerning the assessment of patients requesting MAiD. Quebec's medical regulator, in collaboration with five other regulatory bodies, has developed extensive practice guidance for MAiD.¹⁶ The Canadian Nurses Association (CNA) has developed a National Nursing Framework on MAiD to guide all nurses and to supplement regulatory and employer standards as well as provincial/territorial legislation and policy (Canadian Nurses Association 2017).

2.5 Reports of the Council of Canadian Academies

In the fall of 2018, the Council of Canadian Academies (CCA) published a suite of expert panel reports on three aspects of MAiD: mature minors; requests made in advance of loss of capacity; and MAiD for persons whose sole underlying medical condition is a mental disorder. These reports did not contain recommendations, since doing so was intentionally not included in the mandate for the expert panel. Rather, the panel's reports were restricted to comprehensive assessments of the evidence concerning these three practices.

We will not summarize the MD-SUMC report (Council of Canadian Academies 2018b), but we note that, among other things, it considered the following issues:

- diagnosis, prognosis and treatment effectiveness in the context of mental disorders
- differences between mental disorders and the conditions that motivate most MAiD requests under the current eligibility criteria
- socio-economic/demographic correlates of mental disorders
- Indigenous peoples and other specific populations (gender; immigrant, refugee, ethnocultural and racialized groups; LGBTQ+; seniors; youth; Armed Forces; incarcerated) and mental health
- access to mental-health care services and social supports
- suicide and suicide prevention in the context of mental disorders

¹⁶ The document is available on request from the Collège des médecins du Québec.

- the legal governance of persons living with mental disorders (health care decision-making, including advance directives and involuntary hospitalization and treatment)
- the double-edged sword of vulnerability (that is, vulnerability to being indirectly or directly pressured to request MAiD and vulnerability to being treated paternalistically and denied the opportunity to request MAiD)
- the experience with MAiD for persons with MD-SUMC in other jurisdictions with different eligibility criteria and procedural safeguards

2.6 Quebec National Assembly Expert Panel on the Question of Incapacity and Medical Aid in Dying Report

An expert panel appointed by the Quebec Minister of Health and Social Services released its report in November 2019 (Quebec 2019). It recommended that the rights of persons living with mental disorders be respected and their requests be assessed according to their capacity and not their diagnosis.¹⁷ It also recommended that MAiD be available for persons who lose capacity between the time of being found eligible for MAiD and the provision of MAiD.¹⁸ It further recommended that MAiD be available through requests made before the person has met all of the eligibility criteria but after the diagnosis of a serious and incurable disease.¹⁹ If the National Assembly follows this recommendation and amends the Quebec legislation, persons with MD-SUMC (which includes dementia for the purposes of this report) may be able to access MAiD through a request made in advance of loss of capacity in Quebec but after having being diagnosed with a serious and incurable disease, such as Alzheimer's disease.²⁰

2.7 The future of MAiD for persons with MD-SUMC

Important decisions about the legal status of MAiD for persons with MD-SUMC lie ahead for the federal Parliament and Quebec National Assembly. What they do in response to the CCA reports, the *Truchon and Gladu* decision and, in Quebec, its expert panel report, will have implications for the extent of the eligibility for MAiD for persons with MD-SUMC.

¹⁷ "Recommandation 12: Que l'égalité des droits de la personne qui vit avec une déficience intellectuelle ou un trouble de santé mentale soit respectée. Les demandes de ces personnes doivent être évaluées en fonction de leur aptitude à faire une demande anticipée d'AMM et à consentir à l'AMM et non en fonction de leur diagnostic."

¹⁸ "Recommandation 1: Qu'une personne apte qui devient inapte à consentir à l'AMM entre le moment où sa demande d'AMM (qu'elle a rédigée lorsqu'elle était apte) est acceptée et le moment de son administration conserve son droit de recevoir l'AMM."

¹⁹ "Recommandation 3: Qu'une demande anticipée d'AMM puisse être rédigée. Que la rédaction de la demande anticipée d'AMM se fasse après l'obtention du diagnostic de maladie grave et incurable."

²⁰ On January 27, 2020, the Quebec government held the "Forum Nationale sur l'évolution de la Loi concernant les soins de fin de vie" to consult on advance requests and MAiD. See <https://www.msss.gouv.qc.ca/professionnels/soins-et-services/forum-national-sur-l-evolution-de-la-Loi-concernant-les-soins-de-fin-de-vie/>.

3. THE IRPP REPORT

3.1 Objectives

This IRPP report is intended to contribute to the evolution of MAiD law, policy and practice as Parliament, the Quebec National Assembly, the civil service, clinicians, lawyers, academics and the public respond to the legal developments outlined above.

3.2 Method

In May 2019, eight individuals who had been part of the CCA's Expert Panel Working Group on MAiD MD-SUMC gathered in Halifax to explore whether, on the basis of their expertise and experience serving as members of the CCA expert panel, they could make any recommendations with respect to MAiD for persons with MD-SUMC. This IRPP report is the result of the in-person meeting and subsequent virtual deliberations.

Members of the Halifax Group brought a wide variety of perspectives on the issues associated with MAiD for persons with MD-SUMC. They come from the fields of psychiatry, geriatric medicine, nursing, sociology, ethics and law. And they come from as far east as Nova Scotia and as far west as Alberta. They participated as individuals rather than representatives of any organizations or positions.

The group acknowledged that there is a spectrum of views within society on MAiD for persons with MD-SUMC when natural death is not reasonably foreseeable (and, in Quebec, when the individuals in question are not at the end of life). The following is a range of these views:

- It is ethically acceptable for
 - all persons with MD-SUMC to have access to MAiD (assuming the basic protections of informed consent, capacity, etc. are in place in the current law)
 - some persons with MD-SUMC to have access to MAiD, and we can identify those cases (i.e., distinguish between those for whom it is acceptable and those for whom it is unacceptable)
 - some persons with MD-SUMC to have access to MAiD. We cannot reliably identify those cases, but we should nonetheless not have a blanket prohibition on MAiD for persons with MD-SUMC
 - some persons with MD-SUMC to have access to MAiD, but we cannot reliably identify those cases and so should not allow any access for those with MD-SUMC.
- It is never ethically acceptable for anyone
 - with MD-SUMC to have access to MAiD (unless they meet all of the conditions present in the law, including reasonable foreseeability/end of life)
 - to have access to MAiD regardless of whether they meet the conditions in the current law.

The group also acknowledged that all six views aim to reflect and promote the interests of people with mental disorders, but they balance a series of competing values and interests differently.

The group reviewed the assessment of the evidence before the meeting and then, during the meeting,

- explored the possible concerns that might attach to MAiD for persons with MD-SUMC (as identified in the CCA report and the academic literature, and as generated by group members);
- reviewed the possible safeguards and responses to all the possible concerns (as identified in the CCA report and the academic literature, and as generated by the group);
- developed a set of recommendations about how the federal Parliament should respond to MAiD for persons with MD-SUMC if pushed to amend the Criminal Code as a result of decisions in *Truchon and Gladu* or *Lamb*,²¹ or if deciding to do so on its own.

3.3 Terminology and application

First, for the purposes of ensuring comparability with the CCA report and to be able to build upon it, the authors decided to work with the definition of “mental disorder” stipulated by the CCA Expert Panel MD-SUMC Working Group: “Mental disorders can be defined as health problems that disturb or impair a person’s thoughts, experiences, emotions, behaviour, and/or ability to relate to others” (Council of Canadian Academies 2018b, 37).²²

Second, some of what is discussed in this report is applicable to all types of requests for MAiD and some is more narrowly applicable to any cases of MAiD requests in which natural death has not yet become reasonably foreseeable, nor is the person at the end of life. However, because we are considering MAiD for persons with MD-SUMC, we use illustrative examples from among that group of persons and focus our discussion on MAiD for them.

4. FOUNDATIONS FOR RECOMMENDATIONS

The following foundations for recommendations apply to circumstances in which mental disorders coexist with physical disorders as well as to MD-SUMC. Certain challenges may not present in cases of mental disorder coexisting with physical disorders. For example, the difficulty of establishing prognosis associated with mental disorders will not be relevant for a case in which a person has a mental disorder but whose request

²¹ Neither *Truchon and Gladu* nor *Lamb* had yet been decided. See note 9 for explanation of launch and subsequent adjournment of *Lamb*.

²² We do, however, acknowledge that criticisms can be made of the use of this definition in this context – for example, it includes conditions that are so diverse with respect to features relevant to MAiD as to require distinct consideration; the issues with respect to uncertainty regarding prognosis and treatment effectiveness are acute for mental disorders such as depression but not usually for intellectual disabilities or dementia.

for MAiD is grounded in the person's end-stage lung cancer. However, it is always relevant in cases of MD-SUMC. We therefore focus on MD-SUMC but acknowledge the relevance to those with a mental disorder with a coexisting physical condition.²³

4.1 Suffering and its social contexts

Some people with mental disorders suffer greatly. This can be because of the disorder itself and/or its social impacts and social meaning. There are also psychosocial antecedents such as psychosocial problems (e.g., adverse childhood experiences or trauma from childhood sexual abuse) or social injustices (e.g., discrimination on the basis of mental disorder) that can contribute to the suffering of people with mental disorders. These factors may thus form part of the motivation for a request for MAiD for persons with MD-SUMC.

Further, lack of access to adequate mental health services and social supports (e.g., housing) can interfere with a person's perception of their condition being irremediable and/or their suffering being enduring, intolerable and unable to be relieved under conditions that the person considers acceptable. Different social determinants of health may interact, and intersectional impacts of multiple social determinants may be more likely in people with mental disorders. These issues are particularly acute for individuals who need long-term follow-up or long-term housing support (e.g., severe mood disorders and severe personality disorders). It is therefore critical to address the social determinants of mental suffering and improve access to mental health services and social supports (especially for people experiencing the intersectional impacts of multiple social determinants and those with chronic, difficult-to-treat disorders²⁴).

At the same time, it is important to acknowledge that some people with MD-SUMC receive adequate or even excellent mental health services and social supports yet still experience great suffering as part of their mental disorder because treatments are partially effective or ineffective, and because some treatments or their side effects are unacceptable to the individual.

Just as better access to palliative care is no justification for denying access to MAiD in individual cases, so improved mental health services and social supports generally speaking are not in and of themselves justification for denying access to MAiD to all individuals with MD-SUMC. One does not preclude the other; access to MAiD can be permitted in certain cases and efforts can simultaneously be undertaken to address the social determinants of mental suffering and to improve mental health services and social supports. Similarly, just as bringing more attention to the need for more and better palliative care does not justify denying access to MAiD in individual cases, so bringing more attention to the need to better support those living with a mental

²³ Some of the foundations for recommendations also apply to nonmental disorders (e.g., physical disabilities). Again, we acknowledge the relevance to those disorders but focus on MD-SUMC.

²⁴ Mental disorders can be difficult to treat for a variety of reasons: the disorder does not respond well to treatment; the lack of effective treatments; and the nature of the condition itself. We use "difficult to treat" as an umbrella term to capture all of these circumstances.

disorder does not in and of itself justify denying access to MAiD to all individuals with MD-SUMC. Furthermore, we are not aware of any evidence that permitting MAiD for persons with MD-SUMC will divert attention from the need for investments in better support for mental health services and social supports.

4.2 Vulnerability

In the preamble to Bill C-14, the federal legislation states that “permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other.” With the criterion “natural death has become reasonably foreseeable” now struck down in *Truchon and Gladu*, it is timely to revisit the foundational question of who exactly is vulnerable and what protections they require. In the case of persons with MD-SUMC (and others whose access to MAiD will be changed by *Truchon and Gladu* and what the federal and Quebec governments do in response to it), “protection of the vulnerable” should be viewed as two sides of a coin – with inclusion on the one side and exclusion on the other. There is a need to protect some people’s access to MAiD and a complementary need to protect some people from access. Individuals can be vulnerable to inappropriate exclusion (hence protection of access) and to inappropriate inclusion (hence protection from access).

4.3 Stigmatization of mental disorder

Stigmatization is understood here as referring to “the pervasive negative stereotypes associated with mental disorders that lead to fear, avoidance, exclusion and neglect of people with these conditions” (Canadian Mental Health Association 2019). The stigmatization of mental disorders is linked to the rates of poverty, homelessness, unemployment and social isolation experienced by people living with mental disorders.

Social stigmatization of mental disorders may play a number of roles in the context of MAiD for persons with MD-SUMC.

First, stigmatization of persons with mental disorders contributes to the adverse social and economic conditions facing some people with these disorders and thereby to the suffering they experience.

Second, stigmatization may result in the misperception that the suffering caused by mental disorders is trivial or that mental disorder is a result of individual character failure.

Third, stigmatization may result in the misperception that all people with mental disorders have diminished capacity to make major decisions. They may then be seen as vulnerable and have their views disregarded and their autonomy eroded. On the other hand, stigmatization of persons with mental disorders may actually undermine the voluntariness of requests for MAiD. Such persons might internalize prevalent negative attitudes toward mental disorders and seek MAiD out of a belief that their lives are not worth living.

Fourth, if both the federal and Quebec MAiD laws were amended to the effect that they imply that people with mental disorders need to be protected from themselves, these laws could be seen as stigmatizing persons with mental disorders (suggesting that they lack the capacity for self-determination).

4.4. Decision-making capacity, prognosis and treatment effectiveness

Given the nature of many mental disorders, it can be very difficult or even impossible to determine with confidence a person's capacity to make a decision about MAiD. For example, in order to make decisions about one's health care, one needs to be able to weigh the potential harms and benefits of various treatment alternatives. A feature of some mental disorders (e.g., a major depressive disorder) is the feeling of hopelessness about the possibility of future change. If one does not really believe that one's suffering can be relieved by treatment, then one will not see any potential benefit in treatment. It could be difficult to distinguish the feeling of hopelessness that is symptomatic of the disorder from the hopelessness that may arise when several treatments have not been effective. Therefore, where the challenges with respect to capacity are too great, practitioners will not be able to reasonably form the relevant opinion and therefore individuals will not be eligible for MAiD.

It can also be very difficult or impossible to provide with confidence the prognosis of the condition and predictions of treatment effectiveness. These factors, in turn, can make it difficult to assess the incurability of the disorder, the irreversibility and/or advanced nature of decline in capability, and thus lead to the inability to relieve the suffering.

These difficulties create a risk of overinclusion – that is, persons being judged to meet the eligibility criteria when they should not be eligible. This results in lives lost that might, in the future, have come to be valued by those individuals because, for example, their suffering had been sufficiently alleviated. These difficulties also create a risk of underinclusion – that is, persons judged not to meet the eligibility criteria when they do so. This results in an ill-defined and sometimes lengthy period of intolerable suffering that could not be remediated for a person who wanted that suffering to end or, instead, underinclusion results in death by suicide.

In some cases, however, the required assessment of capacity, prognosis, or treatment effectiveness will not be difficult, and it will be clear whether a person meets or does not meet the eligibility criteria. Furthermore, the federal MAiD legislation requires that two medical or nurse practitioners be of the opinion that the eligibility criteria have been met.²⁵

Therefore, where the challenges with respect to decision-making capacity, prognosis and treatment effectiveness are too great, providers will not be able to reasonably

²⁵ Both the federal and Quebec declaration forms require that the MAiD provider confirm that the person was capable of making decisions about MAiD. In Quebec, the practitioner is further required to document the reasons they believed the person was capable.

form the opinion and therefore individuals will not be eligible. Where the challenges are not too great, they will be able to reasonably form the opinion and therefore individuals will be eligible. In other words, assessors may reach one of three opinions: (1) a person satisfies the eligibility criteria; (2) a person does not satisfy the criteria; or (3) it is uncertain whether the person satisfies the eligibility criteria. The default position in cases of uncertainty about decision-making capacity, prognosis, and treatment efficacy is that the person is ineligible for MAiD.

Some express a concern that individuals with mental disorders will go from practitioner to practitioner until they find two who will conclude that they meet the eligibility criteria. A counter concern, however, is that some practitioners will hold an unreasonably narrow view on eligibility – for example, that a person with a mental disorder cannot or should not be found to have decision-making capacity for MAiD. These individuals may need to be able to seek out more than two practitioners in order to access balanced MAiD assessments. Here again there are risks of both underinclusion and over-inclusion.

4.5 Nonambivalent, settled or well-considered

Some individuals will make a request for MAiD, be found to meet the eligibility criteria but choose not to proceed with MAiD. This might be seen as evidence of an ambivalent, unsettled or poorly considered desire for MAiD. Alternatively, it might be seen as reflecting a desire for a backup or exit route, revealing that the option of MAiD is itself a form of palliation, enabling individuals to persevere through their suffering.

A variety of legal and regulatory approaches have been taken to respond to concerns about decision-making for MAiD. Beyond requiring decision-making capacity, these approaches include requiring that a request for MAiD be nonambivalent, settled or well-considered.

Justice Smith, the trial judge in the *Carter* trial explicitly addressed the issue of non-ambivalence (understood by her as “persistently and consistently requesting”²⁶). Her declaration of invalidity applied to “a fully-informed, non-ambivalent competent adult patient.”²⁷ However, although the SCC quoted the nonambivalence discussion and criterion in the trial decision, it did not include the nonambivalence criterion in its declaration of invalidity.²⁸

At present, neither the federal or nor the Quebec legislation requires that a request for MAiD be nonambivalent. Nor must any other health care decisions made by capable people be nonambivalent, whether or not they have a mental disorder. This includes refusals of potentially life-sustaining treatment.²⁹

²⁶ *Carter v. Canada (Attorney General)*, [2012] BCSC 886 [*Carter trial*] at paragraph 313.

²⁷ *Carter trial* at paragraph 1393.

²⁸ *Carter SCC* at paragraph 127.

²⁹ See review of the law regarding refusals of treatment in *Carter trial* and Council of Canadian Academies (2018b).

In some provinces, provincial regulators have issued additional guidance regarding MAiD. For example, the College of Physicians and Surgeons of Newfoundland and Labrador (2017) requires that the clinician assess the “genuineness” of the patient’s wish for MAiD. And the College of Physicians and Surgeons of Saskatchewan (2019) and the College of Physicians and Surgeons of Manitoba (2019) say that the wish should be made thoughtfully and “after due consideration” and represents “a clear and settled intention to end his/her own life by medical assistance in dying.” However, no further explanation is given regarding how to interpret these expressions.

Under Dutch legislation, a request for MAiD must be “well considered.”³⁰ The Netherlands provides the most detail about how these terms should be understood in practice. Through the *Euthanasia Code 2018*, the Regional Euthanasia Review Committees³¹ provide guidance to physicians and the public, and facilitate harmonization across its five committees. With respect to what “well-considered” means, the code states:

This means that the patient has given the matter careful consideration on the basis of adequate information and a clear understanding of his illness. The request must not have been made on impulse. Caution is also required in cases where the patient expresses doubt by repeatedly making and withdrawing requests over a given period of time. That a patient hesitates or has doubts regarding such a profound step as euthanasia is understandable and is not necessarily a contraindication. The important thing is that the request should be consistent, taking account of all the patient’s circumstances and utterances. A repeated request can be a sign that the patient is consistent in his desire for euthanasia.

In cases involving, for instance, psychiatric patients, patients with dementia... particular questions may arise in considering whether the patient’s request is voluntary and well considered (Regional Euthanasia Review Committees 2018, 20).

In the “key elements of ‘voluntary and well-considered request,’” the *Euthanasia Code 2018* includes the following advice:

- Well-considered request: well-informed, consistent, not on impulse
- Consistence apparent from patient’s repeated request or other utterances...
- Exercise particular caution in certain situations...[such as advance directives; minors; patients with a psychiatric disorder, dementia, an intellectual disability, aphasia; coma/reduced consciousness; palliative sedation; “completed life”; organ and tissue donation] (Regional Euthanasia Review Committees 2018, 21)

³⁰ Section 2(1), *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, reproduced in *Euthanasia Code 2018* (Regional Euthanasia Review Committees 2018).

³¹ The Regional Euthanasia Review Committees are the national oversight mechanism for euthanasia and assisted suicide in the Netherlands. They have the authority and responsibility to review the reports submitted on all cases of euthanasia and assisted suicide in the Netherlands, to respond to instances of possible breaches of the Act and to issue guidance documents and annual reports.

The Euthanasia Code 2018 specifically flags the complexity of some cases involving mental disorders in particular in relation to voluntariness, irremediability, decision-making capacity and lack of reasonable alternatives.³²

Under the Belgian legislation, a request for MAiD must be “well-considered and repeated.”³³ This is reflected in the statutory requirement that the physician must “be certain of the patient’s constant physical or mental suffering and of the durable nature of his/her request. To this end, the physician has several conversations with the patient spread out over a reasonable period of time, taking into account the progress of the patient’s condition.”³⁴ In cases in which the physician “believes the patient is clearly not expected to die in the near future, he/she must also:... allow at least one month between the patient’s written request and the act of euthanasia.”³⁵

In Canada, the federal legislation requires a waiting period of at least “10 clear days” between the request for and the provision of MAiD (unless natural death or loss of capacity is imminent).³⁶ This 10-day waiting period³⁷ does not seem to be a procedural safeguard well-suited to protecting against ambivalent, unsettled or poorly considered decisions. Nonambivalent, settled and well-considered decisions could be made within 10 days. Decisions made well beyond 10 days could be ambivalent, unsettled or poorly considered. In other words, 10 days is an arbitrary and a potentially underinclusive or overinclusive procedural safeguard in any given case.

4.6 Potential for conflict with involuntary hospitalization legislation

All provinces and territories have mental health legislation allowing involuntary hospitalization of those considered dangerous to themselves and/or others (Council of Canadian Academies 2018b, Appendix B, 243-4). Individuals with mental disorders (either as SUMC or as a coexisting condition) may request MAiD from health care providers. If such a request can be interpreted as a sign of danger to the individual, a health care provider confronted with a request for MAiD from someone with a mental disorder may face a challenging question: how can MAiD legislation be reconciled with involuntary hospitalization legislation?

³² Some of the complexities of MD-SUMC cases are reflected in the scenarios presented in appendix A.

³³ The *Belgian Act on Euthanasia of May 28, 2002 [Belgian Act]*, chapter II, section 3, subsection 1, unofficial translation by Dale Kidd (2002, 182-8). Accessed January 8, 2020. <http://eol.law.dal.ca/wp-content/uploads/2015/06/Euthanasia-Act.pdf>

³⁴ *Belgian Act*, chapter II, section 3, subsection 2.2.

³⁵ *Belgian Act*, chapter II, section 3, subsection 3.2.

³⁶ Criminal Code, section 241.2(3)(g): “Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must ... ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or – if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent – any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances.”

³⁷ The Quebec law does not stipulate a waiting period. However, the 10-day waiting period must be respected in Quebec because of the federal Criminal Code.

In some provinces/territories, this question is less challenging because the criteria for involuntary hospitalization require not only dangerousness to oneself and/or others but some form of decisional incapacity (e.g., in Nova Scotia, a patient must also lack capacity to make admission and treatment decisions).³⁸ Even if MAiD were considered to constitute “danger to self,” a person who retains decisional capacity could not be hospitalized involuntarily and may be able to pursue MAiD. Alternatively, a person who did not retain the decisional capacity required to avoid involuntary hospitalization, might be involuntarily hospitalized and would be unlikely to have the decisional capacity required for MAiD.

In most provinces/territories, however, one can be involuntarily hospitalized solely on the basis of danger to oneself or others (Saya et al. 2019, table 2, 271). In these jurisdictions, the question whether a request for MAiD per se constitutes danger to self needs to be addressed. If it does, a person could be involuntarily hospitalized for danger to self under the provincial/territorial legislation for requesting MAiD and at the same time, if capable of making a MAiD decision, be eligible for MAiD. Here the potential conflict between the MAiD and involuntary hospitalization laws is more apparent.

4.7 Impact upon suicide rates and related issues

Concerns have been expressed that increased access to MAiD for persons with MD-SUMC (with the removal of the “reasonably foreseeable” natural death and “end of life” criteria) could influence suicide rates (Jones and Paton 2015).

The CCA expert panel concluded, “[t]here is no evidence of any association between the legal status of assisted dying in a country and its suicide rate: some jurisdictions where assisted dying is legal have higher suicide rates than jurisdictions where the practice is illegal, and vice-versa” (Council of Canadian Academies 2018b, 96). The expert panel members did not agree on what conclusions could be drawn from the evidence about the potential impact of permitting more MAiD MD-SUMC on suicide prevention strategies (Council of Canadian Academies 2018b, 36).

Two expert witnesses in *Truchon and Gladu* raised the related issues that greater access to MAiD for persons with MD-SUMC could have a suicide contagion effect, and that it could undermine suicide prevention efforts; and they suggested that these effects could result in more suicides or premature deaths.³⁹ However, Justice Baudouin noted that “[t]o date, no study on the impact of medical assistance in dying on suicide contagion has been conducted in Canada or elsewhere in the world. There is, therefore, no probative data in this regard” [at para 331]. She concluded that “there is nothing to indicate that removing the impugned requirement will lead to an increase in requests for medical assistance in dying, influence the suicide rate in Canada, or undermine suicide prevention efforts” [at para 384].

³⁸ *Involuntary Psychiatric Treatment Act*, SNS 2005, c. 42, s. 17(c)(i) and (e).

³⁹ See, for example, the testimony of Sinyor on suicide contagion (at paragraph 332) and Sareen on suicide prevention (at paragraph 322) in *Truchon and Gladu*.

It is important to acknowledge that establishing the suicide rate can itself be challenging because of the difficulties in classifying deaths in certain circumstances as suicides or nonsuicides (Statistics Canada 2017). Establishing a causal association between legally permissible MAiD and variation in (unassisted) suicide rates would be extremely difficult given the large number of variables that influence the suicide rate in a particular geographical area among a specific population at a given period of time.

5. RECOMMENDATIONS AND CONCLUSION

As a group we reflected upon the CCA expert panel's report and the preceding foundations to generate a set of recommendations addressing the policy decisions that are now squarely in front of the federal and Quebec governments in respect of MAiD for persons with MD-SUMC. The first seven recommendations, which are directly related to MAiD, speak to ways of revising the MAiD eligibility criteria as well as to improving the professional competencies for clinical assessments to determine whether persons with MD-SUMC meet the eligibility criteria. They also call for the establishment of a new oversight process (for an initial five-year period) and the establishment of a consultation service for complex cases.

5.1 Statutory eligibility criteria

Recommendation 1: The federal and Quebec governments should not amend their laws to exclude all persons with MD-SUMC from accessing MAiD.

We do not recommend responding to the removal of the “reasonably foreseeable” natural death or “end of life” criteria by amending the Criminal Code and Quebec’s *Act Respecting End-of-Life Care*, respectively, to exclude all persons with MD-SUMC from accessing MAiD. This conclusion is grounded in the following beliefs and values:

- There is no reason to believe that suffering from mental disorders in some cases is not as intolerable and deserving of relief as suffering from physical disorders.⁴⁰
- Excluding all persons with mental disorders solely on the grounds that they have a mental disorder reinforces the false and stigmatizing view that all persons with mental disorders need to be protected from themselves (e.g., because they lack capacity).⁴¹
- Excluding all persons with MD-SUMC from accessing MAiD is discriminatory on the basis of diagnosis rather than on the basis of real capabilities (decisional capacity, ability to form well-considered judgments, etc.).

⁴⁰ Illustrations of this can be found in, for example, Styron (1992); Solomon (2001); and Toews (2014). High-profile Canadian cases include that discussed in Browne (2016) and *Canada (Attorney General) v. E.F.*, 2016 ABCA 155.

⁴¹ It would also remove access for a group of individuals who can be eligible under the current law – those with a mental disorder and a comorbid condition that meets the eligibility criteria (e.g., cancer).

- In some cases, it is possible for a practitioner to be of the opinion that a person's mental disorder is incurable and the person's suffering is enduring and intolerable and cannot be relieved under conditions that the person considers acceptable.
- It is possible to allow access to MAiD for certain persons with MD-SUMC and still protect those who need to be protected against overinclusion. This can be done through the improvement of mental health services and supports as well as the introduction of the additional eligibility criteria and procedural safeguards set out below.

Recommendation 2: The federal and Quebec governments should not add an eligibility criterion of a “nonambivalent decision” to their legislation.

We understand ambivalence to mean “having or showing simultaneous and contradictory attitudes or feelings toward something or someone” (*Merriam-Webster Dictionary* 2020). Ambivalence suggests that the person is torn between the options available. Persons may be ambivalent about many high-stakes or even life-threatening decisions (e.g., stopping dialysis or not trying another round of chemotherapy) and in our present system, such decisions are respected. In addition, under the current MAiD laws, people requesting MAiD are allowed to be ambivalent (i.e., ambivalence does not make them ineligible). For example, it would not be uncommon for individuals requesting MAiD to not want to leave their children but also want their suffering to end. They are torn between competing values and yet eligible for MAiD.

There is nothing unique to MD-SUMC that would justify adding an eligibility criterion of a “nonambivalent” decision for MAiD MD-SUMC.

We believe that a criterion of “well-considered” (discussed below) more properly takes into account aspects of decision-making that the law should be concerned about. It also achieves what most, if not all, people who are advocating for a criterion of non-ambivalence are actually seeking.

Recommendation 3: The federal and Quebec governments should add an eligibility criterion that a person's decision to request MAiD be “well-considered,” and they should define this criterion explicitly in the legislation to make clear that it does not require an assessment of the quality of the decision the person is making – that is, whether the assessor believes it to be a good decision – but rather an assessment of the decision-making process to ensure that it is well thought out and not impulsive.

We accept that it is reasonable for the law to have as an objective protection against impulsive and ill-thought-out decisions – whether MAiD is sought in relation to a physical or mental condition. The federal and Quebec governments can serve this objective by adding a generally applicable requirement that a decision to request MAiD be well-considered. In order to avoid the phrase being misinterpreted as requiring a certain quality of decision or as too anemic to achieve the desired protections, it is

essential that this phrase be explicitly defined in the legislation.⁴² The definition should include the following: (a) The person has given the matter careful thought on the basis of adequate information and an understanding of their condition and any alternatives to MAiD; and (b) The medical or nurse practitioners involved in assessing the person's eligibility for MAiD are of the opinion that the person would not change their mind about wanting MAiD if MAiD were not provided.⁴³

It must be emphasized that this criterion allows practitioners to take account of the phenomenon of adaptation – particularly relevant in the context of traumatic injury or onset of a serious disorder (a practitioner can, for example, reasonably believe that a person has not had a chance to develop an adequate understanding of their condition and alternatives to MAiD in the immediate aftermath of a serious car accident or cancer diagnosis) and in the context of MAiD for persons with MD-SUMC in the immediate aftermath of a diagnosis of schizophrenia or onset of bipolar disorder).

5.2 Standards for clinical assessments of eligibility criteria

Recommendation 4: Provincial/territorial regulators of physicians and nurse practitioners should establish explicit standards for clinical assessments of MAiD for persons with MD-SUMC.

None of the standards referenced earlier in section 2.4 of this report deal specifically with MAiD for persons with MD-SUMC. Yet the complexity of assessments in the context of MD-SUMC (as illustrated through the cases included in the appendix) warrant special attention. We recommend that standards be developed by provincial/territorial regulators⁴⁴ of physicians and nurse practitioners to make it clear that, in addition to anything required by standards established for MAiD in general (including the new requirements regarding well-considered decisions), a clinical assessment for MAiD for persons with MD-SUMC should include the following:

- Assessment by an assessor or provider who has, or obtains, a formal consultation with someone with, expertise in the grievous and irremediable medical

⁴² Unlike the Netherlands, which did not include the definition in its legislation (Regional Euthanasia Review Committees n.d.), we recommend the inclusion of a definition in the legislation. This is because, unlike the Netherlands, Canada does not have anything like that country's Regional Euthanasia Review Committees (2018) that can produce a "Euthanasia Code" to guide medical and nurse practitioners about the meaning of the federal MAiD law. It is also because we have learned the hard way how confusing and corrosive it can be to have key unfamiliar and undefined terms at the heart of the legislation (see, for example, the confusion and controversy over the meaning of the term "reasonably foreseeable" (Downie and Chandler 2018).

⁴³ Hesitation, expressions of doubt and even rescheduling MAiD would not be automatic exclusions under this criterion. A practitioner can reasonably form the opinion that a person has reached a point of not changing their decision about wanting MAiD even if previously hesitating, etc. As noted in the Dutch Euthanasia Code (Regional Euthanasia Review Committees 2018), "That a person hesitates or had doubts regarding such a profound step as euthanasia is understandable and is not necessarily a contraindication. The important thing is that the request should be consistent, taking account of all the patient's circumstances and utterances."

⁴⁴ The medical regulator in Quebec has already taken on this role (because nurse practitioners cannot provide MAiD under the Quebec legislation). We remain agnostic as to which body should perform this function but recommend that in every province/territory, the regulators and societies together ensure that it gets done.

condition that is the basis for the request for MAiD (preferably, but not necessarily, someone who is already familiar with the patient).⁴⁵

- An exploration of the available alternatives to MAiD with the person requesting MAiD (by the assessor, or by a specialist and documented for the assessor) with particular attention being paid to access to mental health services and social supports.
- A review of the person's social context. This should include discussions with friends, relatives and carers (if given permission by the person requesting MAiD).⁴⁶
- Reflection on the amount of time the person has had their condition. This goes to the eligibility criterion of appreciation of the consequences of the decision and irremediability of the condition and/or the suffering. The assessor should be confident that the person has been fully informed about the phenomenon of adaptation insofar as that is relevant to the person's circumstances. The assessor should also be confident that the person has had sufficient time living with the condition and has had a reasonable opportunity, given their condition and possible treatment options, for (1) the condition/suffering to be ameliorated; and (2) sufficient experience with the condition to reasonably assess the likely course of their condition or suffering.
- An exploration of the person's reasons for requesting MAiD, including whether the person's assessment of the intolerability and irremediability of their suffering is not inconsistent with the facts then known to the physician or nurse practitioner. This is to try to avoid correctable misunderstandings about the effectiveness and side effects of available treatments, correctable pathology-generated false premises or remediable (by means acceptable to the person) psychosocial factors driving the person's decision or subjective appraisal of their suffering. It is also to encourage the person to consider whether their decision coheres with their beliefs and values. This process will enable clinicians, as moral agents, to decide whether they can in conscience provide the assistance in light of the person's reasons.
- A review of the reasons given for any prior findings of ineligibility for MAiD (if the person requesting MAiD is willing to release their relevant medical records, recognizing that assessors should exercise extra caution if the person refuses to release prior assessments).

⁴⁵ It is worth noting here that, unlike some other jurisdictions in which MAiD for persons with MD-SUMC is permitted, the federal Criminal Code requires that two clinicians (physicians or nurse practitioners) both be of the opinion that the person requesting MAiD meets all of the eligibility criteria (section 241.2(3)(e)).

⁴⁶ While not identical to this recommendation, it is worth noting that the Quebec MAiD legislation requires that the physician discuss the patient's request for MAiD with "members of the care team who are in regular contact with the patient" and "the patient's close relations, if the patient so wishes" (sections 29(1)(d) and (e)).

5.3 Professional competencies regarding assessment of eligibility criteria

Recommendation 5: Training programs and continuing education providers should offer training to improve the eligibility assessment skills of MAiD assessors and providers for cases of persons with MD-SUMC.

Relevant skills here include the ability to conduct psychosocial assessments in cases of MAiD for persons with MD-SUMC as well as the ability to assess voluntariness and legal capacity to make decisions with respect to health, diagnosis, prognosis, and treatment options in the context of mental disorders. They also include the ability to work collaboratively with interdisciplinary team members which, in the context of MAiD for persons with MD-SUMC, include psychiatrists, family physicians with expertise in mental disorders, psychologists, nurse practitioners specializing in mental disorders, and mental health social workers and nurses.

5.4 Consultation

Recommendation 6: The federal government should establish a consultation service for providers, assessors and patients for an initial five-year period.

Given that the removal of the eligibility criteria (reasonably foreseeable natural death and end of life) is expected to broaden eligible medical conditions and thus increase the number of difficult cases, we recommend the establishment of a federally funded consultation service with an initial five-year mandate (subject to review to determine its ongoing utility). The intended benefits of this consultation service are transparency, accountability, education, quality improvement (both with respect to overinclusion and underinclusion) and support for clinicians and patients in the context of the federal MAiD legislation.

The consultation service should be empowered to establish consultation groups of three to five individuals (including clinical, legal and lay members).

The consultation groups should have a mandate to, on the request of a provider, assessor, or patient (but no other person)

- review relevant documents and clinical files submitted by patients or MAiD assessors or providers who are finding the case difficult;
- provide input to assessors and providers seeking such input to help them in their determination whether to proceed (whether in relation to finding the patient eligible or deciding whether to provide MAiD to the person if eligible);
- offer retrospective reflections on difficult cases (whether patients were found eligible or ineligible).

They should *not* have a mandate to

- formally assess whether an individual is eligible for MAiD (that remains the responsibility of MAiD assessors and providers);

- compel an assessor or a provider to find someone eligible or ineligible or to provide or refuse to provide MAiD.

The consultation service should have a mandate to publish annual reports on the issues that have arisen through their review of the cases that come before them and ensure their dissemination to the relevant communities of practice and to the public at large.

Engagement of the consultation service should be an optional resource to support providers, assessors and patients – that is, in no instances would it be a precondition of access to MAiD.

5.5 Oversight

Recommendation 7: The federal government should establish a *post hoc* peer review process for an initial five-year period for all requests outside Quebec for MAiD in circumstances in which the person did not have a diagnosis of a lethal condition.

It is important for the MAiD system to assure and to be seen to assure protection of and from access to MAiD, especially in such highly charged and complex contexts as MAiD for persons with MD-SUMC and other circumstances in which the person does not have a lethal (i.e., sufficient to cause death) condition. We recommend that in order to achieve this, the system should provide for an initial five-year period of oversight⁴⁷ for MAiD for nonlethal conditions that is more stringent than that applied to other forms of MAiD. We recommend that the additional oversight take the following form: require clinicians outside Quebec⁴⁸ to submit to a federally-funded *post hoc* peer review process involving consideration of explanations of how the eligibility criteria and procedural safeguards were met (for requests granted and declined).

This process will provide transparency that is essential to trust and accountability in relation to protection of and from access.

The following recommendations, which are indirectly related to MAiD, highlight how the current access to mental health services across Canada needs to be improved alongside the implementation of the *post-Truchon and Gladu* eligibility criteria. These are steps to be taken in conjunction with the recommendations directly related to MAiD. It should be emphasized here that for reasons given earlier in this report, they are not preconditions for amending the MAiD legislation.

⁴⁷ After five years, an assessment should be done to determine whether this additional oversight and monitoring of MAiD for persons with MD-SUMC continues to be necessary.

⁴⁸ Clinicians in Quebec would not be required to participate in the federal *post hoc* peer review process because Quebec already has its own oversight system, the Commission on End-of-Life Care.

5.6 Access to mental health services and supports

Recommendation 8: Federal/provincial/territorial governments should significantly improve and increase access to mental health services (especially in rural, remote, underserved and marginalized communities), particularly for persons with chronic, difficult-to-treat mental disorders.

Mental health services should receive a higher percentage of federal and provincial/territorial health funding than is currently provided. As recommended by the Mental Health Commission of Canada, an appropriate minimum level for funding mental health would be 9 percent of federal/provincial/territorial health services budgets (Mental Health Commission of Canada 2012, 126). In Canada, only 7.2 percent of health spending is directed to mental health; by contrast, 11 percent of the UK's NHS spending is directed toward mental health (Quilter-Pinner and Reader 2018).

The federal government should use its strategic spending programs to help provinces and territories improve and increase access to mental health services, particularly for rural, remote, underserved and marginalized communities. A significant amount of new federal funding has been directed toward health care, and we believe a greater portion of that should be explicitly dedicated to mental health services.

The federal government should follow through on its promise of national pharmacare⁴⁹ to ensure that persons who require medication for their condition will be able to access it. However, given the critical role that psychotherapy and rehabilitation plays in the treatment of mental disorders, it must go further than that. A variety of tools are available to the government, including changing the definition of services covered by the *Canada Health Act* to cover all “medically necessary” psychotherapy and rehabilitation services. The federal government should work with the provincial/territorial governments to build on the work of the Mental Health Commission of Canada to address the inequitable access to psychotherapy in Canada (2018).

Due to the differential impact that considerations regarding MAiD may have in relation to historically disadvantaged groups, the federal government should ensure that robust equity analyses are performed on all its mental health programs (whether funding or service delivery through Health Canada or on reserve and for armed forces, veterans, RCMP, federal prisons and federal employees), taking into account a variety of socio-demographic factors, including gender, race, ethnicity and income (Status of Women Canada 2018; Ontario n.d.). Specifically, in responding to this recommendation, the federal government should ensure that the risk of different levels of quality and access to mental health services and supports for men⁵⁰ and members of historically disadvantaged groups is explicitly assessed and addressed.

⁴⁹ “The Government will take steps to introduce and implement national pharmacare so that Canadians have the drug coverage they need” (House of Commons 2019).

⁵⁰ Men underuse mental health services (only about 30 percent of people receiving mental health services are men) and men represent 80 percent of deaths by suicide (Whitley 2018, 577-80).

The federal government should also work with provinces and territories to ensure that there is a national suicide prevention strategy in place.

Recommendation 9: Federal/provincial/territorial governments should improve and increase access to social supports for persons with mental disorders, particularly for persons with chronic difficult-to-treat mental disorders.

A number of new federal funding programs and strategies – such as the national housing strategy and the recent infrastructure funding – could improve and increase access to social supports for persons with mental disorders. Indeed, persons with mental disorders are an identified group in the national poverty reduction strategy, and specific steps are being taken to reduce poverty in this group (Employment and Social Development Canada 2018). We recommend that the federal government pay particular attention to social supports and use its spending power (direct and indirect through strings attached to transfers of funding to provinces and territories) to improve the lives of persons with mental disorders, particularly those with chronic difficult-to-treat mental disorders.

Recommendation 10: Provincial/territorial health departments should increase and improve “corridors of service” to facilitate family physicians and nurse practitioners taking on patients with mental disorders.

This recommendation is designed to respond to the serious problem of physicians and nurse practitioners being unable or unwilling to take care of patients with mental disorders, particularly those with chronic difficult-to-treat mental disorders (CAMH 2016). In order to act as primary care providers to such persons, family physicians and nurse practitioners need ready access to psychiatric consultation and a range of mental health services (including social workers, nurses, psychologists, occupational therapists and psychotherapists).

5.7 Interaction with some involuntary hospitalization legislation and practices

Recommendation 11: The federal departments of justice and health should work together with provincial/territorial departments of health (as well as with clinicians and experts in health law and ethics) to resolve the potential for overlap in MAiD eligibility criteria and involuntary hospitalization admission criteria.

The potential for confusion, controversy, and subsequent moral distress for all involved demands attention from legislators.

5.8 Voluntarily stopping eating and drinking or personal care

Recommendation 12: Professional associations should develop clinical practice guidelines to enable physicians and nurses to better respond to cases where voluntary stopping eating and drinking or personal care is used as an alternative to MAiD.

Even with the removal of the criteria “reasonably foreseeable” natural death and “end of life,” some individuals will not qualify for MAiD or will not want MAiD but will choose to voluntarily stop eating and drinking (VSED) or voluntarily stop personal care (VSPeC) as a way to end their suffering.⁵¹ We recommend that professional associations develop clinical practice guidelines to enable physicians and nurses to respond better to VSED and VSPeC (KNMG Royal Dutch Medical Association and V&VN Dutch Nurses’ Association Guide 2014). They would then be better able to (1) prevent VSPeC or VSPeC when individuals lack the capacity to make their own decisions or their condition/suffering may be remediable; and (2) palliate patients through VSPeC when it cannot be prevented (i.e., when patients have the capacity to decide and do not meet the criteria for involuntary hospitalization) and they are ineligible for or do not want MAiD but want to end their suffering.

5.9. Conclusion

Canadians must now decide under what conditions to permit and how to regulate MAiD for persons with MD-SUMC. The *Truchon and Gladu* decision has partly brought eligibility conditions back to those provided by the Supreme Court of Canada in *Carter SCC*, with real implications for MAiD for persons with MD-SUMC. The five-year review of the federal legislation, as mandated in the legislation itself, should commence in June 2020, and the issues involved in MAiD for persons with MD-SUMC can reasonably be expected to also be a part of that review. It is our hope that this report will contribute to the imminent public policy debate as both federal and Quebec legislators reflect upon how best to respond to the issue of MAiD for persons with MD-SUMC.

⁵¹ Personal care includes medical treatment (including artificial nutrition and hydration), oral feeding and turning to prevent pressure ulcers for a person with paralysis. For more on VSED and VSPeC, see Health Law Institute (n.d.).

APPENDIX: CASES TO INFORM REFLECTIONS ON MAiD LAW AND PRACTICE

The decision to request and obtain MAiD is the result of individuals' reflections about their experience of illness, disease or disability, as well as their values, commitments and life trajectory. Mental disorders potentially affect all of these spheres of human life. The following cases – fictionalized but derived from real circumstances – illustrate this point and provide a glimpse into the diverse situations in which a person with a mental disorder as the sole underlying medical condition might make a request for MAiD. The cases are designed to stimulate reflection on whether existing or recommended eligibility criteria properly identify persons who should have access to MAiD and those who should not. We suggest a few guiding questions to assist in this exercise:

1. What is the central issue or problem in the case?
2. Should the person be considered eligible or not for MAiD? Why or why not?
3. If it is uncertain whether the person ought to or ought not to be considered eligible, is there additional information that would be convincing in either direction?
4. Is there uncertainty in the case that cannot be resolved through further information?

Case 1

Ms. A. is a 63-year-old single woman who was diagnosed with bipolar disorder at age 35. She is the older of two siblings. Her younger sister died by suicide 20 years ago. Her mother lives independently in an apartment and is in reasonable health. Her father died 10 years ago of a heart attack. Ms. A. was a secondary school teacher but was unable to maintain her employment due to the frequency and duration of her absences from work resulting from her disorder. She has been hospitalized approximately 10 times since diagnosis, and involuntarily on 4 occasions. She was given electroconvulsive therapy on three occasions against her prior expressed wishes and despite the fact that her mother (her substitute decision-maker) refused consent, but on the authority of the medical director of the hospital (as is permitted by law in British Columbia where she lives). She has had ongoing care with a psychiatrist since she was first diagnosed, and she has tried multiple different medications and combinations of medications for her condition. She has also had extensive psychological and social service supports through the local hospital's department of psychiatry. Despite regular treatment by her psychiatrist and mental health team, her depressive episodes have grown longer and more severe as she has aged, and the side effects of treatment have become more limiting. She also fears another psychiatric hospitalization, which she does not want. She has never attempted suicide because she fears further traumatizing her mother given her sister's suicide. However, over the last few years, she has come to the conclusion that she does not want to go on living with her condition. She asks her psychiatrist for MAiD.

Case 2

Mr. F. is a 64-year-old single man with no children. He is an only child and his father is deceased. His mother has Alzheimer's dementia and does not recognize him anymore. He was a model until his early 40s and has always been admired for his physical attractiveness. He has maintained himself in good physical shape by regular exercise at his gym, which he attends as often as possible. Despite reassurances from his friends that he looks good, he hates his aging body. Over the last few years, he has grown increasingly anxious about his perceived bodily defects and how others might judge his looks. He limits his social interactions to telephone calls with his friends and goes out to do errands and to the gym when he is likely to encounter the fewest number of people. He has consulted a psychiatrist and was told he had an anxiety disorder. However, he does not believe he requires treatment because he believes his worries are appropriate in light of his circumstances. When he looks to the future, he thinks about how his appearance will continue to worsen. He does not want to die a "withered old man" but prefers to die now so that whoever comes to his funeral will see a "handsome corpse." At his annual appointment with his general practitioner, he asks if he is eligible for MAiD.

Case 3

Ms. C. is a 55-year-old woman with one adult son aged 33. She and her son's father divorced when she was 30 and shared custody of their son. She has suffered from fibromyalgia since age 35 and has not worked since that time. She was diagnosed with a major depressive episode at age 38. She has had numerous depressive episodes for which she has taken and continues to take various treatments but whose symptoms have never fully remitted. She has consulted a few different psychiatrists regarding treatment options but her main health care provider is her family doctor. She maintains a good relationship with her son, although sees him only occasionally as he does not live close by. Her only source of revenue is provincial disability benefits. She cannot afford many outings but also lacks interest in most activities and over the last 10 years has grown increasingly isolated. She made a serious suicide attempt 12 years ago after which she was hospitalized involuntarily for four weeks. A year and a half ago she considered taking an overdose of medication but instead she called 911. She was seen by a psychiatrist in the emergency room but was not hospitalized as she said she felt safe and promised to follow up with her general practitioner regularly, which she has done. Now she asks her GP for MAiD, stating that her situation is unlikely to improve and she sees no point in going on any further. She says, "I have wanted to die for almost 20 years."

Case 4

Mr. D. is a 22-year-old man who was diagnosed with schizophrenia six months ago. He first became symptomatic 18 months ago while he was attending university for a bachelor's degree in engineering. He became certain one of his professors was leading a plot against him. He stopped attending classes and devoted himself to finding proof that would expose the professor. One night in a paranoid state, he shouted threats at passersby in the street who he believed were also involved in the plot. The police were

called and brought Mr. D. to the emergency room. He was subsequently hospitalized for the first time in the psychiatry unit. He remained in hospital for five weeks undergoing evaluation and stabilization with treatment that has been effective in reducing his paranoia. Since being discharged, he has had regular follow-up with the team in the hospital's highly regarded first-episode psychosis clinic. He is living with his parents but has had to withdraw from university. This has been a source of disappointment and shame for him. Since his hospitalization, he does not contact his friends from university because he does not want to tell them about his diagnosis. He has read about schizophrenia and is terrified about his long-term prognosis. He tells the team at his next clinic appointment that he wants MAiD.

Case 5

Ms. E. is a 48-year-old single woman. She was abandoned by her parents when she was a baby and raised in a series of foster homes. She was sexually abused on multiple occasions by a 16-year-old foster brother when she was 11 years old. She lived on the streets for about one year following her release from the foster system at age 16. While on the streets, she regularly used crack cocaine and at times resorted to prostitution to survive. She made two suicide attempts by drug ingestion during this period. She was arrested at age 19 but was offered a place in the drug rehabilitation program instead of prison. As a result of this intervention, she ceased using drugs, completed her education, and obtained employment at a hotel as an administrative assistant. She was referred to a psychiatrist on one occasion after she reported feelings of depression to a general practitioner whom she saw infrequently at a walk-in clinic. The psychiatrist said she had dysthymia and suggested she seek out psychotherapy, which she did not do. She has a few acquaintances from work and in her apartment building but no close friends or known family members. She has had a few short-term intimate relationships. She has long-standing beliefs that she is worthless and unlovable. She goes back to the walk-in clinic and requests MAiD.

Case 6

Mr. G. is a 78-year-old widower with congestive heart failure currently in hospital recovering from a recent exacerbation of this condition. He lives independently but has difficulty going out because walking leaves him short of breath. He has two adult children, a daughter who is 50 and a son who is 48. They live nearby but do not have a positive relationship with him. When they were young, their father was a heavy drinker. He was never physically abusive, but he was bad-tempered when he was intoxicated. He no longer drinks but continues to be demanding, and belittles those around him. His contact with his children is restricted to occasional phone calls, and they have not come to see him in hospital. His dismissive behaviour in hospital leads the treating team to request a psychiatric consultation. The psychiatrist diagnoses him with narcissistic personality disorder. Given his lifelong pattern of behaviour, the psychiatrist is not optimistic that much change is possible and, in any case, Mr. G. does not believe he has a problem. During the assessment he revealed that he feels hurt that his children do not visit him. However, he refuses any social intervention likely to facilitate a

visit by his children because he does not want to “beg” them to come. He requests MAiD in order to “make them pay” for their behaviour.

Case 7

Mr. H. is a 30-year-old single man who started using marijuana at age 14. He is the youngest of three boys in his family. He lives in the basement of his parents’ home. He has worked occasionally at part-time jobs but much of the time he remains in the basement using pot. His marijuana use is heavy, up to 9 grams per 24 hours. At his family’s urging he has attended various substance abuse programs but has never been abstinent for more than a week because he does not want to stop. He also had a psychiatric consultation the last time he was involved in such a program and the psychiatrist diagnosed a substance-use (marijuana) disorder. His marijuana use has led to much conflict within his family over the years because his siblings want his parents to ask their son to move out. However, his parents do not wish to do so, even though they are upset and angry about their son’s behaviour, because they fear he will come to harm. Their other two sons will no longer visit the family home, but their parents visit them at their homes. Everyone avoids the topic as much as possible. Mr. H. sees no resolution to this impasse. He goes to the emergency room at a nearby hospital and asks the doctor who sees him if he can receive MAiD.

Case 8

Ms. B. is a 32-year-old woman, the youngest of four siblings with a 10-year age gap between her and her next sibling. She has suffered from anorexia nervosa since age 16. She has been hospitalized four times for the condition, once in a pediatric hospital before she was 18 and three times as an adult. All hospitalizations were in specialized eating disorder programs. During the last two hospitalizations at ages 26 and 27, her treating physician obtained a court order to force-feed her because she would not eat and her weight was judged to be dangerously low. She has received mental health care with the eating disorder team after each hospitalization. After her first two hospitalizations, she was discharged from specialized follow-up because she was considered to be stable. Following the third hospitalization she lost weight during her follow-up period and had to be rehospitalized. After her last hospitalization, her weight remained stable for several months, but she dropped out of treatment and has not followed up. Since that time she has continued to seriously restrict her intake. She ensures that her body mass index is just above the cut-off for involuntary hospitalization in the eating disorder program. Ms. B. lives alone and receives social welfare. Her parents also provide her with some financial assistance. She has regular contact with them by phone but visits only occasionally because when they see her, they want to engage her in discussions about her weight and eating. She has cordial but distant relationships with her siblings. She had a brief period during her early 20s when she worked as a receptionist, but she has not worked since. She is aware that others stare at her because of her size, and she finds this embarrassing. She perceives her quality of life as very low in her current state of health but will not entertain gaining any weight. She decides to draft an advance directive stating that she does not want to be force-fed under any circumstances. She also asks her family physician whether she is eligible for MAiD.

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